Hope Crossing Christian Counseling, Inc.

Please read carefully and initial each line indicating that you agree with the statement. If you do not understand any of these statements, please ask your counselor to explain before you initial.

Privacy Policy:

_____ *I acknowledge having been offered Hope Crossing's "Notice of Privacy Policies" and "Client Rights Statement".*

Authorization for Release of Personal Health Information:

_____ *I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment to me, obtaining payment for my care, or for the purpose of conducting the healthcare operations of Hope Crossing Christian Counseling, Inc. I authorize Hope Crossing Christian Counseling, Inc. to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Hope Crossing Christian Counseling, Inc. may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. I understand in the case of marriage counseling that my record is legally considered joint marital property and can only be released with the consent of both parties.*

Mailings:

_____ *I agree to have my name placed on a mailing list to receive follow-up contact from Hope Crossing Christian Counseling, Inc., including printed newsletters, seminar information, educational information, and/or e-newsletters via my email address.*

Appointments:

_____ *I understand that 24 hours notice is required for all changes to scheduled appointments or I may be subject to charges for the missed appointments.*

Emergencies:

_____ *In case of an afterhours emergency, I am to go to the nearest emergency room. To contact my therapist or the therapist on call I can call the afterhours emergency line. I understand that there may be a charge for this call that is not covered by insurance.*

Inclement Weather:

_____ *In case of inclement weather I understand I am to call Hope Crossing Christian Counseling, Inc. to check the status of my appointment. When possible, Hope Crossing Christian Counseling, Inc. will attempt to contact me and reschedule or offer alternatives.*

Financial Responsibility:

_____ *I understand that I am fully responsible for all services rendered and that full payment is expected at the time of service, unless other contractual arrangements apply. Payment options include cash, Visa/Master Card, and check; to be made payable to Hope Crossing Christian Counseling, Inc. There will be a $35 fee for all payments returned as non-sufficient or non-payable. If I have questions regarding my account balance, I will ask my therapist or the billing specialist. I understand that Hope Crossing Christian Counseling, Inc. can only discuss my account with me, my Guarantor, and my insurance company (if applicable).*

_____ *I understand that if my account becomes delinquent, that I will not be allowed to schedule an appointment.*

Insurance Billing:

_____ *I understand that if my counselor is contracted with my insurance company, that I am still responsible for contacting my insurance company and verifying my benefits. I understand that insurance company-quoted benefits are not a guarantee of payment.*

Confidentiality:

_____ *I understand that my client records are the property of Hope Crossing Christian Counseling, Inc. and treated as confidential. I understand that my records will not be released without my written consent -unless a situation arises where it is required by law to comply with medical record requests; such as a in cases of suspected/reported child abuse, court-order, etc. I understand that if I want a third party informed of my progress in counseling, I must sign a release of information form.*

Consent for Treatment:

_____ *I hereby consent to the treatment provided by employees and/or designees of Hope Crossing Christian Counseling, Inc. I authorize the services deemed necessary or advisable by my caregivers to address my needs.*

Consent for Treatment of a Minor:

I certify that I am the Legal Parent/Guardian to _____
And that I do have the legal custody of the above named child/adolescent. In the case of a child of divorce, as the presenting parent, I agree to follow my divorce decree as written regarding legal custody. I understand that Hope Crossing Christian Counseling, Inc. will treat my child in the good faith that I have done so. I, hereby, give my consent for the above named minor to receive outpatient assessment/ therapy from Hope Crossing Christian Counseling, Inc.
I understand that since I have brought the minor to Hope Crossing Christian Counseling, Inc. for treatment, that I will be responsible for the payment of services at the time those services are rendered, regardless of any financial arrangement I have for payment of the minor's medical care either oral, or written with the minor's other parent or responsible party.
I understand that Hope Crossing Christian Counseling, Inc. assumes no responsibility for collecting payment from the other parent or responsible party.

Signed: _____ Date: ____/____/____

Witness:_____ Date: ____/____/____