**NOTICE OF PRIVACY PRACTICES**

Effective April 14, 2003

**THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU**

 **MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS**

 **TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

We are required by law to maintain the privacy of your protected health information (PHI) and to provide you with notice of your privacy rights and my legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of this notice with respect to your PHI but reserve the right to change the terms of this notice and make the new notice provisions effective for all PHI that we maintain.

**Understanding Your Personal Health Information**

Each time you visit a hospital, physician, mental health professional or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses and treatment, in the case of a mental health professional, psychotherapy notes, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

* basis for planning your care and treatment
* means of communication among the many health professionals who contribute to your care
* legal document describing the care you received
* means by which you or a third-party payer can verify that services billed were actually provided a tool in educating health professionals
* a source of data for medical research
* a source of information for public health officials charged with improving the health of the nation a source of data for facility planning and marketing
* a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

* ensure its accuracy
* better understand who, what, when, where, and why others may access your health information
* make more informed decisions when authorizing disclosure to others

**Your Health Information Rights**

Although your health record is the physical property of my practice, the facility that compiled it, the information belongs to you. You have the following privacy rights:

1. The right to request restrictions on the use and disclosure of your PHI to carry out treatment, payment or health care operations. We keep billing records that include payment information and documentation of the services provided to you. Your information may be used to obtain payment from you, your insurance company, or other third party. We may also contact your insurance company to verify coverage for your care or to notify them of upcoming services that may require prior authorization or approval.

You should note that we are not required to agree to be bound by any restrictions that you request but am bound by each restriction that I do agree to.

2. In connection with any patient directory, the right to request restrictions on the use and disclosure of your name, location at this treatment facility, description of your condition and your religious affiliation.

1. To receive confidential communication of your PHI unless we determine that such disclosure would be harmful to you. You may request that we send information to another address or by alternative means. We will honor such request as long as it is reasonable, and we are assured it is correct.
2. To inspect and copy your PHI unless we determine in the exercise of our professional judgment that the access requested is reasonably likely to endanger your life or physical safety (Note: if state law allows, “emotional safety” may be included as well) or that of another person.

You may request copies of your PHI by providing us with a written request for such copies. We will provide you with copies within fifteen (15) business days of your request at my office. You will be charged $40 and an additional .25 cents for each page copied. You will be expected to pay for the copies at the time you pick them up.

1. To amend your PHI upon your written request to me setting forth your reasons for the requested amendment. We have the right to deny the request if the information is complete or has been created by another entity.

We are required to act on your request to amend your PHI within sixty (60) days but this deadline may be extended for another thirty (30) days upon written notice to you. If we deny your requested amendment we will provide you with written notice of my decision and the basis for our decision. You will then have the right to submit a written statement disagreeing with our decision which will be maintained with your PHI. If you do not wish to submit a statement of disagreement you may request that we provide your request for amendment and our denial with any future disclosures of your PHI.

1. Upon request to receive an accounting of disclosures of your PHI made within the past 6 years of your request for an accounting. Disclosures that are exempted from the accounting requirement include the following:
* Disclosures necessary to carry out treatment, payment and health care operations.
* Disclosures made to you upon request.
* Disclosures made pursuant to your authorization.
* Disclosures made for national security or intelligence purposes.
* Permitted disclosures to correctional institutions or law enforcement officials.
* Disclosures that are part of limited data set used for research, public health or health care operations.

We are required to act on your request for an accounting within sixty (60) days but this deadline may be extended for another thirty (30) days upon written notice to you of the reason for the delay and the date by which we will provide the accounting. You are entitled to one (1) accounting in any twelve (12) month period free of charge. For any subsequent request in a twelve (12) month period you will be charged $.25 for each page copied and you will be expected to pay for the copies at the time you pick them up.

1. To receive a paper copy of this privacy notice even if you agreed to receive a copy electronically.
2. The right to complain to us and to the Secretary of the U.S. Department of Health & Human Services (HHS) if you believe your privacy rights have been violated. You may submit your complaint to us in writing setting out the alleged violation. We are prohibited by law from retaliating against you in any way for filing a complaint with us or HHS.

