Acknowledgement of Payment and Notice of Privacy Practices

THE UNDERSIGNED HEREBY AUTHORIZES THE RELEASE OF ANY INFORMATION TO ALL OF MY INSURANCE COMPANY(IES) FOR CLAIMS SUBMITTED ON BEHALF OF MYSELF AND/OR MY DEPENDENTS. I FURTHER EXPRESSLY AGREE AND ACKNOWLEDGE THAT MY SIGNATURE BELOW AUTHORIZES DR. KRACKE & ASSOCIATES, P.A. TO SUBMIT CLAIMS FOR SERVICES RENDERED WITHOUT OBTAINING MY SIGNATURE ON ANY & ALL CLAMI(S) SUBMITTED. ANY FAILURE TO DISCLOSE ADDITIONAL INSURANCE WILL RESULT IN OUR BILING YOU FOR THE CHARGES.

I UNDESTAND I AM THE PARTY RESPONSIBLE FOR ALL CHARGES FOR SERVICES- REGARDLESS OF INSURANCE COVERAGE & AGREE TO ASSIGN ALL BENEFITS TO DR. KRACKE & ASSOCIATES, P.A. AND/OR PAY FOR SERVICE FOR ME AND/OR ANY OF MY DEPENDENTS, OR PERSON LISTED AS PATIENT, REGARDLESS OF REALTIONSHIP TO ME.

My Signature or Initials below indicates my understanding of my financial obligations.

_____ _____

Signature Date

OUR NOTICE OF PRIVACY PRACTICES DESCRIBES IN MORE DETAIL HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED, AND HOW YOU CAN ACCESS YOUR INFORMATION. THIS FOUR PAGE DOCUMENT WILL BE IN OUR LOBBY, ALONG WITH THE PATIENTS' RIGHTS AT ALL TIMES, FOR YOUR CONVENIENCE. YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE OFFICE POLICY, CONSENT TO TREAT AND CONTRACT IN FULL; THE PRIVACY PRACTICES POLICY WAS OFFERED AND IS AVAILABLE TO VIEW AND YOU AGREE TO ENTER THERAPY UNDER THESE CONDITIONS.

I HAVE READ THIS CONTRACT, RECEIVED THE PRIVACY PRACTICES POLICY & AGREE TO ABIDE BY IT.

_____ _____

Signature Date

For **MEDICARE** and **MEDICAID** Patients:

The undersigned hereby authorizes the release of information to the patient's primary care physician, _____ . This will permit your therapist to contact the patient's primary care physician to inform him/her of the initiation of therapy and may include the patient's diagnosis and the proposed treatment plan.

_____ _____

Signature Date

***If client is under 18 years of age, parent(s) or legal guardian must read & sign this contract. ***