PATIENT: _____

RESPONSIBLE PERSON AND RELATIONSHIP TO PATIENT:_____

Insurance Authorization

I acknowledge that Prospering Hope Counseling, PLLC ("the Clinic") will file insurance claims on my behalf. I authorize assignment of benefits and further give permission for the Clinic to release information to my insurance company if requested.

Signature: _____ Date: _____

Patient Privacy

In compliance with state and federal requirements of HIPAA I have been provided with a copy or access to the Clinic's policy and procedures regarding the protection, security, and release of my Protected Health Information. As part of those procedures I understand that there will be no friending on any social media outlet with the therapist. I also understand that if there are any reports of abuse or neglect my therapist will report to the appropriate reporting agency.

Signature: _____ Date: _____

Scheduled Appointments

I understand that if I have not provided the Clinic with a notice of my intention to cancel within twenty-four (24) hours of the scheduled appointment time that appointment will be marked as "missed". I also understand that after three (3) missed appointments I will be discharged from services and provided with a list of providers that I can contact to continue services with.

Signature: _____ Date: _____

Billing and Payment for Services

I agree to pay for services at the time they are provided, unless I have agreed otherwise or unless my insurance coverage requires another arrangement. Further, I understand that the Clinic and/or Arkansas Premiere Billing staff will contact insurance providers to determine benefits, however, I also understand that neither the Clinic nor Arkansas Premiere Billing can guarantee that the information provided by the insurance provider is accurate. I agree to pay for all agreed to services that **might not be** covered by my insurance plan including non-covered diagnoses or procedures (e.g., testing, group, marital counseling).

Signature: _____ Date: _____

Treatment Coordination

I understand and give consent for the Clinic's treatment providers to share pertinent medical records and information with my primary care physician in order to coordinate care. These may include diagnoses, regular treatment updates, evaluation reports, and other medical/mental health information. My treating physician is _____.

Signature: _____ Date: _____

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