Acknowledgments and Agreements

1. FINANCIAL AGREEMENT:
I agree to pay in full for all services and supplies received by me or the designated client from B Johnson LLC. I agree to pay at the time of the services or supplies, unless special arrangements are made by me, the managed care organization, or the insurance carrier.

Initial:_____

2. ASSIGNMENT OF INSURANCE BENEFITS:
B Johnson LLC will file insurance claims as a courtesy to me. It is my responsibility to notify B Johnson LLC of any changes to insurance and to supply B Johnson LLC with any documentation or information necessary to file claims. If my insurance company(s) pays nothing or only a portion of the charge(s), I will be required to pay the balance of the account. Insurance companies' policies differ in paying for services. I am responsible for all fees on services not covered by my insurance policy, including deductibles and co-payments. I authorize payment to B Johnson LLC/ Bethany Johnson LCSW for insurance or any other third party benefits payable to me. I also understand that verification of benefits by B Johnson LLC does not guarantee payment from third party carriers. These benefits will be determined at the time claims are processed by third party carriers.

Initial:_____

3. Sliding scale application
As a courtesy B Johnson LLC is open to providing individualized adjustments for fees for services based upon individuals who are experiencing financial hardship,these adjustments are made according to Federal Guidelines on Income. Completing application does not guarentee rate reduction, additional income questions may be requested by the provider as well as supporting documentation justifying need.

MONTHLY INCOME (to nearest $1,000 before tax) _____ **FAMILY SIZE** (# supported by income listed) _____
DEPENDENT CHILDREN ☐ Yes ☐ No
Client refused to disclose or participate _____ (please initial)
*RECOMMENDED THAT YOU APPLY TO MEDICAID IF YOUR INCOME IS BELOW $1565/MONTH IF YOURE UNINSURED. IF YOU HAVE MEDICAID OR MEDICARE YOU ARE NOT SUBJECT TO THE DIFFERENCE BETWEEN THE FEE AND AMOUNT ALLOTTED BY MEDICAID/ MEDICARE PER PROVIDER AGREEMENT.

Initial:_____

4. APPOINTMENT AGREEMENT:
I understand that my appointment times are being reserved for me and that efficiency of scheduling often depends on my keeping my appointment as scheduled. I understand that it is my responsibility to notify Bethany Johnson of my arrival via text as indicated in the waiting area, and failure to do so may result in forfeiture of scheduled appointment. I understand that knocking on the door of the therapist when status sign indicates "In Meeting"/ "Do not Disturb" may be disruptive or triggering to other clientele and result in further delay.
I understand that repeated missed appointments may delay my treatment progress and result in closure of my case following 60 days of no contact. I understand that as of the nature of private practice Bethany Johnson,LCSW may be delayed up to 15 minutes in starting my appointment and it is my right to be seen for the amount of time prearranged if desired. I understand that with choosing to engage in private practice that Bethany Johnson availability is subject to change without notice according to the in the moment needs of all clientele who have chosen B Johnson LLC as their service provider.

Initial:_____

5. CONFIDENTIAL USE OF PROTECTED HEALTH INFORMATION:
The Notice of Privacy Practices gives an in-depth description of reasons for access to your protected health information, where consent is required and when it is not necessary. Initialing below acknowledges receipt of the Notice of Privacy Practices.

Initial:_____

6. CONSENT FOR MENTAL HEALTH SERVICES:
I, the undersigned, agree and consent to participate in the mental health services offered, including service provided by telehealth (virtual or by phone) methods provided by B Johnson LLC/ Bethany Johnson LCSW as defined in Indiana IC 25-23.6. I understand that I am consenting and agreeing only to those mental health services provided by Bethany Johnson are qualified to provide within the scope identified by the Indiana Board of Social worker and the Kentucky Board of Social work in which Bethany Johnson LCSW is licensed.

Initial:_____

7. ACKNOWLEDGEMENT OF COOPERATIVE AND BUSINESS ASSOCIATES
I, the undersigned, acknowledge, and consent to participate in the mental health services of B Johnson LLC/ Bethany Johnson, LCSW a participant in the Mental Health Offices of 606 E Main Street, Madison, Indiana 47250 cooperative in which physical office space and administrative staff, and billing solutions are shared to minimize the cost of operation necessary to business operation and quality services. Additionally, the undersigned acknowledges other necessary business associates for business operations in which minimal necessary client information is shared and protected under nondisclosure agreements/ HIPAA compliant Business Associated Agreements, these business associate agreements are provided upon request for review by client/representative.

Initial:_____

_____ **initial** Client acknowledges haven been given the opportunity to review Client Rights Policy.
Client acknowledges that they have been given instruction to on access Client Rights Policy via www.bjohnsonllc.com/new-clients

_____ **Initial** Client acknowledges they have been given opportunity to review Client Privacy Policy and instruction accessing and review the policy via www.bjohnsonllc.com/new-clients

_____ **Initial** Client has been given a copy of or virtual access to Financial Policy
Clt has opted to access Financial/fee policy online via www.bjohnsonllc.com/new-clients

The undersigned certifies that he/she has read the foregoing, is the client, or the client's parent or guardian, and agrees to and accepts the terms and acknowledgments of the above.

Client/Guardian
Signature: _____ **Date:** _____ **Relationship:** _____

Witness
Signature: _____ **Date:** _____