­­­

Dear Client,

Thank you for choosing Radiant Counseling. We hope your experience with our service meets your expectations and helps you along your journey. We strive to be a leading force in mental health treatment by fighting the stigma that seeking therapy is something to be ashamed of. We believe that engaging in the therapeutic process should be as celebrated as engaging in physical fitness and as vital as going to the doctor. We work to assist our clients in discovering that through open and honest dialogue, we can find clarity, a sense of peace and individual inner radiance.

Attached to this letter, you will find our client intake packet. Please fill out as much information as you can. Please bring this information with you to your first appointment and we are happy to help answer any questions or concerns you may have.

In staying with our ethical and professional practices, please note that if we happen to see each other outside of our office, we will wait until you acknowledge us before we engage in conversation so as to maintain your privacy and confidentiality.

Thank you again for choosing Radiant Counseling for your therapeutic needs.

Sincerely,

RADIANT COUNSELING, LLC Staff

Today’s Date \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **CLIENT INFORMATION** | | | | | | | | | | | | |
| Client’s Last Name | | First | | | Middle | |  Mr. | | Marital Status | | | |
|  | |  | | |  | |  Ms | |  Single | |  Married | |
| Is this your legal name? | If No, What is Your Legal Name | | | Former Name | | | Birth Date | | | Age | Sex | |
|  Yes  No |  | | |  | | | MM | DD | YY |  |  M  F | |
| Street Address | | City | | State | ZIP Code | | Social Security | | | Home Phone No. | | |
|  | |  | |  |  | |  | | |  |  |  |
| Occupation | | | | Employer | | | | | | Cell Phone No. | | |
|  | | | |  | | | | | |  |  |  |
| Referred to Radiant Counseling by (Check one box & list) | | | | | | | | | | Work Phone No. | | |
|  Dr. | | | |  Insurance Plan | | |  Website | | |  |  |  |
| Your Email Address | | | | | | Alternative Email Address | | | | | | |
|  | | | | | |  | | | | | | |
| **INSURANCE INFORMATION (Please Provide Your Card & Photo ID)** | | | | | | | | | | | | |
| Is the Client Covered By Insurance?   Yes  No | |  Medicare  Medicaid  Wellcare  Aetna  Blue Cross Blue Shield | | | | | | | | | | |
|  Humana  Cigna  Meritain  Tricare  United Healthcare   Other: | | | | | | | | | | |
| Policy No. Group No. | | | | | | | | | | |
| Insured’s Name | | | | | Insured’s Social Security | | | | | Birth Date | | |
|  | | | | |  | | | | | MM | DD | YY |
| Client’s Relationship to Insured  Self  Spouse  Child  Other | | | | | | | | | | | | |
| Co-Payment: | | Deductible: | | | | Has Deductible Been Met?  Yes  No | | | | | | |
| Secondary Insurance | | Insured’s Name | | | | Policy No. | | | | | | |
|  | |  | | | | Group No. | | | | | | |
| Is This an EAP Visit?   Yes  No | | Authorization No. | | | Total Sessions Allowed | | | | Company Information | | | |
|  | | |  | | | |  | | | |
| **SELF PAY INFORMATION** | | | | | | | | | | | | |
| Responsible For Bills | | Birth Date | | | Address (If Different) | | | | | Home Phone No. | | |
|  | |  |  |  |  |  |  |
| Employer: | | | | | | | | | | Cell Phone No. | | |
|  |  |  |
| Occupation | | | | Employer Address | | | | | | Work Phone No. | | |
|  | | | |  | | | | | |  |  |  |
| **IN CASE OF EMERGENCY** | | | | | | | | | | | | |
| Name of Local Friend or Relative (Not at same address) | | | | | | Relationship to client | | | | Work Phone No. | | |
|  |  |  |
| **FOR OFFICE USE ONLY** | | | | | | | | | | | | |
| Axis #1\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Axis #2\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Axis #3\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Axis #4\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
| Procedures Codes  90791  90832 (30Min)  90834 (45Min)  90837 (60Min)  90847  90853 | | | | | | | | | | | | |

