Empowered Pathways
Policy and Procedures

Practice Policies and Procedures:

Welcome to Empowering Healthcare Services,

Please read the following information carefully so you have a clear understanding of our policies concerning communication, fees, insurance, confidentiality, etc. This acknowledges that we have provided you the opportunity to review our Practice Policies and Procedures as is required by federal law. Please take your time to review and fully understand this document. Please sign and date at the end to indicate that you have understood and agree.

Thank you for your cooperation.

Professional Services:

At Empowering Healthcare Services we realize how stressful it can be to establish a relationship with a therapist especially when discussing your mental health. As such, we aim to provide a patient-centered, nonjudgmental environment where you can feel comfortable discussing your concerns. While we offer multiple services to our patients, the greatest service you will receive from our office is healthcare with a personalized touch.

As we are a small practice, we have the ability to get to know our patients better than the larger clinics. We offer a thorough diagnostic evaluation in a comfortable setting. At the conclusion of your first visit we will share our thoughts on your diagnosis, answer your questions, and discuss potential evidence-based treatments. We also offer a variety of follow-up visits to suit your needs. Whether you prefer a 25 minute follow-up visit or a more comprehensive 40 minute or 55 minute follow-up visit we can work to meet your needs. We also offer some evening and weekend hours, a service that many mental health offices cannot accommodate.

Services include assessment, diagnosis, on-going medication management, and supportive and behavioral therapy. We treat a variety of mental health conditions including depression, anxiety, PTSD, Panic Disorder, Obsessive Compulsive Disorder, ADHD, Bipolar Disorder, and addiction problems.

For patients who are interested, ongoing therapy is available on a case-by-case basis and is determined at the end of the assessment. Psychotherapy appointments are usually scheduled weekly or biweekly.

For your convenience, we offer telepsychiatry appointments. Through this videoconferencing service, you will be able to attend your psychiatric visit from the comfort of your home. Some insurance companies do not cover telepsychiatry visits.

We do not provide forensic services such as custody evaluations, assessments recommended by probation, ability to stand trial, legal matters of medical opinion, etc.

We do not perform disability determinations or fill out paperwork for short-term or long-term disability or workers compensation.

We do not offer neuropsychological or psychoeducational testing or evaluations for bariatric surgery.

We do not fill out paperwork for any organization unless you have been a patient for 6 months or longer or have been seen a minimum of 6 times.

We do not write letters in support of an Emotional Support Animal.

In some situations, Empowering Healthcare Services, may not be able to meet your mental health needs and we will give you information where you can obtain care elsewhere. Additionally, if you feel that Empowering Healthcare Services and/or your doctor is not well matched to your needs, we will be happy to provide you referrals to other mental health professionals.

Consent for Treatment/Treatment Issues:
All treatment is strictly voluntary and you may choose to stop treatment at any time you wish. If you experience any problem(s) with psychotherapy, it is your responsibility to inform the clinical supervisor of the problem(s)

Office Hours and Appointments:
Business Hours: Office hours are from 8:30am-5pm Monday, Tuesday, Wednesday, Thursday, and Friday. Weekends by appointment only.

No Shows/Late Cancellations/Late Arrivals:

We do not overbook appointments. Your appointment time is a reservation just for you. If you are not able to come to your appointment, please reschedule through the patient portal or leave a message on the office line during business hours to reschedule. If you contact the office within **48 business hours (excluding weekends and holidays)** of your appointment you may reschedule with no additional cost, and the appointment will be offered to someone else.

Failure to show for your follow up appointments (or violation of this cancellation policy) on two or more occasions may be grounds for discharge from the clinic.

Note that the cancellation fee may be waived in special circumstances, determined on an individual basis (eg: medical emergency- patients may be asked to provide documentation for the same).

For our part, we will make every effort to provide you with adequate notice if the physician will be unavailable for a scheduled appointment and will work to reschedule your appointment in a timely fashion.

Inclement Weather Policy:

In some cases of inclement weather (i.e., hurricane, snowstorm, ice storm under 34 degrees Farehenheit.), your appointment may need to be canceled or rescheduled. We

If your appointment is cancelled, every effort will be made to reschedule your appointment. If you need to cancel your appointment due to inclement weather, you may cancel without a fee. However, you must call or send a portal message at least three hours before your appointment to cancel. If you do not show up or call after your appointment time, you will be charged a missed appointment/late cancellation fee regardless of the weather.

