PATHWAYS
Center for Learning & Behavioral Health, LLC

Thomas B. Allen II, Ph.D. — *Christine Migdole, LCSW*
Suzanne D. Pascoe, LPC — *Loren B. Sterman, LCSW*
Susan Scott, LMFT — *Tracy A. Shiring, M.S. Ed*
Tori Piraino, LCSW — *Lisa N. Backus, Ph.D.*
Mari Jo MacInnis, LMFT — *Sarah A. Hallwood, LCSW*
Jarel Gallman, LMSW — *Rolando Martinez, LCSW*
Christina Ignatiadis, LMSW — *Margaret R. Watson, Psy.D.*
Kristina Belevich, LCSW — *Judith Mohr, LMSW*

FINANCIAL POLICY

We will bill your insurance provider when we participate in their insurance network as a courtesy to you. However, should your insurance provider refuse to pay for services rendered, it is your responsibility to cover the cost of these services. We require arrangements for payment be made at the time of each visit. In the event that your insurance carrier requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit that amount to *PATHWAYS.*

I understand and agree that if I fail to make any of the payments for which I am responsible within 90 days, my account will be charged an additional 1.25% interest fee. Not to exceed 15% annually. If my account becomes delinquent and is sent to a collection agency, I may be responsible for additional fees incurred in the collection process.

PAYMENT IS DUE WHEN SERVICES ARE RENDERED: co pays, co insurance, deductibles or self pay balances.

I have read and understand the above information. I understand my responsibility for the payment of my account.

X_____ _____
Patient or Parent 1 or Guardian 1 **Date**

X_____ _____
Parent 2 or Guardian 2 **Date**

X_____ _____
Provider Signature **Date**

CONSENT FOR TREATMENT

I, the undersigned, do hereby agree and give my consent for *PATHWAYS* to provide psychological/psychiatric assessment and treatment to _____ as considered necessary and proper in diagnosing or treating his/her condition.
(name of patient)

Patient or Parent 1 or Guardian 1_____ Date_____
(signature)

Patient or Parent 2 or Guardian 2_____ Date_____
(signature)

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all mental health benefits to include major medical benefits to which I am entitled, including Medicaid, private insurance and third party payers to *PATHWAYS.* A photocopy of this assignment is considered to be as valid as the original. I, hereby authorize the release of all information necessary, including patient records, to secure payment.

Patient or Parent 1 or Guardian 1_____ Date_____
(signature)

Patient or Parent 1 or Guardian 1_____ Date_____
(signature)

251 Westbrook Rd., Essex, CT 06426 Phone: 860-767-1277 FAX: 860-767-7712
314 Flanders Rd., Suite 2 B, East Lyme, CT 06333 FAX: 860-691-1546
2418 Boston Post Rd., Guilford, CT 06437 FAX: 203-689-5096
152 Broad St., Guilford, CT 06437
www.pathwaysct.com