**USES & DISCLOSURES**

Your written authorization is required before we can use or disclose my psychotherapy notes which are defined as our notes documenting or analyzing the contents of our conversations during our counseling sessions and that are separated from the rest of your clinical file. Psychotherapy notes do not include medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis and progress to date.

It is our policy to protect the confidentiality of your PHI to the best of our ability and to the extent permitted by law. There are times however, when use or disclosure of your PHI including, psychotherapy notes, is permitted or mandated by law even without your authorization.

Situations where we are not required to obtain your consent or authorization for use or disclosure of your PHI psychotherapy notes include the following circumstances:

* By our office staff for treatment, payment or health care operations as they relate to you.

**For example**: Information obtained by us will be recorded in your record and used to determine the course of treatment that should work best for you. We will document in your record our work together and when appropriate we will provide a subsequent counselor or healthcare provider with copies of various reports that should assist him or her in treating you once we have terminated our therapeutic relationship.

**For example**: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

* In the event of an emergency to any treatment provider who provides emergency treatment to you.
* Discussion with a supervisor or colleague over the course of treatment.
* To defend ourselves in a legal action or other proceeding brought by you against us.
* When required by the Secretary of the Department of Health & Human Services in an investigation to determine my compliance with the privacy rules.
* We may disclose information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure. There might also be a need to share information with the Food and Drug Administration related to adverse events or product defects.
* When required by law in so far as the use or disclosure complies with and is limited to the relevant requirements of such law.

**Examples:**

* To a public health authority or other government authority authorized by law to receive reports of child abuse or neglect.
* If we reasonably believe an adult individual to be the victim of abuse, neglect or domestic violence to a governmental authority, including a social services agency authorized by law to receive such reports to the extent the disclosure is required by or authorized by law or you agree to the disclosure and we believe in the exercise of my professional judgment disclosure is necessary to prevent serious harm to you or other potential victims. If we make such a report we are obligated to inform you unless we believe informing the adult individual will place the individual at risk of serious injury.
* In the course of any judicial or administrative proceeding in response to:
* An order of a court or administrative tribunal so long as only the PHI expressly authorized by such order is disclosed, or
* A subpoena, discovery request or other lawful process, that is not accompanied by an order of a court or administrative tribunal so long as reasonable efforts are made to give you notice that your PHI has been requested or reasonable efforts are made to secure a qualified protective order, by the person requesting the PHI.
* Child custody cases and other legal proceedings in which your mental health or condition is in issue are the kinds of suits in which you PHI may be requested.
* In addition we may use your PHI in connection with a suit to collect fees for our services.
* In compliance with a court order or court ordered warrant, or a subpoena or summons issued by a judicial officer, a grand jury subpoena or summons, a civil or an authorized investigative demand or similar process authorized by law provided that the information sought is relevant and material to a legitimate law enforcement inquiry, the request is specific and limited in scope to the extent reasonably practicable in light of the purpose for which the information is sought and de-identified information could not reasonably be used.
* To a health oversight agency for oversight activities authorized by law as they may relate to me (i.e. audits; civil, criminal or administrative investigations, inspections, licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions.)
* To a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law.
* To funeral directors consistent with applicable law as necessary to carry out their duties with respect to the decedent.
* To the extent authorized by and the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.
* If use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.
* To a public health authority that is authorized by law to collect or receive such information for the purposes of preventing or controlling a disease, injury or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth, death, and the conduct of public surveillance, public health investigations, and public health interventions.
* To a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if the covered entity or public health authority is authorized by law to notify such persons as necessary in the conduct of a public health intervention or investigation.
* To a public health authority or other appropriate governmental authority authorized by law to receive reports of child abuse or neglect.
* To a law enforcement official if we believe in good faith that the PHI constitutes evidence of criminal conduct that occurs on my premises. We also have the right to involve enforcement when we believe an immediate danger may occur to someone.
* Using our best judgment, to a family member, other relative or close personal friend or any other person you identify, we may disclose PHI that is relevant to that person’s involvement in your care or payment related to your care.
* To authorized federal officials for the conduct of lawful intelligence, counter-intelligence, and other national security activities authorized by the National Security Act and implementing authority.
* To Business Associates under a written agreement requiring Business Associates to protect the information. Business Associates are entities that assist with or conduct activities on my behalf including individuals or organizations that provide legal, accounting, administrative, and similar functions.
* Military and Veterans: If you are a member of the Armed Forces, we may release medical information about you as required by military command authorities.

