Written Acknowledgement of Receipt of Notice of Privacy Practices – HIPAA, Informed Consent, and Payment Consent

I hereby acknowledge that I have received the Notice of Privacy Practices--HIPAA and consent to treatment with Kansas City Therapy, LLC under the policies discussed in the consent information packet. An electronic copy of the consent information packet and this document will be included in my records.

Client Demographic Information

Client Name:	**Social Security #:**
Street Address:	**Date of Birth:**
City, State, Zip Code:	**Home Phone:**
Gender:	**Work Phone:**
Email Address:	**Mobile Phone:**
Primary Physician:	**Psychiatrist (if any):**
Emergency Contact Person:	**Emergency Contact Phone:**
How did you hear about us?	**Marital Status:**

Responsible Party is the person who will be paying the per-session fee for services (leave blank if same as Client)

Responsible Party:	**Home Phone:**
Street Address:	**Work Phone:**
City, State, Zip Code:	**Mobile Phone:**
Relationship to Patient:	**Responsible Party SSN:**

Credit/Debit Card Information

I wish to use the following credit/debit card to pay for my sessions or co-payments upon scheduling with your therapist:

Type of Card:	Billing Name:
Card Number:	Billing Address:
Security Code:	City, State:
Expiration Date:	Zip Code:

I will be charged $_____ per 60 minute weekly individual session and $_____ per 60 minute weekly couples/family session, and understand that if this is a sliding scale rate, my therapist will review this rate every three months and/or at such time my sessions are no longer weekly. I will be charged $_____ for my _____ evaluation.

Insurance Information

Should you wish us to bill your insurance, please provide all of the following information. Your therapist will make a photocopy of your ID and insurance card.

Primary Insurance:	**Policy Holder Name:**
Company Address:	**Policy Holder Date of Birth:**
City, State, Zip Code:	**Identification Number:**
Company Phone:	**Policy/Group Number:**
Employer:	**Policy Holder SSN:**
Secondary Insurance:	**Policy Holder Name:**
Company Address:	**Policy Holder Date of Birth:**
City, State, Zip Code:	**Identification Number:**
Company Phone:	**Policy/Group Number:**
Employer:	**Policy Holder SSN:**

Should my insurance not reimburse for my sessions within 30 days, I understand that I will be charged $_____ per session.

Treatment of a minor (under the age of 18) patient will be provided only with the permission of the minor patient's legal guardian. By signing this form for a patient who is a minor, the undersigned represents and warrants that he/she is the legal guardian of the minor patient and has the legal right to consent to treatment of the minor patient. The undersigned also agrees to provide a copy of the current divorce/child custody order, if any exists, prior to the minor patient's first treatment session.

Signature: _____

Print Name: _____

Relationship to patient: _____

Staff: _____ Date:. _____