**CONSENT FOR THERAPY AND THERAPY INFORMATION**

* \_\_\_\_ I request and consent for Radiant Counseling LLC to provide treatment that includes psychotherapy and counseling services for me or for someone under my care. If I am consenting for treatment for another person, I certify that I am legally responsible for that person and entitled to consent to their treatment.
* \_\_\_\_ I am aware that I am an active member in the counseling process and that I share the responsibility for therapy. I understand that therapy outcome depends upon cooperation, and further I understand that the practice of counseling is not an exact science. I acknowledge that no guarantees have been made as to the result of evaluation or therapy.
* \_\_\_\_ I understand that in order to fully benefit from therapy, I must participate in giving information needed to guide the therapeutic process. This includes legal and health information, including current prescribed medications.
* \_\_\_\_ I understand that if my therapist has information that I am at risk of hurting myself or others, she/he is legally and ethically required to take appropriate action to ensure the safety of all concerned. I understand that if I am consenting ***for therapy for another person that I am responsible for informing the therapist if I have any knowledge that this client is* *at risk of hurting him/herself or others.***
* \_\_\_\_ I understand that I am responsible for keeping my appointments and contacting the office/therapist 24 hours in advance if I need to reschedule. If I notify the office under 24 hours, I will be charged **$40.00.** If I do not show up for scheduled appointments, and **do not call**, I will be charged **$65.00** for the session.
* \_\_\_\_ I understand that sessions are 50 minutes in duration and as often as agreed upon between therapist and me.
* \_\_\_\_ I understand that I am responsible for charges incurred while being in therapy with Radiant Counseling LLC.
* I understand that payment for services must occur in a timely manner, and any changes in payment arrangements must be promptly reported to the therapist.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE OF INFORMATION**

Client Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date\_\_\_\_\_\_\_\_\_\_ Soc.Sec #\_\_\_\_\_\_\_\_\_\_\_

I understand by signing this form, I am allowing Radiant Counseling to disclose to and/or obtain information concerning the above named client to / from:   
Person or Agency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Information to be disclosed

□ Assessment □ Testing Information □ Diagnosis

□ Evaluation □ Treatment Plan □ Educational Information  
□ Continuing Care Plan □ Progress Notes □ Medication List  
□ Billing Information □ Presence/Participation in Treatment   
□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
  
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_This authorization is voluntary and I may cancel this consent to release information at any time by sending written notice to Radiant Counseling at the address above. I understand that any release which was made prior to my cancellation in compliance with this authorization, shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized re-disclosures and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Radiant Counseling at the above address. I further understand that Radiant Counseling may not require this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in denial of those services. I understand that this authorization will remain in effect for the period necessary to complete the sharing of information related to services provided to me, not to exceed 365 days from the date below. After 365 days, this authorization expires, unless it is revoked by me previously. I understand that unless otherwise limited by state or federal regulations, and unless action has been taken based on my consent, I may withdraw this consent at any time. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Client, Parent, Guardian or Personal Representative Date  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to the Client   
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Staff Witness Date

**NOTICE OF PRIVACY ACT**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996, (HIPPA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically on paper, or orally, is kept confidential. This federal law gives you, the client, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose said information.

