The Atrium
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Phone: 215-550-1818
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Waiver of Medicaid Coverage for Mental Health Care

Patient Name: _____

Parent Name (if child is under 18 years old): _____

I hereby acknowledge that I have been informed that my therapist, _____ , and Bucks County Anxiety Center are not credentialed Medicaid providers. As a result, I will not be able to use my Medicaid benefits and I will not be able to submit receipts for reimbursements. I will have to pay for each session completely out of pocket at the time of the session. I have also been informed that, should I choose to use my Medicaid benefits, I will need to terminate treatment with my therapist and any connection to Bucks County Anxiety Center in order to see a Medicaid provider at another practice.

Patient Signature: _____ Date: _____

Parent Signature: _____ Date: _____