Therapy Resource Associates
One Professional Square
10824 Old Mill Road, Suite 21 Omaha, NE 69154-2642
Phone 402.330.6060 Fax 402.330.6108

CONSENT TO TREATMENT

I, ____, consent for treatment for therapy/counseling for
your name

( )myself or for ( )minor ____
minor's name

by ____.
therapist / Dr.

I grant this psychologist / therapist / physician to perform those procedures and treatment necessary

for my condition that are generally used in this and similar settings.

____ ______________
signature date

If the minor child in your care is placed with you by the authority of his/her parents or the court, please provide said legal documentation and appropriate consent to treat.

PAYMENT POLICY

In consideration for services rendered or to be rendered, I understand that I am responsible for payment at the time of service. THERAPY RESOURCE ASSOCIATES, INC. files for insurance benefits as a convenience to TRA clients. In such case, I am responsible for making my insurance copayment at the time of service. If my policy prohibits direct payment to TRA then I hereby also instruct and direct the insurance company, Policy # _______________________________ and Group# ______________ to make the check to the insured and mail it to TRA at the above address.

I further agree that should the insurance be insufficient to cover the entire expense or does not cover the expense once the Explanation of Benefits is received, that I am responsible for payment of services. Bills for unpaid charges and filing dates for insurance claims are sent monthly. My prompt payment of unpaid balances is expected monthly.

____ _________________ _______________
Responsible Party Signature Social Security # Date