* Without specific written authorization, we are permitted to use and disclose your health care records for the purpose of payment and health care operations. Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we disclose treatment information when billing insurance or an agency for your treatment services. Health care operations include the business aspect of running our practice. For example, client information may be used for quality assessment or for training purposes. Unless you request otherwise, we may use your confidential information to remind you of appointments by sending a reminder through the mail and/or leaving messages at home and/or work.
* Any other use and disclosure will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, expect to the extent that we have already taken actions relying on your authorization.
* With written authorization, we are permitted to obtain and release information with other mental health care providers in order to provide quality, coordinated services. You have certain rights in regard to your protected health information, which you can exercise by presenting a written request to the practice address listed below.
  + - The right to request restrictions on certain uses and disclosures of protected health information.
    - The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
    - The right to request an amendment to your protected health information.
    - The right to access copy and inspect your protected health care information.
    - The right to review an accounting of disclosures of protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of January 2007, and we are required to abide by the terms of the Notice of Privacy Practices (NoPP) currently in effect. We reserve the right to change the terms of our NoPP and to make the new notice provisions effective for all protected health information that we maintain. Revision to our NoPP will be posted on the effective date and you may request a written copy of the Revised Notice form this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event that you feel your privacy has been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practice, please contact:

Radiant Counseling, LLC The U.S. Department of Health & Human Services

513 Gloucester Street Office of Civil Rights

Brunswick, GA 31520 200 Independence Avenue, S.W.

912-580-9580 Washington, DC 20201

877-696-6775

I have received the NoPA and I have been provided an opportunity to review it.

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF NO SURPRISE ACT**

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS.

When you receive emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

**What is “balance billing” (sometimes called “surprise billing”)?**

When you see a health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, or deductible. You may have other costs or have to pay the entire bill if you see a provider that isn’t in your health plan’s network. “Out-of-network” describes providers and facilities that haven’t signed a contract with your health plan. These providers may bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balanced billing.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit. “Surprise billing” is an unexpected balance bill. This can happen when you can’t control who is involved in your care -like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

**You are protected from balance billing for:**

**Emergency Services**

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider of facility may bill you is your plan’s in-network cost-sharing amount. You can’t be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

* **Certain services at an in-network hospital or ambulatory surgical center**
* When you receive services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. These providers can’t bill you and may not ask you to give up your protections not to be balance billed.

If you receive other services at these in-network facilities, out-of-network providers can’t balance bill you unless you give written consent and give up your protections. You are never required to give up your protection from balance billing. You also aren’t required to get care out-of-network. You can choose a provider or facility in your plan’s network.

When balance billing isn’t allowed, you also have the following protections:

* You are only responsible for paying your share of the cost. Your health plan will pay out-of-network providers and facilities directly.
* Your health plan generally must:
  + Cover emergency services without requiring you to get approval for services in advance.
  + Cover emergency services by out-of-network providers.
  + Base what you owe the provider or facility on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  + Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

For more information about the No Surprise Act, please contact:

[www.cms.gov/nosurprises](about:blank) or call HHS at (800)368-1019

If you believe you have been wrongly billed, please contact:

Georgia Secretary of State at [soscontact@sos.ga.gov](about:blank) or call (404)656-2817

I have received the NoNSA and I have been provided an opportunity to review it.

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTICE OF GOOD FAITH ESTIMATE**

This form is signifying that you have received and completed our *Payment Agreement & Good Faith Estimate* forms. These documents enable you to self-select or inquire of insurance concerning your expected payment amounts for services rendered at our practice. Concerning these forms and the legal rights you are guaranteed within our practice…

**Disclaimer**

The Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute the bill.

**If you are billed for more than the Good Faith Estimate, you have the right to dispute the bill.**

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more about your right to a Good Faith Estimate or get a form to start the dispute process, please contact:

[www.cms.gov/nosurprises](about:blank) or call HHS at (800)368-1019

Keep a copy of your *Payment Agreement & Good Faith Estimate* in a safe place or take pictures of it. You may need it if you are billed a higher amount.

I have received a copy of your *Payment Agreements and Good Faith Estimate* and been provided an opportunity to review it.

Printed Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT to Unsecure Electronic Communication Form**

I, , understand there is a reasonable chance that communicating through electronic methods may be intercepted and eavesdropped on by a third party, including, but not limited to, family, co-workers, employers, and hackers.