Communication and After-Hours Policy:

Electronic Communication:

The preferred method of communication is through the secure patient portal. You will get the fastest and most complete response if you state your concern by sending a message through the portal. Please note that all communications will be added to your medical records. Messages received through the portal are checked daily during business hours Monday, Tuesday, Wednesday, Thursday, and Friday 8:30am-5pm. Messages received after hours, on weekends, or holidays are reviewed the next business day. Please allow at least 1-2 business days for a response for portal messages.

Portal communication is not for emergency or urgent issues. Please **do not** send us a message through the portal that is of an urgent or emergent nature. Please note if you need immediate assistance, are having suicidal or homicidal thoughts, a serious medication reaction, or any emergency, please call 911 or go to the emergency room.

Please note A **fee** may be charged for clinical phone calls/portal messages between appointments. This fee is not covered by insurance. This fee does not apply to phone calls or messages strictly related to scheduling, billing, or other non-clinical questions.

We do not communicate via text or email. These communications are not protected and cannot be guaranteed as private.

Phone Calls:

Phone hours are Monday to Friday 8:30am – 5:00pm. Brief phone calls of 5 minutes or less are not charged. Longer, more involved calls are charged as outlined in Professional Fees. Please note that all communications will be added to your medical records.

Most routine calls are returned within **48 hours** during the above stated **business hours**. If you have an after hours concern that cannot wait for the next business day please call and leave a voicemail. Your call will be returned as soon as possible. For any emergencies, please do not wait for a call back. Instead, please go immediately to the emergency room or call 911. ***Please note a fee may be applied for after hours phone calls. Portal messages are not checked after hours, on holidays, or on the weekends. Please check our website for the **holiday schedule**. If you at any time feel that you require care that includes 24 hours per day coverage, Empowering Healthcare Services will provide information for another practice.

Hospitalization:

The clinicians at Empowering Healthcare Services do not have admitting privileges. If there is a crisis regarding your safety, you will be directed to the closest hospital emergency room for evaluation and possible admission.

Crisis Management:

Empowering Healthcare Services does not provide crisis management or are in crisis, are having suicidal or homicidal thoughts, or have any emergency, please call 911 or go to your nearest emergency room.

- National Suicide Prevention Hotline 800-273-8255
- National Domestic Violence Hotline 800-799-SAFE (7233)

Patient Portal:

Through the patient portal we may send you questionnaires or other information prior to your appointment. Please complete any forms/questionnaires at least **24 hours** prior to being seen for a follow up appointment. For an initial evaluation, **ALL** paperwork/forms must be completed within **3 days** after the request is accepted or the appointment may be cancelled. Again, the patient portal is not for urgent/emergency messages.

Insurance Claims: As a courtesy, Empowering Healthcare Services will file insurance claim. Your insurance company, in lieu of reimbursing you directly, will pay the physician or Empowering Healthcare Services any benefits for services rendered. Your medical insurance carrier may pay less than the actual bill for services, so you may be responsible for payment of some or all services rendered. You are responsible for making available complete insurance information for accurate filing of claims. To meet this end, we require updated insurance information at each visit. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. It is your responsibility to know and understand your medical insurance coverage. Not all services are a covered benefit in all contracts. Please call your insurance company to verify.

Insurance Claims:

As a courtesy, Empowering Healthcare Services will file insurance claim. Your insurance company, in lieu of reimbursing you directly, will pay the physician or Empowering Healthcare Services any benefits for services rendered. Your medical insurance carrier may pay less than the actual bill for services, so you may be responsible for payment of **some or all** services rendered. You are responsible for making available complete insurance information for accurate filing of claims. To meet this end, we require updated insurance information at each visit. Reduction or rejection of your claim by your insurance company **does not** relieve the financial obligation you have incurred. It is your responsibility to know and understand your medical insurance coverage. Not all services are a covered benefit in all contracts. Please call your insurance company to verify your benefits.

Empowering Healthcare Services will not be able to file claims to your insurance company unless you provide us with accurate and complete information about your insurance plan. Please review your policy carefully and be aware of any limitations on your
benefits. Please be aware of your **copay, coinsurance,** and **deductible** prior to your appointment.

By signing this agreement, you authorize Empowering Healthcare Serbices to release all medical information necessary to your insurance company to secure payment. You further understand your share of the cost of the services, e.g., co-payments, co-insurance, and deductibles, will be collected on the same day or service, prior to or after the visit.