We may contact you with appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. If you have any questions and would like additional information you should bring this to our attention at the first opportunity. We will be glad to respond to your questions or request for information. Please contact us at **14673 Midway Rd, #110, Addison, TX 75001 or 469-904-2408.**

**FORMAL COMPLAINTS**

If you feel your provider has provided negligent or inappropriate service(s) you have the right to file a complaint to the Texas State Board of Examiners of Professional Counselors. Their contact information is:

Texas State Board of Examiners of Professional Counselors

Texas Department of State Health Services

Mail Code 1982

P.O. Box 149347

Austin, Texas 78714-9347

E-mail: lpc@hhsc.state.tx.us

Telephone: (512) 834-6658

Fax: (512)834-6677

Website: http://www.dshs.texas.gov/counselor/

**CHANGES TO THIS NOTICE**

We reserve the right to amend this notice at any time as allowed by law. If we amend this notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. The most current Notice will be located in our office.

**CLIENT CONSENT FORM**

I understand that as part of my healthcare, the undersigned therapists originates and maintains health records describing my health history, symptoms, evaluations and test results, diagnosis, treatment, psychotherapy notes, and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals.

I have been provided a copy of or access to the *Notice of Privacy Practices* and that I have been given the opportunity to review the notice prior to signing this consent. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment, or healthcare operations and that I am not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that the undersigned therapists have already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I request the following restrictions on the use and/or disclosure of my personal health information.

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Therapist response: Agree to restriction/Do not agree to restriction

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I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

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Signature of Client or Legal Representative Date

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Signature of Counselor Date

**Methods and Risk**

Psychotherapy is not easily described in general statements and varies depending on the particular problems you are experiencing. There are many different methods that may be used to deal with the problems that need to be addressed. Psychotherapy is not like a medical doctor visit. It calls for a very active effort on the part of the client. In order for the therapy to be most successful, the client will have to work on things we talk about both during our sessions and at home. During the course of treatment, established methods of counseling will be used, including listening, questioning, summarizing information, and promoting personal insight taking place in an atmosphere of empathy, caring concern, and encouragement.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of the client’s life, one may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience.

The understanding in counseling is that your relationship with the counselor is considered professional and that we will not acknowledge you in public unless spoken to by you (and we will not engage in an extended conversation with you in a public place). Further, we will not attend any social events with you or engage in any activities outside of counseling at the counseling office.

**Confidentiality**

What is discussed during treatment will be kept strictly confidential within legal boundaries, and no information will be divulged without your written consent. Some information cannot be held confidential by law, such as information regarding child abuse, and will be reported to the designated authorities. **If we are subpoenaed by a court of law, information may be divulged. In the case of divorced parents, generally both parents have access to information about their child. Please consult your divorce decree/agreement. A current signed and stamped copy of all custodial agreements including divorce decrees, mediated settlements, and/or other legally binding documents must be kept on record for all minor clients involved in such cases.** Threats of danger to self or others can also be divulged to appropriate others. Information may be shared in consultation with other licensed professionals (less personally identifying information) to ensure the best possible therapeutic care. Should you use third party providers (insurance), please be informed that oftentimes these companies require a diagnosis, or other information as well. This information will be granted as a matter of course should you decide to utilize their services.

Exceptions to confidentiality are prescribed by the licensing board in the State of Texas and include but are not limited to the following situations: abuse or neglect of minors; abuse, neglect, or exploitation of the elderly; a therapist’s duty to warn due to danger, physically or emotionally to the client, therapist or another person; a subpoena or court order; fee disputes between the therapist and the client; or the filing of a complaint with the licensing board. We will maintain a record of your counseling, which will be kept for 7 years after counseling is terminated. The records of minors will be kept for 6 years past the minor’s 18th birthday. If you have any questions regarding confidentiality, you should bring them to our attention.

**Good Faith**

Our first couple of sessions will include an evaluation. By the end of the evaluation, we will provide you some first impressions of what our work will include, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with us. This process can involve a large commitment of time, money, and energy, so you should be very careful about the counselor you select. If you have questions about the procedures used in session, we should discuss them whenever they arise.

