AGREEMENT REGARDING CONSENT TO TREATMENT, POLICIES, SERVICES & FEES

Thank you for choosing North Star Counseling Services as your health care provider. I am committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of your Consent to Treatment and my Financial Policy which you are required to read and sign prior to any treatment.

All patients must complete my Information and Insurance form before seeing me.

FULL PAYMENT FOR DEDUCTIBLES AND COPAYS ARE DUE AT THE TIME OF SERVICE. ACCEPTABLE FORMS OF PAYMENT ARE CASH, CHECK, AND ALL MAJOR CREDIT CARDS.

Regarding Insurance

Please keep in mind that all charges are the responsibility of the patient regardless of your insurance coverage. I will be happy to file your claims with your insurance carrier. However, if your insurance has not paid within 60 days, I will expect you to work with your insurance company to receive reimbursement. If no payment has been received within 90 days of the date of service, you will be billed for the full services rendered.

Usual & Customary

I am committed to providing the best treatment for my patients and I charge what is usual and customary for this area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please refer to your insurance policy fee schedule for more detailed information.

Confidentiality

Information regarding your treatment at North Star Counseling Services is confidential and will not be released without your written consent.

Exceptions to the written consent rule

- If you become a danger to yourself or others, the proper authorities must be contacted.
- Your records will be released to a court if records are requested by them.

Treatment

It is my policy that each client will receive specific, complete and accurate information regarding the treatment that they receive at this clinic. This information will be in both written and verbal form.

- Treatment shall be done in the following modes: individual, couple, or group.
- If you would like to receive a different treatment mode or to seek treatment elsewhere you are free to do so.
- You are free to withdraw this consent at any time and to terminate your treatment.

Emergencies

You may call the clinic at any time should an emergency arise and/or immediate services be needed.

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AGREEMENT REGARDING CONSENT TO TREATMENT, POLICIES, SERVICES, & FEES (cont'd)

Cancellations and changes of your appointment time

Unless canceled at least 24 hours in advance, my policy is to charge for missed appointments at the rate of a normal office visit. You will be billed directly. Insurance carriers do not assume any financial responsibility for failed appointment changes. Please help me to serve you better by keeping scheduled appointments.

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initials

Client's responsibility

THE CLIENT IS RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE.

It is my policy that the portion of the fee not covered by insurance is paid at the time services are rendered.

All clients are responsible to provide me with accurate insurance information and to contact me should coverage be changed. I will verify your benefits and limitations, but I will not be responsible for any changes in your insurance benefits.

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initials

Statement of agreement

Thank you for understanding my Consent to Treatment Financial Policy. Please let me know if you have any questions or concerns. *I understand and agree to this Consent to Treatment Financial Policy.*

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Client signature Date