Comprehend, Inc.
Your Community Source for Mental Wellness

Forms & Information Receipt / Billing Authorization / Payment Agreement

By signing this form, *I certify that on the date below, I received, read and/or had explained to me, the following checked forms pertaining to my admission to treatment as a client of Comprehend, Inc.*
My signature also indicates approval of authorizations and agreements contained herein and/or repeated here.

☐ **"Notice of Privacy Practices"** – Informing you of HIPAA requirements to protect your "Personal Health Information" (PHI).

☐ **"Confidentiality Information"** – Describing our general confidentiality practices. (You should get both the "Confidentiality Information" sheet and the "Notice of Privacy Practices".)

☐ **"Voter Registration Rights and Declination"** – We are required to give you the opportunity to register to vote! This form outlines your voter rights, and says either you o **do** or you o **do not** want to register to vote at this time.

☐ **"Billing Policies" & "Prescription Call-In Policy"** – Two different policies on one sheet! This information is about our prescription and renewals policies, and about billing and making appointments. Both of these could be important to you, and we need you to know what our policies are.

☐ **"Client Rights & Responsibilities Statement"** – We want you to know up front what we expect and what you can expect from us.

☐ **"Resolving Complaints/Grievances"** – There's a way to make your complaint heard.

☐ **Offered Advance Directive**

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☐ **"Billing/Insurance Information"** — You have filled in complete information about your Primary and Secondary insurance, including this release of PHI:

I authorize Comprehend, Inc. to release to my third party payor any medical or psychiatric information (including any documents or reports requested) that may be required to process my claim with my primary or secondary payor as listed.
I understand that my claims cannot be processed without this release. I further understand that I may be billed at a future date for any services not covered by my policy. I agree to pay for any services not covered by my policy, based on Comprehend's sliding fee scale.
I hereby authorize and instruct my insurance company to make any benefits payable to Comprehend, Inc.

☐ **Physical Health Records** — I ☐ agree ☐ do not agree to allow Comprehend to have a copy of my physical health records (which includes yearly physical, current medical status and lab test).

☐ The indicated forms & policies have been explained to me. ☐ I have received a copy of these forms & policies.
☐ I authorize & certify #1 & #2 as stated above. ☐ I understand my rights/responsibilities as a client of Comprehend.

_____ _____-_____-_____ _____
PRINT Client Name Client Social Security # Client ID #

_____ _____ _____ _____
Client/Parent/Guardian/Client Representative Signature Date Witness Signature Date