During the course of treatment, stated goals may need to be changed at any time. It is understood that there is no guarantee that treatment goals will of necessity be met, but rather that we will apply our professional skills in good faith at all times.

**Session Duration**

Counseling sessions are normally 45-60 minutes in duration. These session times are strictly adhered to in the interest of others who may be waiting for their appointed time. There are times when we may be dealing with an emergency and our schedule may get delayed. We will ensure that your own session will take place; either through staying past your scheduled time, or rescheduling whatever time has been missed. The session time, however, will be adhered to strictly. This means that should you be running late, the session cannot be “held” until you arrive. Please note that the full charge will be assessed in any regard. An exit session, or termination interview will be conducted at the end of therapy. You have the right to terminate therapy at any time.

**Cancellation Policies**

If you are not satisfied with the progress made with treatment, you may cancel any future appointments. We ask that you please give such notice that this is indeed your intention. Should information be forthcoming that would necessitate referring to another professional with greater expertise in a particular area, we will make such a referral. Although we are trained to work with regard to a number of different personal problems, we want you to have the most specialized person available. We will provide you the names of other qualified professionals whose services you might need. Should you miss a session without canceling at least 24 hours in advance, you will be financially responsible for a ‘holding fee’ of half the standard fee per session. Failure to cancel or “no shows” will be assessed that ‘holding fee’ for the session. Generally, third party payers (i.e. health insurance) will not reimburse for missed appointments. Missed appointments are so noted on the bill. Please call the office or email to reschedule or cancel an appointment.

**Emergencies**

Emergencies are urgent issues requiring immediate action. If there is a life-threatening emergency, go to the Emergency Room and ask for the psychologist on call or call 911. You can reach the NorthSTAR Mobile Crisis Unit at 1-866-260-8000. The national suicide hotline is 1-800-273 TALK (8255).

**Duty to Warn/ Duty to Protect**

In the event we believe you (or your child if your child is the client) is at risk of harming yourself or someone else, you give permission for the counselor to contact anyone who is in a position to prevent said harm, including the person who is in danger, if applicable.

**Counselor’s Incapacity or Death**

In the event the undersigned counselor becomes incapacitated or dies, it will become necessary for another therapist to take possession of your file and records. By signing this information and consent form, you give your consent to allowing another licensed mental health professional selected by the undersigned counselor to take possession of your file and records and provide you with copies upon request, or to deliver them to a therapist of your choice. You will select a successor therapist within a reasonable time and will notify the appointed licensed mental health professional.

**Clinical Supervision, Research, Teaching and Publications**

Ensuring that data is *de-identified* (names and identifying information are removed) you give permission for release of *de-identified* case information and *de-identified* photographs of artwork for consultation with professional clinical supervisors, for research, teaching, publication, and/or educational presentations that may further professional knowledge of mental health issues and treatment techniques.

**Consent to Treatment**

**I voluntary agree to receive counseling services from The Davis Counseling Center, PLLC, and authorize them to provide such care, treatment or services, as are considered necessary and advisable.**

**By signing this Client Information and Consent form, I acknowledge that I have both carefully read and understand all the terms and information contained herein. I have asked and sought clarification on any unclear terms or concepts at this time. I also acknowledge that I agree to all of the terms in this form and have received a copy.**

**Please Initial**:

\_\_\_\_\_\_ You affirm that you have been informed of the likely benefits and material risks of treatment, and that you have been informed of some of the strictures and/or responsibilities of this counseling treatment. This disclosure was understood by you and enabled you to make an informed voluntary consent to this treatment. It is understood that you may revoke this consent at any time.

\_\_\_\_\_\_ You are financially responsible for payment in full of all services rendered through the Davis Counseling Center, PLLC, including assessment services, session fees, phone consults, email responses, court/legal fees assessed, reports/letters written, and the like. Should you get behind in your financial responsibilities, the Davis Counseling Center, PLLC has the right to withhold further treatment until payment for prior services has been received. All payments will be made to the Davis Counseling Center, PLLC.

\_\_\_\_\_\_ You authorize the release of any information necessary to process any insurance claims and authorize payment of insurance benefits to The Davis Counseling Center, PLLC.

\_\_\_\_\_\_ You authorize the release of any information necessary to coordinate treatment with medical professionals, therapists, hospitals, insurance or managed care companies involved with this case.

