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thetalkingplace@gci.net
www.thetalkingplace.org

Notice of Policies and Practices to Protect the Privacy of Your Health Information

I acknowledge that I have received the Notice of Policies and Practices to Protect the Privacy of Your Health Information Form.

_____ Initials

Counselor – Patient Service Agreement

I acknowledge that I have received the Counselor – Patient Service Agreement and have reviewed the information contained therein. I understand and agree to the terms and conditions specified.

_____ Initials

Professional Disclosure Statement

I acknowledge that I have received the Professional Disclosure Statement

_____ Initials

Fee Schedule and Litigation Related Services

I acknowledge that I have received the Fee Schedule and Litigation Related Services information and have reviewed the information contained therein.

_____ Initials

Payment Agreement

I understand that insurance is billed as a courtesy and that I am responsible for full payment of all services provided regardless of my insurance coverage. I agree that I, as the guarantor, am responsible for payment of all services regardless of any court ordered financial agreements; it is my responsibility to collect from other parties.

_____ Initials

Release, Assignment and Statement of Responsibility

I authorize release of any information necessary to process my insurance claims and herby assign and request that payment be made directly to the provider. I understand that I my revoke this consent anytime by providing written revocation to this office. I further understand that I am responsible for payment of all products and services rendered to my or any patient for which I am the guarantor of payment.

_____ Initials

Authorization for Treatment

I, _____, parent or legal guardian of _____
Printed Name Printed Name
authorize treatment by the offices of The Talking Place, Child & Adolescent Counseling, LLC

Date: _____ Signature: _____

Relation to Patient: _____