Payment for Service

Please note that you are ultimately responsible for all charges incurred for your treatment or the treatment of those for whom you are responsible. If for any reason your insurance company, or other third-party payer (such as a divorced spouse or lawyer), does not promptly reimburse Empowering Healthcare Services for services rendered, you will be responsible for those charges.
You may pay with cash or credit/debit/FSA/HSA card at the time of service. Checks may be accepted on an individual basis for established patients. If a check is returned by your financial institution for any reason, a fee of $25 will be charged and future payments must be made by cash or credit/debit card. If you choose to pay with cash, please have the exact amount.

You will be required to leave a confidential credit card on file that may be billed for services provided outside the office, like clinical phone calls/messages through the portal. Your credit card is used to secure payment in the case that there is a no-show/ late cancellation/returned check fee. A **test transaction** may occur to verify the card on file is active prior to your appointment. If for any reason the card is rejected, your appointment may be cancelled and may not be rescheduled.

You are responsible for fees from credit card companies, collection agencies or banks due to non-sufficient funds, payment disputes, or non-payment of fees. Please notify us if there is any change in your payment information or if any problem arises in your ability to make payments. Overdue accounts may be referred to collection agencies as a last resort.

Fees are subject to change and reflect the complexity and type of service(s) provided. You will be notified thirty days in advance of any changes in our fees.

Basic Fees:

Consultation appointment (45-90 min): $350
Short follow-up appointment (25 min): $175
Long follow-up appointment (40 min): $250
Extended follow-up appointment (55 min): $300
Psychotherapy appointment (55 min): $220
Psychotherapy appointment (40 min): $165
Telepsychiatry short follow-up (25 min): $175
Telepsychiatry long follow-up (40 min): $250
Telepsychiatry extended follow-up (55 min): $300
Telepsychiatry psychotherapy appointment (55 min): $220 Telepsychiatry psychotherapy appointment (40 min): $165
Phone calls: $50 per 10 minutes (phone calls under 5 minutes are not charged)
Bounced / invalid / returned check: $25
Straightforward letter: $10

Please contact us if you have questions about which types of services are billed. Some examples include letter preparation, clinical phone calls, clinical emails, etc. Services will be billed at **$50 per 10-minute increment. This amount is not covered by insurance and cannot be billed to insurance. Please note that you will not be billed for phone calls/messages related to scheduling, billing, or other non-clinical questions.

Please note that all services provided after business hours (outside 8:30AM- 5PM Monday-Friday) are billed at **twice** the standard rate.

Medical Record Requests, Letter, and Forms:
We will try to complete all work during our scheduled sessions. It may occasionally be necessary for us to charge on a prorated basis for professional services that require extensive time commitment such as report/letter writing, completing forms, telephone conversations lasting longer than 5 minutes, and consultations with other professionals that you have requested.
Medical records requested for the patient's own use carry a charge and may be provided in the form of a treatment summary at the discretion of the physician and if you are in agreement. Parts of your record that could potentially be detrimental to your psychological well-being may be withheld. Insurance does not cover these fees. Please allow for at least two weeks for processing of records/letters/forms requests.
Record Fee:
To cover the costs incurred in handling, copying, and mailing medical records to the patient or the patient's designated representative the maximum fee for each request shall be seventy-five cents (75¢) per page for the first 25 pages, fifty cents (50¢) per page for pages 26 through 100, and twenty-five cents (25¢) for each page in excess of 100 pages, provided that the health care provider may impose a minimum fee of up to ten dollars ($10.00), inclusive of copying costs for sending medical records for the patient or the patient's designated representative.

Discontinuation of Treatment:

- Non-payment of your account.
- Canceling/missing appointments too often.
- Non-compliance with treatment recommendations.
- Withdrawal of treatment is necessary due to medical, financial, or legal problems or geographic relocation.
- Lack of attendance and/or motivation prevents further progress toward goal achievement.
- Inappropriate behavior relative to self, staff or other clients (i.e. threatening and/or intimidating behaviors)
- Failure to comply with the provisions of the Policies and Procedures as stated in this document.
- Successful completion of the treatment program initially agreed upon, implying that the patient has made significant progress toward meeting treatment goals.
- Client chooses to terminate therapy

If you foresee problems in any of these areas, please let your therapist know your concerns. If you decide to discontinue treatment, you can do so at any time in person, by phone, or in writing.

