Tri-County Behavioral Care, LLC
973-691-3030 tcbllc.org

1. Assignment of Benefit Release

I hereby agree to treatment and release of payment by my insurance plan to Tri-County Behavioral Care, LLC for services rendered. I understand that I am financially responsible to Tri-County Behavioral Care, LLC for charges which are not covered by my benefit plan.

_____ _____ _____

Date **Signature of Parent/Guardian** **Signature of Patient**

2. Missed Appointment Fee

24 hours notice is required if you have an appointment you are unable to keep. This policy is in effect to ensure that canceled appointments can be given to patients who need to be seen. Please be advised that the missed appointment fee will be $25 for each appointment that is missed without 24 hours notice given. By signing this notice, you indicate that you understand and agree to this policy.

_____ _____ _____

Date **Signature of Parent/Guardian** **Signature of Patient**

3. Notice of Privacy Practices

Client's Name:_____ DOB_____ SSN_____

I hereby acknowledge that I have read a copy of the Notice of Privacy Practices. If I request a written copy of this notice, then I will be given one. I understand that if I have any questions regarding this Notice or my privacy rights, I can contact Tri-County Behavioral Care, LLC at 973-691-3030.

_____ _____ _____

Date **Signature of Parent/Guardian** **Signature of Patient**

- Client Refuses to Acknowledge Receipt of Notice of Privacy Practices