SAPIA PSYCHOLOGICAL ASSOCIATES, INC.
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CONSENT FOR TREATMENT AND CLIENT AUTHORIZATION

I_____ give consent for mental health services / treatment from Sapia Psychological Associates Inc. and request the payment of authorized insurance benefits to be made on my behalf to Sapia Psychological Associates Inc. for these services. I authorize any holder of medical information about me to release to my insurance company or to the Center of Medicaid and Medicare Services and it agents any information needed to determine these benefits or the benefits payable for related services. I understand that my records will be kept on file at the facility listed at the top of this form. My responsible party may be informed that I am receiving services for billing purposes unless I request otherwise. If applicable I authorize the release of information to the facility where I reside as deemed necessary by Sapia Psychological Associates Inc.

I was informed of the right to treatment, including medical care and habilitation, regardless of my age or degree of MH/IDD/SA disability. I was given a copy of the grievance and complaints related to the Trillium provider network.

I was informed of the right to contact the Governor's Advocacy Council for Persons with Disabilities (GACPD)(sic) Disability Rights North Carolina, the statewide agency designated under federal and State law to protect and advocate the rights of persons with disabilities.

I grant permission to seek emergency medical care from a hospital or physician.

_____ _____
Client or legal guardian Date

_____
Witness