The Ida Karlin Healing Center for Youth

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Informed Consent/Agreement:

- ✓ I have been informed of and understand the Center's *Late Policy*.

- ✓ I have been informed of and understand the Center's *No-Show/Late Cancellation Policy*. I understand that a no-show or late cancellation will result in a $20 charge that is not covered by any insurance. I understand that three consecutive no-shows or late cancellations may result in dismissal from the Center.

- ✓ I understand that I am ultimately responsible for payment of all charges incurred by the medical services rendered by the Center. I understand that the Ida Karlin Center is committed to providing quality care for ALL patients and that financial arrangements may be negotiated in an effort to meet the financial challenges families may be experiencing. I also understand that I am responsible for informing the Center of my need to make these arrangements.

- ☐ I have been informed and understand that the following services are not covered by my (DSHS) medical insurance/assistance plan and are not included as part of another service, or have been determined (by DSHS) as not medically necessary. **I still choose to receive the specific service. I agree to pay for the specific service.** The following is the specific service the guarantor requests to receive and for which the guarantor agrees to pay:

  _____

  _____

  _____

  _____

  I also understand that if my (DSHS) medical program covers the service listed above or if the provider fails to satisfy (DSHS) conditions of payment as described under WAC 388-87-010(6), then I am under no obligation to pay the provider for these services.

- ☐ I understand that I am responsible for payment of the charges incurred by the medical services rendered on _____/_____/_____. If my (DSHS) medical insurance determines me ineligible for coverage, I understand that payment for these charges become my personal responsibility.

Signature of patient/guardian/representative: _____

Date: _____/_____/_____

I understand the purpose of this form and my questions were answered to my satisfaction.
Provider #: DSHS 7110653