Radiant Counseling, LLC offers electronic communication through the following methods:

* Phone
* Mail
* Office Ally for text/email appointment confirmation

Although these methods do not guaranty me against a breach, they are to support my confidentiality.

I consent to allow Radiant Counseling LLC to communicate with me using the following unsecured methods:

* Email: address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Text/Voicemail: cell number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To transmit the following information:

* Reminders for appointments
* Billing information

**PRIVATE PAY OPTIONS**

If you choose to use the private pay option, we have provided a sliding scale below. Each salary rate is based on household income and NOT individual salary (exceptions can be made for dependents). Each session will be paid for at the time services are rendered and will be considered paid in full at that time.

|  |  |  |  |
| --- | --- | --- | --- |
| **Annual Income** | **50 Minute Session Fee** | **FEE for 6 Session Package** | **Adjusted 50 Minute Session Fee with Package** |
| < $30,000. | $100.00 | $540.00 | $90.00 |
| $31,000. - $55,999. | $125.00 | $690.00 | $115.00 |
| $56,000. (+) | $150.00 | $840.00 | $140.00 |

**\*\* PLEASE NOTE THAT THE DISCOUNTED RATES ARE FOR PACKAGES ONLY AND CANNOT BE APPLIED ON A SESSION TO SESSION BASIS. Packages must be used within 6 months and payment must be paid in full before the first session.\*\***

**Payment Methods:**

* Acceptable payments are Credit/Debit, Check, or Cash. Check should be made out to Radiant Counseling, LLC.
* **Returned check fee** is **$50** and the payment for the bounced check and fee must be paid within 15 days of notification of the returned check.
* Payment option must be decided upon prior to initial session. *See Payment Agreement*.
* A Credit Card needs to be on file and a **$40** **late cancellation fee** will be charged if not communicated before 24 hours of scheduled sessions. There will be a **$65 no-show fee** should you miss an appointment without prior communication.
* Credit Cards will be charged with your verbal or written consent OR after 7 days have passed from the time that you receive an invoice with an outstanding balance.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature

**FINANCIAL RESPONSIBILITY DISCLOSURE**

I understand that I am responsible for my fee payment on the day of each appointment. I agree to be responsible for the full payment of fees for services rendered regardless of whether insurance reimbursement will be sought.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ will honor contractual agreements made with those managed health care companies which stipulate specific reimbursement restrictions. I also understand that if I cancel my appointment less than 24 hours in advance, I can be charged the billable fee for the session.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT/GUARDIAN SIGNATURE DATE

I hereby consent to treatment by specified provider. Although the chances for obtaining my goals for therapy will best be met by adhering to therapeutic suggestion, I understand that I have a right to discontinue or refuse treatment at any time. I understand that I am responsible, however, for any balance due prior to a decision to stop.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT/GUARDIAN SIGNATURE DATE

I hereby authorize the release of necessary medical information for insurance reimbursement purposes.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT/GUARDIAN SIGNATURE DATE

I authorize the payment of medical benefits to the provider of services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENT/GUARDIAN SIGNATURE DATE

**PRIVATE PAY AGREEMENT**

The private pay sliding scale is based on household income and family size.

Client’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gross Household Income Amount\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Household size *(number of individuals living at home you financially support)* \_\_\_\_\_\_

Agreed upon fee per session \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OR agreed upon fee per package \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Payment Type: □ Card □ Check □ Cash

□ Contact me to re-up package once my 6 sessions have been used.

Client Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_

Client Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_

Manager Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_

\*This Payment Agreement expires on 12/31/2024 at which point, a new payment agreement must be completed and signed. \*

\*\*This Good Faith Estimate shows the cost of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

To learn more, go to [www.cms.gov/nosurprises](about:blank) or call HHS at (800) 368-1019.

Keep a copy of this Good Faith Estimate in a safe place or take a picture of it. You may need it if you are billed a higher amount. \*\*