Counseling Solutions KC

Client name: _____ Date: _____

Statement of Financial Policy

Co- Payment: Due at time of each appointment. Credit Card Type and Number: _____

_____ Expiration Date: _____ CCV Number_____

24 Hour Cancellation Policy

You will be charged a fee for every scheduled appointment unless you cancel at least 24 hours in advance

Payment of Balance Due

If a balance accrues your therapist will work out a payment plan with you. Those accounts 90 days delinquent will be turned over to a collection agency, unless you and your therapist have a signed payment agreement.

Signed: _____ **Date:** _____

Notices of Privacy Practices Acknowledgement

Notice to patient:

We are required to provide you with a copy of your Notice of Privacy Practices, which states how we may use and disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment.

I acknowledge I have received a copy of the Notice of Privacy Practices.

Signature of Patient or Personal Representative: _____ Date: _____

Personal Representative: Name of Patient _____

Relationship to patient _____