Financial Agreement/ Assignment of Benefits

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I understand that an essential part of the practice of psychotherapy involves the origination and maintenance of health records, and that these records may contain personal information describing my family, relationships, social and health history, including descriptions of symptoms, diagnoses, therapeutic interventions, and any plans for future care or treatment. Such personal health information records are kept in a secure location according to standards mandated by state and federal guidelines, and are accessible only to authorized staff except as authorized by written consent.

I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among other health professionals who contribute to my care – by consultation by phone or letter;
- A source of information in support of diagnoses;
- A means by which third party payers (when applicable) can verify that services billed were provided;
- A tool for assessing quality and reviewing competence of healthcare professionals.

I authorize my provider, as part of my healthcare, to routinely disclose certain information, described below. I understand that communication of certain minimal information is necessary for health care operations, treatment, and payment. I understand that I have the right to request restrictions as to how my health information may be used or discussed to carry out treatment, payment, or healthcare procedures, and that my provider., is not required to agree to the restrictions requested.

I understand that I may revoke this consent verbally or in writing at any time, except to the extent that my provider has already relied upon and acted on prior consent. This consent shall be considered in effect and valid unless modified or revoked by myself, and shall remain in force for the duration of treatment through this office, or otherwise expire after one year after the last contact, in lieu of any scheduled appointments.

Financial Agreement/Assignment of Benefits:

I hereby grant lifetime authorization for the payment of insurance payments to be made directly to my provider for services rendered. I understand that I am financially responsible for all charges, whether or not they are covered by insurance. In the event of default, I agree to pay the costs of collection and reasonable attorney's fees. I hereby authorize my provider to release the minimum information necessary** to secure the payment of benefits. A photocopy of this agreement shall be as valid as the original.

[** 'Minimum information necessary' may constitute information regarding: dates of service, services or procedures performed, modalities and frequency of therapy, medications, results of any testing performed, diagnoses, functional status, treatment plan, symptoms, prognosis, expected length of treatment, and progress to date.]

This form is a requirement of the Health Insurance Portability & Accountability Act, 1996, Rev. Dec. 200; Rev. Aug. 2002

My signature indicates that I have read this document and been given an opportunity to ask questions. I understand and accept the conditions..

Statement of Acknowledgment: **"I have read and understood the above."**

Client Signature:_____
Date:_____