# *Indianapolis TMS*
# Consultation and Insurance Consent

**AUTHORIZATION FOR INDIANAPOLIS TMS TO OBTAIN AND RELEASE MEDICAL INFORMATION FOR AUTHORIZATION AND CLAIM FILING PURPOSES:**

I hereby authorize Indianapolis TMS to release any information regarding services rendered by professionals at Indianapolis TMS to my insurance company, and allow a photocopy of my signature to be used, for the purpose of obtaining reimbursement from my insurance company. (Initials) _____

I understand that Indianapolis TMS may or may not be in network with my insurance company or network. I further understand that Indianapolis TMS will work with my insurance company for coverage for these services. I further understand that I am responsible for whatever amount my insurance does not pay. (Initials) _____

**I also understand that Indianapolis TMS is not a certified Medicaid, Medicare or TriCare provider and, if one of those is my medical plan, that Indianapolis TMS cannot submit a claim for services provided here and neither will the insured.** (Initials) _____

**X**_____ _____

signature of client or guardian — date

**INDIANAPOLIS TMS PRIVACY PRACTICE ACKNOWLEDGMENT:** A copy of the Indianapolis TMS **Notice of Privacy Practices has been provided for me to read and review. I understand that a copy will be made available for me to keep if requested.**

**X**_____ _____

signature of client or guardian — date

**X**_____ _____

signature of Indianapolis TMS Staff — date