2022 Annual Update For Client Information, Financial Agreement, Treatment, and Consent

First Name:_____Last Name:_____ Preferred Name:_____

Address:_____City:_____State:_____

Zip:_____County:_____SS#: _____ Date of Birth:_____ Age:_____

Phone #:_____ May we leave a message _____ Email:_____

Cell phone #:_____ May we leave a message _____ Can you receive text notifications _____

Race: _____ Gender Identification _____ Preferred Pronouns_____

INSURANCE INFORMATION:

Primary:_____Policy #:_____Group: _____

Address:_____City, State, Zip: _____

Phone Number: _____

Secondary:_____Policy #: _____Group:_____

Address:_____City, State, Zip: _____

Phone Number: _____

I give my permission for the following people to gain access and have knowledge regarding my (or my child's) treatment with Insight Out Therapeutics, LLC.

_____ _____ _____

Financial Policy Change for 2022 to begin 01/01/2022:

I have read and understand this policy change ☐

Due to the increase in charges by financial institutions, we will be adding a surcharge for credit card transactions. The charges are to be 3% of the total charge plus 30 cents (30¢). (Example: a charge of $150.00 would incur a charge of $4.80 for a total charge of $154.80 - - - (150.00 + $4.50 (a 3% charge) +$.30). To avoid the charge, we will gladly accept cash or check payments prior to services being rendered.

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I authorize the provider of services to release all information necessary to secure payment of benefits to carry out a reasonable level of treatment. I directly assign all medical benefits from my insurance to the provider, if applicable. I agree to abide by the attached Financial Statement of Understanding (rev. 05/21) and, if applicable, by the limits defined in the previously signed informed consent and minor client informed consents. If I have Medicaid as my insurance, I hereby agree that I have been given a freedom of choice of my treatment provider.

I understand, acknowledge, and agree to be bound by the conditions set forth above and those carried forward from last year (to include Treatment Consent, Financial Policies, Cancellation Policies, HIPAA/Protected Health Information Rights and Responsibilities (attached) and Client Rights) which were revised 05/2021.

Client/Guardian Signature: _____ Date: _____

Print Name/Relationship to Client: _____