Susan Weltner-Brunton, Ph.D. & Associates, Inc.
921 Chatham Lane, Suite 112
Columbus, Ohio 43221
Phone 614-754-7648
Fax 614-754-7965

An Association of Independent Practitioners

Susan Weltner-Brunton, Ph.D.
Laura L. Williams, Ph.D.
Patty Lathrop, Ph.D.
Amy Coleman, MSW, LISW
Marla Arnold, Ph.D.
Alissa Shrader, MSW, LISW-S

Financial Responsibility & Release of Information (Third Party Payers)

I hereby agree to financial responsibility for services rendered to members of my family or myself by Susan Weltner-Brunton, Ph.D. & Associates, Inc. I understand that, even though I might have health insurance benefits for all or some services, I am responsible for my deductible and any co-payments as specified by my insurance plan. I hereby authorize Susan Weltner-Brunton, Ph.D. & Associates, Inc. to release any and all information needed to obtain payment from third party payers for services rendered. I authorize use of this form on all of my insurance submissions. I authorize Susan Weltner-Brunton, Ph.D. & Associates, Inc. to act as my agent in helping me obtain payment from my insurance carriers. I authorize payment directly to Susan Weltner-Brunton, Ph.D. & Associates, Inc. I permit a copy of this authorization for use in place of the original.

_____ _____

Signature Date Witness Date

Consent

I hereby give consent for _____ to receive services rendered by employees and associates of Susan Weltner-Brunton, Ph.D. & Associates, Inc. This consent will expire upon the termination of services unless otherwise revoked in writing by the client or the client's guardian.

_____ _____

Parent/Guardian Signature Date Witness Date

(Continued)

Private Pay

I understand that I have elected a service which is not covered by my health insurance or I have elected to pay privately for services. I hereby agree to accept financial responsibility for _____ rendered by _____
(service) (clinician)
of Susan Weltner-Brunton, Ph.D. & Associates, Inc.

_____ _____
Signature Date Witness Date