Please initial that you have read and understand the following statements:

\_\_\_\_\_\_We realize that confidentiality is a very important part of your treatment. Therefore, we do not release any information regarding our patients without a patient’s signed release except in the case of a Court subpoena or as requested by your insurance company.

\_\_\_\_\_\_I request that payment of authorized insurance company benefits be paid to River City Comprehensive Counseling Services/River City Integrative Counseling Services for any services provided to me. I understand that my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim.

\_\_\_\_\_\_As a courtesy to you, River City will submit claims to your insurance on your behalf. You will be expected to make your co-payment, deductible, or any amount not covered by your insurance company at the time of your appointment. Pre-authorization from your insurance company is not a guarantee of coverage, and you will be responsible for payment of any services that were not covered by your insurance.

\_\_\_\_\_\_All unpaid balances are expected to be paid in full within 60 days, unless alternate arrangements have been made. Any remaining balance after 60 days will be referred to a collection agency and you will be responsible for any additional costs of collection.

\_\_\_\_\_\_An appointment is required to have forms filled out by your therapist.

\_\_\_\_\_\_You are required to notify our office staff of any change of insurance PRIOR to your next scheduled appointment. If you do not notify our office of new insurance information, you will be required to pay in full for your visit. Please make us aware of any change in address or telephone number as well so that we may contact you if needed.

\_\_\_\_\_\_I have read and understand the Attendance and Cancellation policy given to me.

\_\_\_\_\_\_I have read and understand the HIPAA Notice of Privacy Practices given to me.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_