PROFESSIONAL SERVICES AGREEMENT

(Please **initial** in the spaces provided and sign at the bottom)

Fees, Payment, and Insurance Billing

____ I agree to make payment at the time of service. I agree to pay my known co-pay, coinsurance, or the full fee (if I am a cash paying patient or meeting a deductible) at the time of my visit.

____ As a parent or legal guardian obtaining services for a minor child I agree that it is my responsibility to pay for any services provided at Creekside Counseling at the time of service. Issues due to child custody agreements must be sorted out by the parents and are not the responsibility of Creekside Counseling. In signing for services for a minor, I certify that I am the legal guardian and I have the legal right to approve of the evaluation, treatment and release of information.

_____ **We require a 24 business hour cancelation notice for all appointments.**

If you miss your appointment, a fee of $40 will be charged for counseling services, and $100 for medication management. Creekside Counseling will try to provide courtesy reminder calls or texts, but this is not guaranteed. Clients may not dispute a fee based upon not receiving a reminder. If a pattern of late cancelations or no shows is established, clients will be required to sign a "Special No Show Contract" and pay the full fee for missed appointments if they wish to continue services.

____ Additional fees may be billed for services such as phone calls of more than 10 minutes in length, written reports or letters and other professional services.

Finance Charges

____ If there is an additional balance on your account 30 days after insurance payment has been received (or after the date of service if self pay) a service charge of $5.00 per month will be charged. Any account that has had no payment activity for 90 days will qualify for submittal to a collection agency or court action. If your account is sent to collection, a 12% interest rate will be applied. I understand that failure to pay my bill will result in information being sent to a third party for collection purposes.

Authorization

____ I authorize the release of my personal health information necessary to process fee for service claims to my insurer. I authorize payment of insurance benefits to Creekside Counseling. I accept the financial responsibility to settle whatever balance is generated when payment is not received after 60 days from the billing date. I understand that failure to pay my bill will result in information being sent to a third party for collection purposes.

Consent for Treatment

____ Most people benefit by participating in mental health services; however, there is no guarantee that you or your family members will be helped. I give consent for treatment.

____ ***Consent for Treatment of Minor Patients***

As the guardian/responsible party, I hereby give my consent for the treatment of the child, _____, with a DOB: _____/_____/_____.

Privacy Practices

____ We are required by law to maintain the privacy of protected health information, and must inform you of our privacy practices. A copy of this notice had been made available. We reserve the right to change this notice at any time. Any changes will be effective for all protected health information that we maintain. You may receive a copy of the revised notice at any time.

By signing below, I acknowledge that I understand the risks and responsibilities noted above and agree to the inherent conditions implied or stated.

Name of Responsible Party Signature Date

*Patient Name:*_____