

**Acknowledgement of Privacy Practices and Mental Health Informed Consent; Acknowledgement and Release for Billing/Payment**

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

By providing your signature below you are acknowledging you understand and accept ALL of the following items:

1. I received copies of the Notice of Privacy Practices and Mental Health Informed Consent, and they have been reviewed with me.

2. I understand the service and conditions as described on the Mental Health Informed Consent form, and I consent to treatment.

3. I understand that if I acknowledge or communicate with Intentional Self staff using social media, it is my own choice and I am responsible for self-identifying. I acknowledge and accept that Intentional Self staff use email, text, fax, and voicemail to communicate.

4. I hereby authorize payment directly to Intentional Self of the policy benefits otherwise payable to me, but not to exceed the provider’s regular charges for the period of treatment. I understand that I am financially responsible to Intentional Self for all charges not covered by my current benefits. I am responsible to advise Intentional Self of any insurance change or loss of coverage. Should I secure services without coverage, it is my responsibility to pay for services received. I understand that Intentional Self will utilize any and all debt collection means available to collect payment for services and understand

5. I authorize Intentional Self to release/exchange personal, medical, diagnostic, treatment, and any other information with my insurance company and/or any billing or collection partners, to coordinate treatment and/or receive payment:

Primary Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. I understand that my financial obligation with my insurance company may be as follows:

Co-payment per session $\_\_\_\_\_\_\_\_ Co-payment per month $ \_\_\_\_\_\_\_\_ Deductible per year $\_\_\_\_\_\_\_\_

These values are determined by insurance benefit/obligation information provided. All insurance benefits/obligations quoted are a general outline of coverage, not a guarantee of payment/coverage, and coverage is subject to all other terms, conditions, authorizations, network requirements and definitions in the subscriber and provider contracts.

7. I understand that if my insurance does not pay for services I am aware and accept the following rates per session: Diagnostic Assessment $200.00, 60 minutes $160.00, 45 minutes $120.00.. If not covered by insurance, copays and/or session fees are paid with either cash or check at the end of the session. We offer negotiated/sliding self pay rates. Negotiated self pay rate is as follows: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_/diagnostic evaluation, $\_\_\_\_\_\_\_\_\_\_\_\_/60-min.; $\_\_\_\_\_\_\_\_\_\_/45-min.

This authorization automatically expires, unless otherwise provided by state law, one year from date of signature.

Client’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_

Printed name of client’s legal representative (if minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s legal representative signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_