In the event that you discontinue treatment without notifying your p, it will be assumed that your therapeutic relationship with him or her terminated **90 days after your last visit,** unless you have an appointment scheduled for a future date, beyond which Empowering Healthcare Services carries no further responsibility for your care. You may re-enter treatment with your physician at Empowering Healthcare Services as long as your treatment ended in good standing and he/she is accepting new patients.

Thank you for reading through this important information. We look forward to working with you.

This Agreement shall not be :

any provision of this Agreement be declared void or ineffective by virtue of any state or federal statute or regulation, or decision of any court or regulatory authority, such declaration shall not invalidate any of the provisions of this Agreement that otherwise remain in full force and effect.

By signing below, you certify that you have read and understand the terms stated in this Policies and Procedures Treatment Consent Form. You agree to abide by the terms stated above throughout the course of the professional relationship.

_____

Print Client Name

_____

Patient Signature / Date

OR

_____

Print Name Client's POA/ caregiver/next of kin

_____

Signature of Clients POA/caregiver/next of kin

Empowering

HEALTHCARE SERVICES

Patient Referral & Intake Form

Last Name: _____ First Name: _____ MI: _____

SSN: _____ DOB: _____

Race: _____ ☐ Male ☐ Female

Primary Insurance: _____ Policy Number: _____

Secondary Insurance: _____ Policy Number: _____

Patient Location: ☐ Home ☐ Facility Name: _____

Address: _____

Home/Facility Phone: _____

E-mail address: _____

Emergency Contact: _____ Relationship: _____

Address: _____

Person Making Referral: _____ Relationship: _____

Phone: _____ E-mail: _____

Reason for referral/Presenting issue(s):

_____

_____

_____

_____

_____

_____

Preferred Location For Services: ☐ Home ☐ Telehealth ☐ Facility: _____

Empowering Healthcare Services abides by the HIPPA privacy act. Confidential material may be included in this facsimile and it is to be utilized solely by the intended person and entities for the intended purpose. If you have received this in error or it is not addressed to you, its use, determination, or copying is strictly prohibited and prosecutable. Immediately notify EHS and return this error communication to fax 678-840-3887 or email info@empoweringhealthcareservices.com

CONSENT TO TREATMENT

Thank you for choosing Empowering Healthcare Services. Your initial appointment will take approximately 60 minutes. The fee for the intake session is $275.00, and subsequent sessions is $200.00. We realize that starting counseling is a major decision and you may have many questions. This document is intended to inform you of our policies, State and Federal Laws and your rights. If you have any other questions or concerns, please ask us and we will try our best to give you all the information you need. You can reach our office by email at info@empoweringhealthcareservices.com or phone at Our clinicians use a variety of approaches that are both evidenced-based and individualized to serve each client. We believe that our clients are ultimately the experts in their own lives. Throughout the therapeutic relation will be discuss treatment practices, goals, plan limitations.

HIPAA

This document also contains summary information about the Health Insurance Portability and Accountability ACT (HIPAA). HIPAA is a federal law that mandates privacy requirements and patient rights pertaining to the use and disclosure of you Protected Health Information (PHI) in connection with treatment, payment and health care operations. HIPAA requires me to provide you with a Notice of Privacy Practices (which is attached to this agreement). It explains HIPAA and its application to your PHI in great detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. Although these documents are long and sometimes complex, it contains important information about your rights, and we ask that you review them carefully. We can discuss any questions you have about the procedures. When you sign this document, it will represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; or unless there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or unless you have not satisfied any financial obligations you have incurred.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: Your verbal communication and clinical records are strictly confidential except for: a) information shared with consultants, b) information (diagnosis and dates of service) shared with your insurance company to process your claims, c) information you and/or your child or children report about physical or sexual abuse; then by Georgia State Law, I am obligated to report this to the Department of Child Protective Services, d) where you sign a release of information to have specific information shared and 3) if you provide information that informs me that you are in danger of harming yourself or others f) information necessary for case supervision or consultation and h) or when required by law. In the unlikely event that your clinician is unable to provide ongoing services, a EHS clinician will provide those services and maintain your records for a period of 7 years. If an emergency situation arises for which the client or their guardian feels immediate attention is necessary, the client or guardian understands that they are to contact the emergency series in the community (911) for those services. EHS clinicians will follow those emergency services with standard counseling and support to the client or the client's family.

