

**Transformation Behavioral Health, LLC
Guarantor/Responsible Party Agreement**

Client's Name _____ DOB: _____

Guarantor/Responsible Party Information (please complete entire form)

Name _____ Relation to client _____

Address _____

City _____ Zip Code _____ Contact #: _____

Employer _____ Address _____

Primary Insurance _____ Secondary Insurance _____

EAP Company _____ Authorization # _____

Number of Approved EAP sessions (if applicable) _____

ID/Social Security #: _____ DOB: _____

Please Read Completely Before Signing

I authorize the release of medical information necessary to process any of my insurance claims and I authorize payment of medical benefits directly to Transformation Behavioral Health, LLC for services rendered. I understand and agree that regardless of my insurance or EAP status, I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. I am aware I will be charged the insurance allowable rate, or standard fee if private pay, for any missed appointments which are not rescheduled or cancelled within 48 hours of the scheduled appointment time of no less than \$65.00. I authorize Transformation Behavioral Health, LLC to file a claim for these services (and to refile as necessary to collect) with the patient's insurance(s) /EAP and bill the patient for any amounts for which they are responsible. I further authorize American Billing, LLC to sign said claim(s) or any refiled claims on my behalf. The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian, or patient that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account. Should the account be referred to an attorney or collection agency, the undersigned shall pay reasonable attorney's fee and collection expenses of no less than **\$75.00.**

Additional Fees not included in therapy process fee: (1 x courtesy letter to Pediatrician or PCP @ no additional cost after **3 sessions only**) Completion of Letters for *school* of service participation \$35.00 ea., *Attorney or Court letters* \$60.00 and up ea., *Subpoena* for any case, which client is a participant \$150.00 paid in advance an hour (no less than 2 hrs. minimum) not limited to the above common request. DOT-SAP assessment fee: includes all required documentation, recommendations, and follow-up services
*Fee upon request

***This form must be signed by persons age 18 or older, or parent or legal guardian**

Responsible Person's Signature: _____ **Date:** _____