Acknowledgment of HIPPA Consent Bill of Rights

Patient Name: _____ **DOB**: _____ **SSN:** _____

Gender: ___ Male ___ Female **Marital Status**: ___ Single ___ Married ___ Divorced ___ Other

Employment Status: ___ Employed ___ Full-time student ___ Part-time student ___ other: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone :_____

Emergency Contact: _____ Emergency Contact Phone:
_____

*By **initialing** next to the following statements and providing my **signature** below, I understand that I have been informed of and agree to abide by the policies and procedures as indicated. I understand that I have the right to have these policies provided to me in an alternative format, including orally, and that I can revoke any or all of these consents at any time by written request.*

Acknowledgment of Receipt of the Following Documents:

_____ (initial) I have been made aware that a copy of Courage Consulting & Counseling for the individual or family (CCCIF), LLC *Notice of HIPAA Privacy Practices* is available to me at my request.

_____ (initial) I have been received a copy and made aware that a copy of the CCCIF, LLC *Information about Our Psychological Services and Policies and Procedures Related to Client Rights and Responsibilities* is available to me at my request. I understand my rights, including those related to confidentiality and its limitations.

____ (initial) I clearly understand that I am ultimately responsible for payment to CCCIF, LLC for any and all services rendered due at the time of the visit or upon receiving explanation of benefit information from my insurance company, whichever comes first. I also understand that if I suspend or terminate my care and treatment, any outstanding balance will be immediately due and payable. I understand that if I should default on any payment obligations as called for in this agreement, CCCIF, LLC will have the right to forward my information to collections.

_____ (initial) Or to a third party billing for services rendered through CCCIF, LLC

Consent to Treatment

_____ (initial) I give my consent to receive mental health services from CCCIF, LLC for myself or for the following *minor child for whom I am the child's parent or legal representative. The services may be provided by clinic professional or administrative staff. Mental health services may include a diagnostic interview, psychotherapy, psychological testing (if indicated), and involvement in the treatment planning process for all services that are received through this clinic.

Fees

____ (initial) I agree to pay copay or agreed upon fees at the beginning of each session _____ copay _____ self-pay.

____ (Initial) **CANCELLATION OF SCHEDULED APPOINTMENTS** must be done with a 24 hours notice. With regards to commercial insurance or self-pay clients, if this 24-hr requirement is not met, a $50 late cancellation/no show fee will be assessed. If there is a second occurrence, a $75 fee will be assessed, and a third occurrence a $75 will be assessed, and a conversation with your therapist to determine if therapy is appropriate at that time. If there is a **No Show No Call (NSNC)** you will be assessed a $85 fee. **Insurance companies do not pay for missed appointments.**

____ **(Initial)** CCCIF, LLC requires a Credit Card on file for all clients with a deductible and/or co-insurance. Your credit card, encrypted and stored securely, will be charged at the end of the month for any unpaid balance in that account billing cycle. Clients are requests to and always have the opportunity to pay on-line, by mail or in person, prior to their card being charged.

____ (initial) I understand these services will be billed to my insurance provider, and the event that they do not pay, I am responsible for payment for services provided at CCCIF, LLC.

____ (initial) In the event that my bill has not been paid or payment arrangements have not been made, My bill will be submitted to collections after 90 days.

A copy of a divorce decree or other legal documents (i.e. court orders, orders for protection, restraining orders, or custody/visitation orders) may be requested by the clinician or administrative staff as it may pertain to this child's mental health care. At the discretion of the clinician, a Child/Adolescent Therapy Contract may be required. Such legal document(s) shall be kept in the child's mental health record.

Signatures:

Name of Client: _____ Date: _____

(please print)

Parent's or Legal Representative's Name: _____

(please print)

Client's (or Legal Representative's) Signature: _____ Date:_____

Witness Signature: _____ Date: _____