APPOINTMENTS AND CANCELLATION POLICY:

All services are by appointment only. If you must cancel an appointment, please let EHS now as far in advance as possible, but at least 24 hours business days in advance so that we can offer that time to someone else.
We will make every effort to offer an alternative appointment during the scheduled week. **Failure to cancel within 24 hours results in a late cancellation/no show fee of $150.00.**

For couples/family therapy appointments, we only meet when all parties are present. So if one person is late or unable to keep the appointment, we will not meet.

There are many valid reasons for late cancellations (sick child, business meeting, traffic jam). I make only one exception to this policy. If there is an area emergency (i.e. major snow storm), there is no charge for a late or missed appointment. For all other late cancels, there is a fee of $150.00.

If you need to cancel or reschedule an appointment, please give 24 hours advance notice, otherwise you will be billed the cancellation/no show fee.

SERVICE FEES: Payment is due at the time of your scheduled session, and will be billed to your credit/bank card on file. Any insurance co-pays or deductibles are due at the time of the session. Unfortunately, we cannot extend credit or provide services until payment is made. *Clients understand they are fully responsible for all fees if insurance or other vendor does not pay for any reason.*

Fees will be discussed during the initial consultation. A statement for insurance submission and for your records will be available by the first week of the month for the previous month.

FINANCIAL/INSURANCE ISSUES: **If you have a health insurance plan, your visits may be reimbursed.** The monthly statement provided contains the standard information needed to swiftly process your claims. Most insurance plans cover a portion of fees for counselors, although the percentages and amounts vary widely. EHS will provide billing services to your insurance company for services provided.

While a patient's diagnosis is very sensitive information and is generally treated as such by insurance carriers. We cannot guarantee how any insurance carrier or employer respects this information. If you prefer that I do not release information to your insurance company for reimbursement purposes, or if your insurance carrier fails to reimburse you at the level you expected, you remain responsible for the fee for services.

You should be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that I provide you. Georgia permits me to send some information without your consent in order to file appropriate claims. We are required to provide them with a clinical diagnosis. Sometimes we are required to provide additional clinical information such as a treatment plans or summaries or copies of your entire clinical record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. Georgia law prevents insurers from making unreasonable demands for information, but there are no specific guidelines about what unreasonable includes. If we believe that your health insurance company is requesting an unreasonable amount of information, we will call it to your attention and we can discuss what to do. You can instruct us not to send requested information, but this could result in claims not being paid and an additional financial burden being placed on you. Once the insurance company has this information, it will

become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it (see fee schedule if applicable).

We sincerely appreciate your cooperation and if, at any time, you have any questions regarding insurance, fees, or payments please feel free to ask. You may have a copy of this form if requested.

CONTACT IN BETWEEN SESSIONS

Although we do not take calls when we are in session, we typically check the voicemail and email at the end of every hour. If you leave a message or an email, we will answer it as soon as other demands permit. Generally, calls and emails are returned within the same day, with the exception being weekends and holidays. If your call is urgent, please state that at the beginning of your message, as we may not fully listen to messages until the end of the day. Calls and emails at night and on weekends will usually be returned during the next business day.

COORDINATION OF TREATMENT: It is important that all health care providers work together. As such, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. If you prefer to decline consent no information will be shared.

ELECTRONIC COMMUNICATION: Telephone and email are not encrypted methods of communication, and some confidentiality risks exits with their use. Counselors at Friends in Transition sometimes communicate using these mediums. If you would prefer to not be contacted by telephone or email, please inform your counselor and we will honor this request.

CLIENT FOLLOW UP: Your counselor may follow up with you after counseling has ended. 1 month, 3 month, and 6 month follow up calls help us to see if gains made in counseling have been maintained. In addition, someone from our team might call you to ask for your feedback on your experience at EHS Services. If you would prefer not to be contacted, simply inform your counselor and your preferences will be respected.

We, the counselor and client, have read and fully understand and agree to honor this agreement.

Client(s)_____ Date_____

Parent/Guardian)_____ Date_____

Provider_____ Date_____

Please read the following items and ask any questions that you have of your counselor.

