

FINANCIAL STATEMENT

THIS IS IMPORTANT – PLEASE READ CAREFULLY AND UNDERSTAND BEFORE INITIALING IN BLOCKS AND SIGNING WHERE INDICATED

(Both Parties Initial and Sign for Couple Counseling)

Client(s) Name(s) _____ / _____

Lighthouse Counseling Center PC (LHCC) is owned by Thomas S. Freeman, Psy. D and offers professional out patient behavioral health services by trained and experienced psychologists and psychotherapists. LHCC staffs' goal is to provide quality, caring and professional services to clients, and their family members, regardless of race, ethnic origin, religion, creed, gender, age, disability status, sexual orientation, or source of payment.

Confidentiality: My session with my therapist is confidential. Information about my sessions will not be released without a signed consent for release ***except*** in emergencies or when there is a court order, determination, or law requiring the information be released. If I have been referred for counseling by a court order, information about my treatment is not confidential and can be released to the court without my permission. I will *not* hold LHCC liable for such disclosure.

Duty to Warn: Information about dangerous behavior, including serious thoughts of hurting myself or others, as well as information about possible child abuse, is NOT confidential and is required by law to be reported by my therapist to the appropriate authorities.

After Hour On-Call and Fees: LHCC provides 24-hour non-life threatening emergency on-call coverage. I can call 770-251-5873 and follow the instructions. However, if I feel I have a **life threatening** emergency after regular office hours, I will call 911 or go to the closest Emergency Room in my area. ***I will be billed a telephone consultation fee***, pro-rated and based on the length of the call and therapist's hourly rate. Insurance will not be billed for this service. I agree to pay this charge. (billed in 10 minute increments).

For collection actions with an outside agency, LHCC may use an outside agency to collect past due accounts. Only information necessary for collection will be disclosed.

Professional Phone consults I may be billed a telephone consultation fee, pro-rated and based on the length of the call (in 10 min. increment) and therapist's hourly rate. Insurance will not be billed for this service. I agree to pay this charge.

Court/Expert Witness Appearance, fees are billed in advance and explained separately.

Professional letters written or forms completed, on my behalf, require a minimum fee of \$15 paid prior to release.

/ **Missed Appointment or Late Cancellation Fees / 24-Hour Notice Required**

(Initial)

I WILL BE BILLED, NOT MY INSURANCE

LHCC IS NOT RESPONSIBLE FOR CONFIRMING MY APPOINTMENT WITH ME

/ **I will pay co-payments, deductibles, and other service charges at the time of my appointment.** (\$30 returned check fees will apply. Credit card payments can be made by phone. Payment deferral will require approval by my therapist prior to my visit.

/ LHCC will charge my account for reimbursement for additional fees related to collection attempts. **LHCC will proceed with collection actions if the account is past due 60 days from date charges were allocated and/or efforts by LHCC have been exhausted to collect on the account.**

HIPPA NOTICE (Rev. 7/6/04)

(As required by the Privacy Regulations, created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) this notice describes how health information about you (a client of this practice) may be used and disclosed, and how you can get access to your protected health information.

I have been provided with access to a copy of the organization's Notice of Privacy Practices that describes how my health information is used and shared. I understand that LHCC has the right to change this notice at any time. I may obtain a current copy by contacting the Privacy Officer in the office or by phone at 770-251-5873.

I decline a copy of my HIPAA / PHI OR I requested and received a copy of my HIPAA / PHI

PLEASE SEE BACK OF FORM

INSURANCE AUTHORIZATION (please read and initial))

/ I agree to provide Lighthouse Counseling Center with accurate and detailed insurance information. I will provide updated insurance information 24 hrs prior to a session or pay the full session fee for that session. I will present proof of ID and insurance coverage upon request. LHCC reserves the right to cancel my session(s) or charge the full session fee if I can not show proof of coverage and/or a claim denied for termination of benefits or changes in my insurance coverage. I am responsible for contacting my insurance carrier(s) to assist with the payment of a claim. Delay in contacting my insurance carrier to assist in getting claims paid will cause my account to become delinquent and LHCC will have no other choice but to refer my account to collections. I am responsible for any balance on my account

/ I authorize the release of any medical or other information necessary to process an insurance claim by LHCC on my behalf. I authorize payment of medical benefits to Lighthouse Counseling Center PC for services rendered. In the event that insurance remits payment directly to me or a third party for services rendered, I will reimburse LHCC and not hold LHCC responsible for collection from the third party.

/ An authorization or a quote from my insurance carrier is not a guarantee of payment or benefits. LHCC will not accept a verbal estimate that my deductible has been met. I am required to pay my *co-payment, deductible, & my patient responsibility portion at each visit*

SELF PAYING CLIENTS

SELF PAYMENT AGREEMENT Fee \$ _____ Effective: _____

(TO BE FILLED IN BY LHCC FOR SELF PAYING CLIENTS)

I (we) do **not** wish to have LHCC file claims with my insurance carrier(s). I will pay the session fee amount at each visit. I can void this self-payment agreement, in writing, 24-hours prior to my visit and will provide all the necessary insurance information to assist LHCC with any billing or claims as stated above.

INITIAL: _____
Client

INITIAL: _____
Client

I have read, understand and agree with all the information provided to me above. Financial responsible party must be 18 years or older.

_____ Date _____ / _____ Date _____
Financial Responsible Party

Print _____ Print _____

Billing Information

Mailing Address: _____

City _____ State: _____ Zip _____

Social Security # _____ DOB: _____

Home # _____ / Other# _____

Employer: _____ Work #: _____

Relationship to Client: _____

