275 East 4th Street, Suite 570
St. Paul, MN 55101
Phone: 651-605-6370
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CONSENT FOR TREATMENT
INSURANCE AND FINANCIAL AGREEMENT

Please initial each section below

Section 1: **CONSENT FOR TREATMENT**

*I, *** give my permission to Hope & Outreach Therapy Services, LLC, to provide a psychological assessment/diagnostic assessment and mental health treatment. I understand that the potential benefits or limitations of a service that is being considered will be explained prior to being implemented. I understand that I have the right to decline a service which is being offered.*

Section 2: **ACKNOWLEDGMENT OF RECEIPT OF PRIVACY RIGHTS AND CLIENT BILL OF RIGHTS**

I have been given information on privacy rights related to HIPAA and the Data Practices Act, and "Client Bill of Rights".

Section 3: **MEDICAL AND PAYMENT RELEASE**

I authorize the release of any medical or other information necessary to process any medical or therapeutic claims. I request payment of government benefits to either myself or my Hope & Outreach Therapy Services provider including either Jessica Cylkowski, LICSW, Kylie Davis, LICSW, Anna Steinmetz, LICSW, John Adams, LICSW or Sadie Clarke, LGSW.

Medical Insurance Provider: ***

Section 4: **FINANCIAL AGREEMENT**

I understand that the fee for a diagnostic assessment is $225, a standard individual 60 minute session is $175, a couples and family therapy session is $180, a standard 45 minute session is $150 and a standard 30 minutes session is $125.

Private Pay
Sliding Scale agreement: $ *** Standard 60 Minute Individual $ *** Standard Couples/Family
All payments are due at the time of service and payable by cash, check or major credit cards.

I agree with the sliding scale arrangement listed above.

I understand that a $125 fee will be charged for all missed or late canceled (less than 24 hours notice) appointments.

If delinquent, I agree to pay all costs of collections including: court costs, reasonable attorney fees, and/or collection agency fees. I understand a collection agency may report my name to various credit bureaus if my portion of the bill remains unpaid.

Section 5: **INSURANCE COVERAGE**

I understand that I am responsible for understanding my Behavioral Health Benefits under my insurance plan and will be responsible for copays, deductibles and any claims denied by my insurance plan.

I understand that copays are due at the time of service and payable by cash, check or major credit cards.

I understand that a fee of $125 will be charged for missed or late canceled (less than 24 hours notice) appointments.

If delinquent, I agree to pay all costs of collections including: court costs, reasonable attorney fees, and/or collection agency fees. I understand a collection agency may report my name to various credit bureaus if my portion of the bill remains unpaid.

Section 6: **MEDICARE/MEDICAID INSURANCE COVERAGE**

Federal and State Law prohibits clients from being charged for missed or late canceled appointments if they are enrolled with Medicare or Medicaid Insurance plans.

If this exception applies, I understand I will be allotted no more than three missed or late canceled appointments; after which, I will be referred to another practitioner/agency for continued care.