Receipt of Privacy Rights

I, _____ was provided with a copy of the Notice of Policies and Practices to Protect the Privacy of your Health Information for the Offices of Lisa Collins LCSW, Jennifer Nichols LCPC and Kristin Hultgren LCPC and have had an opportunity to read and review this notice.

X

_____Date:_____

Witnessed by:_____Date:_____

Financial Policy

Thank you for choosing the Offices of Lisa Collins LCSW, Jennifer Nichols LCPC and Kristin Hultgren LCPC. This is a statement of our financial policy. You are required to read and sign the Financial Policy prior to treatment. By signing the policy, you are agreeing to the terms and conditions set out in it.

—Our practice is committed to providing the best treatment for our clients and we charged what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

—The adult accompanying a minor is responsible for full payment at the time of service.

—We charge our full fee of $130 for all failed and appointments canceled in less than a 24-hour notice. Monday appointments must by canceled by Saturday @6pm. This fee must be paid by you and cannot be charged to insurance.

—There is a $30 charge for bounced checks.

—In the event that your account goes into default and our office has to turn your account over to an outside collections agency/attorney for collections, it is accepted that thirty percent (30%) of the principal amount of the balance will be added as collection/attorney fees.

—If you are not using insurance to assist with treatment costs, please refer to the "Good Faith Estimate" policy found in the Service Agreement to discuss the costs and payment for treatment with your clinician.

Regarding insurance:

—We may accept assignment of insurance benefits after confirming coverage. However, confirmation or authorization of benefits is not a guarantee of payment of services. In the event that your insurance company rejects the claim, you are responsible for non-covered services, deductibles and co-payments.

—You are responsible for notifying you therapist if your insurance coverage changes.

I have read the Financial Policy. I understand and agree to the terms of this Financial Policy.

X

_____Date:_____