SOUTHWEST CARES

CONSENT FOR SERVICES AND CONSENT TO BILL INSURANCE

I give Southwest Cares LLC permission to provide appropriate psychological/mental health and/or psychiatric services, as necessary, to the following individual:

_____	_____	_____
Patient's Name - Please Print	Patient's Date of Birth	Name of Facility or Setting

Southwest Cares provider is to be assigned.

I agree that this consent will remain in effect if the above patient is transferred to another facility contracted with Southwest Cares, LLC. I acknowledge receipt of the Patient Privacy Notice entitled: *Privacy Policy*. Further, I understand that patient's physician has ordered these services, and that the treating provider will confer with patient's physician as needed.

I request the payment of authorized Medicare, Medicaid and other private insurance benefits are made either to me or on my behalf to Southwest Cares LLC for any services furnished to patient by his and her provider.

I authorize any holder of medical information about patient to release to the Center for Medicare and Medicaid Services and other private insurance and its agents any information needed to determine these benefits or the benefits payable for related services.

Sign Here

X _____ _____

Signature - Patient, Legally Responsible Party, or Individual Signing for Patient — Date - mm/dd/yy

X _____

Legally Responsible Party's printed name and relationship to Patient.

- or -

If Patient is unable to sign, print name of person signing for patient, relationship to patient and reason patient cannot sign.

CONSENT MUST BE OBTAINED BEFORE SERVICES ARE PROVIDED. THE CONSENTING PARTY MAY REVOKE THIS CONSENT BY NOTIFYING SOUTHWEST CARES IN WRITING AT ANY TIME.