



Haven Counseling

Patient Agreement to Receive Counseling Services Form

By my signature below, I certify that I have read, understand, and agree to abide by all policies described in the following which are posted on the website:

- Patient Information Form
- Professional Disclosure
- Policies Disclosure
- HIPAA Disclosure
- Legal Disclosure
- Cancellation Policy
- Telehealth Consent Form
- Credit Card Form
- Health Savings Card Form

I authorize, Amanda Plumb, MA, LPC or her agent, to charge no show/same day cancellation fees, counseling sessions, co-pay fees, documentation/letter request fees, legal fees, and outstanding balance fees **as they occur** (in accordance with the payment policies described herein) to the credit or debit card provided by me in this document. I understand I must provide a credit card on file. I understand if I elected to provide or use my Health Savings Card, I understand I am still required to provide a Credit Card on file. I also acknowledge the Notice of Privacy Practices for Protected Health Information posted on the website www.havencounsel.com.

Patient's Printed Name

Date

Patient's Printed Signature

Date