1. Services offered by Empowering Healthcare Services, LLC are offered to help clients (and family) cope with depression, anxiety, dementia, adjust to grief, loss, transitional anxiety (such as move into a senior living facility), and other mental illnesses.
2. All counseling sessions will adhere to the American Counseling Association Ethical Standards.
3. Clients may be requested to complete the Brief Symptom Inventory (BSI), in addition to other assessment that may benefit treatment. The Brief Symptom Inventory is an assessment tool that gives the counselor an overview of the client's symptoms and the severity at a specific point in time.
4. All counseling relationships as well as storage and disposal of records will be kept confidential within legal and ethical limitations. Unless the client poses harm to the Counselor, the client will be informed when information regarding the client is being released. Information may be released without the written consent of the client in the following circumstances:
    a. The client poses harm to himself or others
    b. Suspected abuse of children or the elderly
    c. The client is under the age of 16 and has been sexually or physically abused, raped or the victim of another crime.
    d. When information is ordered by a court subpoena or a parole officer
    e. The client requires hospitalization
5. Deception in any form will not knowingly be used as a form of treatment
6. A primary goal of intervention is for the client to be able to live effectively within his or her own value system
7. Effectiveness of interventions with individuals is greatest when clients share all information related to the problem(s).
8. The purposes, goals, techniques, procedural rules, limitations, risks, and benefits of the intervention have been explained. The client has the opportunity to discuss the type of counseling relationship and intervention proposed and have any questions answered.
9. Clients in a helping relationship with other human services professional must inform all professionals.
10. Clients have a right to terminate counseling at any time.
11. The client understands his/her financial obligations. If appointments are not cancelled within a 24 hour notice, the client will be responsible for fees. In addition, any fees charged to the clinic for release of information will be the responsibility of the client.
12. During the first interview, the therapist will assess the client to determine if he/she is likely to benefit from guidance, counseling, and/or assessment. The counselor may inquire about goals, life history, mental status, and source of occupational and emotional difficulty, if any.
13. If the client does not present for three consecutive sessions and does not notify his/her counselor that he/she will not be able to attend, the counselor will assume the client has prematurely terminated, and will close his/her file. In addition, if the client agrees to receive written correspondence, his/her counselor will notify him/her of the file closure in writing.

14. If the client is not seen over a 30 day period of time the case will be closed. In addition, if the client agrees to receive written correspondence, his/her counselor will notify him/her of the file closure in writing.

Concerning written correspondence:

☐ I can be notified via email if my counselor needs to send me written correspondence concerning mycase.

☐ I can be notified via mail if my counselor needs to send me written correspondence concerning my case.

☐ Please do not contact me via writing, I prefer you only contact me via telephone.

I have read this informed consent and understand that my participation in therapy does not constitute any promise or guarantee of results. I understand that I am financially responsible for all incurred costs of treatment. I agree that anytime I am unable to keep a scheduled appointment, I will notify my counselor 24 hours prior to my appointment. If I fail to do this, I will be charged for the missed appointment.

_____ _____

Client Signature and Date Counselor Signature and Date

_____

Parent/Guardian Signature and Date

Client Insurance Information and Release

I authorize the release of medical information necessary to process any of my insurance claims, and I authorize payment of medical benefits directly to **Empowering Healthcare Services, LLC** for services rendered. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered as well as any additional collection agency fees should their assistance become necessary. I am aware that I will be charged the insurance allowable rate, or standard fee if private pay for any missed appointments that are not rescheduled or cancelled within 24 hours of the scheduled appointment time.

The undersigned agrees, whether he/she signs as a parent, spouse, guarantor, guardian, or client that in consideration of the services to be rendered to the client he/she hereby individual obligates himself/herself to pay the account. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

Name _____ Signature_____

Date _____

Insurance Information

Company Name: _____ Telephone #_____

Policy Holder's Name _____

Policy #_____ Group # _____

Policy Holders Social Security Number---------- ____ Subscribers DOB: _____

Relationship to client: _____

Client's Name: _____ Client DOB:_____

To be completed by Billing Office

Date: _____ Spoke with: _____ In Network or Out of Network

Policy effective :_____ Copay per visit: $_____ Coinsurance per visit: $_____

Deductible amount: $_____ Deductible met: $_____

Max Visits/Max Payable per Year _____ Out of Pocket per Year_____

Exclusions to Policy: _____

Claims Address: _____

Authorization #_____Sessions Approved_____ Auth. Dates: _____ thru _____