10 W. Eager Street
Suite 324
Baltimore, MD, 21201
Phone: (443) 445-0536 Fax: (443)-753-4753

PATIENT ACKNOWLEDGEMENT FORM

I hereby accept financial responsibility to pay Breakthrough Behavioral Health Services LLC, all amounts not covered by my health plan, including amounts for copayments, coinsurance, fee scale payments, deductibles, non-covered services and services for which I have not received a proper authorization or a referral.

In addition, I accept financial responsibility for any health care benefits that are denied because I am not eligible to receive those benefits at the time of service. I understand that Breakthrough Behavioral Health Services LLC, accepts payment by cash, credit card, money order or check. Payment is generally required for all services at the time the services are rendered, although Breakthrough Behavioral Health Services LLC, reserves the right to later send you an invoice for health benefits that may be denied by your health plan. I authorize my health plan to make payment to Breakthrough Behavioral Health Services LLC, for services rendered. I also authorize Breakthrough Behavioral Health Services LLC, to use and disclose my health information as necessary to obtain payment. I understand that Breakthrough Behavioral Health Services LLC, will hold me financially responsible if I choose not to have my health plan cover a service.

I also authorize Breakthrough Behavioral Health Services LLC, to appeal any denial of services or benefits by any health plan on my behalf. If my account is sent to a collection agency for non-payment, I agree to pay all reasonable fees that are charged to collect the outstanding amount that is due to Breakthrough Behavioral Health Services LLC, including reasonable attorney's fees, interest and court costs.

General Consent to Treatment

I, or my legal representative on my behalf, agree to have Breakthrough Behavioral Health Services LLC, care practitioners provide evaluation and treatment for my condition.

Acknowledgement

By signing below, I acknowledge that I have carefully reviewed this form, have had the opportunity to ask questions, and voluntarily agree to its provisions.

Patient Legal Name (printed):_____**DOB**:_____

Signature of Patient or Legal Representative:_____**Date**:_____