\_\_\_\_\_\_ You are not authorized to video-tape or audio-tape counseling sessions without the consent of the therapist.

\_\_\_\_\_\_ You represent that you have the legal authority to obtain counseling for any minor children

treated.

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Client or legal representative’s Signature Date

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Client or legal representative’s Signature Date

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Child’s Name Date of Birth

**Patient Financial Responsibility Statement**

Payment for services is due at the time services are rendered and is the responsibility of the client or guarantor. Due to the wide variety of insurance policies, we cannot guarantee that your policy or your insurance provider will cover the services provided. The client and/or guarantor are ultimately responsible for payment since the services are provided to the client and not to his/her insurance provider. Returned checks are assessed a charge of $35.00. Phone consultations with providers are charged at a rate of $40.00 per fifteen minutes. Providers retain the discretion to charge for email communication or review of therapeutic documents, at a rate of up to $25.00 per email. The rendering therapist holds the right to refuse service to any client not in good standing.

For minor clients, our providers will be available to attend meetings per request, consent, and release of parents/guardians relating to treatment needs such as ARD/504/Special Education service meetings, school observations, or on-site face-to-face therapeutic consultations with other providers. Our providers will assess a $100/hour fee for such services to cover costs of travel and time. Insurance providers generally will not cover these services, but many times these services may be recommended as a part of the treatment planning.

We providetwo payment options at the time services are rendered. The client and/or guarantor may:

* Pay via cash, check, or credit/debit card.
* Place a credit/debit card on file in our secure system. The card on file will then be charged at the time services are rendered.

The following guidelines ensure that the insurance and billing process is as smooth as possible:

* Any co-payment and/or applicable deductible must be paid at the time of service, barring other arrangements with your provider.
	+ The remainder of your bill will be sent to your insurance provider for direct payment to our office for in-network claims. For out-of-network claims, payment is due in full at the time of service and the client will be provided with a “superbill” that they can use to seek reimbursement for their insurance company. The Davis Counseling Center, PLLC does not guarantee reimbursement from insurance companies.
* If you are not insured, or if the services being provided are not covered by your insurance, you are expected to provide payment in full at the time services are rendered.
	+ If required, we can provide a needs based assessment or arrange a payment plan. Please contact the front desk for more information.
* In some instances, your insurance company may mail a payment to you instead of our office. Be aware that this is not necessarily a reflection of a zero-dollar balance on your account. If your provider mails you a check, please notify our office and forward us any paperwork your provider included. In most cases, when the insurance company sends you a check, they are expecting you to pay for the services in full at our clinic.
* Unfortunately, sometimes your health plan may refuse payment of a claim. Reasons include, but may not be limited to:
	+ Services are for a pre-existing illness not covered by your plan.
	+ You have not met your full calendar year deductible.
	+ The service required is not covered by your plan.
	+ The health plan was not in effect at the time of service.
	+ You have other insurance which must be filed first.

Clients who request our appearance in court will be charged. Our rate for legal services (including such things as court testimony, travel time, study time, documents, letters, or reports, and the like) is $300.00 per hour. There is a minimum payment for 4 hours that is required in advance for any legal/court related services. Additional time will be charged in increments of 4 hours out of respect to other clients’ scheduling. A minimum charge of $1200.00 will be assessed for court testimony, due in full three days prior to the date of the court appearance. We require a 48-hour advance notice for any cancellation of a court appearance. Cancellations given within 48 hours of the scheduled court appearance will not be reimbursed. Client records will not be released without written consent, unless court-ordered to do so. Please note our providers require a subpoena for all court-related activity. A subpoena does not constitute a court order. In the event law requires disclosure of your records or testimony, payment will be expected from you, regardless of whose attorney subpoenas our involvement.

Please discuss any payment problems with us. Insurance benefits usually cover only “medically necessary” treatment, requiring a mental health diagnosis. Any diagnosis made will become part of your permanent insurance records and may have implications concerning future applications for life insurance, long-term care insurance, or future health coverage in the event of a change in health care plans. If you have concerns regarding your diagnosis, please discuss these with us.

***I have read and understand my obligations, and I acknowledge that I am fully responsible for payment of any services not covered or approved by my insurance carrier.***

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Name – Printed

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Signature/Date