



Professional Services Agreement

Receipt of Notice of Privacy Practices, Informed Consent, Release to Contact Payor(s), and Payment Agreement Form

Receipt of Notice of Privacy Practices: I acknowledge receipt of the Genesis "Notice of Privacy Practices." I understand that Protected Health Information (PHI) held by Genesis Counseling Center, PC will be handled in accordance with the HIPAA Privacy Rule, which affords me specific rights and responsibilities regarding my PHI.

Informed Consent: This agreement indicates my commitment to enter into treatment, and my understanding of the basic ideas and personal growth goals of counseling. I consent to keep my therapist up to date about any changes in my symptoms or situation that may impact the success of treatment. I understand that effective counseling is a process which unfolds cyclically, from exploration to understanding, and finally, to action. The process may necessitate periodic evaluation of goals and new goals may be agreed upon to serve my long-term best interest. At times, counseling may arouse unpleasant feelings and emotional experiences, particularly in the initial phase of treatment. I acknowledge I give informed consent to treatment.

Payment Agreement: I understand that my payment is due at the time services are rendered. Estimated payment information is listed at the bottom of this form. I understand that I will be billed a fee of \$65 for appointments not canceled 24 hours before the scheduled time, except in cases of true emergencies. If the office is closed, voicemail is available to give notice of cancellation. I am responsible for remembering my appointment. Returned checks are subject to a \$50.00 service charge. Genesis will not accept any more personal checks for the duration of therapy. Unpaid balances that are more than 90 days past due are subject to a 1.5% per month service charge. I understand that I am responsible for all charges incurred during the course of my treatment, including any portion of charges that insurance may not cover for any reason as well as any psychological testing. Written consultations and telephone consultations will be charged at the therapist's discretion. There will be a fee of \$50 for any letters that are requested of the therapist. Failure to make payment on an amount owed may necessitate at the discretion of Genesis Counseling Center, PC the initiation of collections procedures, including possible legal action to recover the amount owed. The undersigned shall be responsible for any fees, including legal and collection agency fees, pursuant to this course of action. My signature below represents my understanding of this payment agreement.

For More Information: I understand if I desire more detailed information regarding Genesis' policies related to privacy, informed consent, professional services, and payment, I may request more information from the Client Care Coordinator.

Insurance or Self Payment Information

Completed by Office Staff

The information below is given to Genesis by the insurance company and represents estimates only. Genesis Counseling Center, PC is not responsible for co-pays and/or deductibles that may differ from what Genesis is told when verifying benefits. The Client/Guarantor gives permission to Genesis to contact any third party payor for payment.

Patient Name: _____

Responsible Party: _____

Primary Insurance: _____

Secondary Insurance: _____

Estimated Insurance Coverage: _____

2nd Estimated Coverage: _____

Estimated Deductible: _____

2nd Deductible: _____

Visits per Year: _____

2nd Visits/Year: _____

Estimated amount due from patient for each service is: \$ _____

Signature of Client or Guarantor

Date

Signature of staff witness

Date