PREMIER PSYCHOLOGICAL
COUNSELING & CONSULTING, PC
PREMIER TMS
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1490 E Foremaster Dr., Suite 340 – St. George, Utah 84790

PATIENT CONSENT FOR TREATMENT

I have read and understand the **Outpatient Service Agreement (OSA)** that explains policies and procedures regarding emergencies, patient confidentiality, billing, insurance, and, I consent to treatment under the conditions described. I authorize the release of information to my insurance company (if applicable). I understand that I am ultimately responsible for the balance due, regardless of how my health insurer may respond to claims. I agree to the OSA described terms regarding interest, collections charges, charges for appointments missed or cancelled, late fees for checks returned unpaid, and payment of costs of collecting delinquent accounts.

The required credit card to be used to bring my account current if it is not paid from another source 30 days after receiving a statement is provided below. I also authorize PremierPCC/PremierTMS to validate this card by making a nominal charge which will be credited to my account.

Visa MasterCard Amex (circle one). # _____ Exp: _____
3 or 4 digit Card Security Code_____ Billing zip code for card: _____

I HAVE READ THE INFORMATION IN THIS DOCUMENT AND CONSENT TO ABIDE BY THE TERMS STATED HEREIN.

_____ _____
Patient Signature Date

_____ _____
Legal Guardian Date
(If client is a minor)

_____ _____
Financially Responsible Party Date
(If different)