CLIENT NAME				TODAY'S DATE
STREET	CITY	ST	ZIP	PHONE
EMAIL ADDRESS				DATE OF BIRTH
THERAPIST				

AUTHORIZATION FOR TREATMENT AND PAYMENT

Welcome to Summit Community Counseling ("Summit"). It is our intent to provide you with excellent services that are based upon a collaborative assessment of your needs and goals. In signing this form you agree to participate in agreed upon services and you authorize payment for these services. If you have any questions regarding this form at any point, please discuss these with a member of our staff.

Treatment and Services

The treatment or services you receive are intended to improve your health and wellness and your overall quality of life. Services will be based upon the information you provide, the assessment of specialists with whom you work, and collaborative decisions regarding your goals and services. You always have the right to raise questions about services and request a second opinion, or to seek a second opinion at your expense. You also have the right to withdrawal from services at any time. However, please be aware that some services provided by Summit may be contingent upon other services, and discontinuing one could affect our ability to provide another because it may make the other service less effective. Whenever possible, we will attempt to accommodate these situations.

The type and frequency of services will depend upon the goals of services and the authorization of the payer. If we know that a declined authorization will substantially affect the effectiveness of treatment, we reserve the right to notify you and discontinue services, and we will assist you in appealing the decision where possible. Please be aware that the effectiveness of services will depend greatly upon the information you provide and in actively participating in services and assignments given.

Grievance

If you have a concern regarding the services you receive, you are encouraged to discuss this with the specialist with whom you are working. If this does not resolve the concern or you would prefer to discuss the concern with another party, you may ask to discuss the concern with the clinical director by contacting the clinic business manager.

Billing and Payment

If you are privately paying for services, payment is required at the time of service. If we will be billing your insurance provider for services, any co-pay that you have for services is also required at the time of service. Co-pays, deductibles, and other arrangements for mental health services are often different under insurance coverage than other healthcare services. We encourage you to contact your insurance provider to understand the benefits available to you for the services we provide, to obtain authorization for services, and to understand your responsibilities regarding payment.

We will bill your provider for services that they may pay, and we will contact your insurance to assist in authorizing services when we know that is required. **We will work to obtain reimbursement from your insurance or other funding sources. However, please be aware that some of the services we provide may not be covered by your insurance. In all cases payment is your final responsibility. If your insurance denies payment for services, you will be responsible.** If Medicaid or Medicare is providing coverage for your services, you will need to provide us with verification of your eligibility monthly. If insurance is covering part or all of your services, you will need to notify us of any changes in your insurance when they occur and provide us with current copies of your insurance card.

Your appointment time is reserved for you. As such, **please be aware that services provided by Summit may have a missed appointment or late-cancelation fee.** For the services where there is a fee, we are required to consistently apply it except when prohibited by contract. A missed appointment is considered any appointment where a person cancels, does not attend, or arrives more than 15 minutes late without at least 24-hour notice. If you have any questions regarding the services to which a fee applies, please contact our clinic business manager.

We accept payment through cash, check, or most major credit cards. Payment is due at time of service. Please be aware that we will otherwise send you notice of payments due that you will need to pay upon receipt. Please also note that delinquent bills will have a late payment charge

according to Summit's current fee policy, and may be sent to a collection agency for resolution if no other agreement is arranged with the business office.

If you have questions regarding payment or billing, please discuss these with our clinic business manager and we will work to try to help you in whatever way we can.

By signing this authorization, you are acknowledging and agreeing to the following:

Should collection become necessary, I/We agree to pay all attorney's fees, court costs, filing fees, and all collection costs not to exceed 40% of the amount owing which may be assessed by any collection agency retained to pursue the matter. I/We further agree to pay a finance charge of 1.5% per month (annual percentage rate of 18% per year) of the unpaid balance. I/We authorize this agency to call on any phone number I/We provide for any lawful purpose.

Medical Emergency

In the event of a medical emergency we will provide basic treatment, such as CPR and First Aid as well as contact emergency assistance to take you to the nearest Emergency Room.

Initial: ______ I consent to receive treatment in the event of a medical emergency.

Initial: ______ I have an Advanced Medical Directive that I would like to have placed in my file (If applicable).

Medicaid Acknowledgement

If Medicaid is providing coverage for your services, you will be given a Medicaid handbook. You will be shown the following sections in your Medicaid handbook by your provider: Grievances, Client Rights, Transportation, Emergency Service, and Choice of Therapist.

By initialing below, I am hereby acknowledging that I have received a Medicaid handbook and was shown the above-listed sections.

Initial: ______ Medicaid Booklet Initial: ______ Advance Directive Brochure *(adult patients only)*

Authorization for Use of Text/Emails

As a client, you have a right to receive or transmit Personal Health Information (PHI) via unsecure methods, such as texts and emails, though it is not advisable. You may opt to authorize this if you would like to communicate with your therapist via text or email regarding scheduling appointments or other questions/concerns. Please be advised that these means are unsecure, and the information may be retrieved by third parties.

I understand that by electing to send and receive texts and/or emails related to the scheduling of appointments and other questions/uses, I acknowledge that these means are unsecure, and the privacy of information transmitted cannot be guaranteed. I understand that I am not required to authorize this in order to receive treatment. I also understand that I may terminate this authorization at any time.

Initial: ______ I authorize the use of texts Mobile Phone: ______________________________

Initial: ______ I authorize the use of emails Email: ______________________________

By signing below, I am hereby acknowledging that I have read and understand the Authorization for Treatment and Payment, and have deferred any questions or concerns to the clinic business manager.

NAME (PLEASE PRINT)	
CLIENT SIGNATURE (if over 18)	DATE:
PARENT/GUARDIAN SIGNATURE (if applicable)	DATE:
WITNESS SIGNATURE (office use only)	DATE: