Counseling Resource Center

Statement of Financial Responsibility / Agreement of Benefits
Counseling Resource Center

I acknowledge that I am legally responsible for all connection with the medical care and treatment provided by representatives of Counseling Resource Center. I assign and authorize payments to Counseling Resource Center. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefits exclusions,coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payment and policy deductions and co- insurance except where any liability is limited by contract or State or Federal Law.

Signature of Client or Guardian   Date

Printed Name of Client or Guardian   Relationship to Client