ACORN COUNSELING LLC

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Acorn Counseling LLC Practice Policy

Thank you for choosing Acorn Counseling LLC as your health care provider. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy that we require you to read and sign prior to treatment. Thank you for your participation.

Insurance: We accept what your insurance company states are usual and customary. **We do require co-pays, deductibles or any other services not covered by your insurance be paid at the time of service.** The balance of your account is your responsibility whether your insurance company pays or not. We bill your insurance as a courtesy to you therefore we ask that you make sure we have the correct information. Your insurance policy is a contract between you and your insurance company. We are not party to that contract so it is **YOUR RESPONSIBILITY** to know your benefits and get referrals if they are required by your insurance. The number for your insurance company is listed on your card.

Missed Appointments and Cancellations: All appointments must be canceled 24 work hours in advance. Friday is the latest cancellation for a Monday appointment. It is our policy to charge **$200** for missed appointments or late cancellations. The insurance company is not liable for paying the bill for missed appointments. By signing this document, you agree to pay all charges not covered by your insurance. Please help us serve you better by keeping your appointments.

Minor Patients: The adult/guardian who accompanies the minor is responsible for full payment regardless if another party is made financially responsible for the medical bills by court order or by virtue of divorce and/or separation decree as such agreements are between other parties and not us. For unaccompanied minors, non-emergency treatment will be denied unless payment arrangements have been made ahead of time.

Insurance Filling: Ohio Law requires that insurance reimbursable mental health services be provided by or under the supervision of an independently licensed physician, psychologist, social worker or counselor. Our therapists are duly licensed by the State of Ohio and are recognized providers for many insurance companies. We may at times receive requests from your insurance company for information regarding your treatment, signing this policy will also allow us to release information to your insurance company.

This document states your rights for privacy with respect to your health care information as covered by the Health Insurance Portability and Accountability Act (HIPAA).

I herein give my consent to Acorn Counseling LLC to use and disclose my protected health information for the purpose of treatment, payment and operations of my health care and this practice.

Consent for treatment: I with my signature, authorize this practice and any employee working under the direction of the licensed counselors or social workers to provide psychotherapeutic care for me, or to this patient for which I am the legal guardian. This psychotherapeutic care may include services and supplies related to my mental health and may include but are not limited to preventive, diagnostic, therapeutic, maintenance, counseling, assessment or review of physical or mental status function of the body and mind. This consent includes contact and discussion with other health care providers and other professionals for care and treatment.

Consent to release information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier(s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the Practice Privacy Notice.

Consent related to the Privacy Notice: I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand that I have the right to request how my PHI has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

Consent for assignment of benefits: I consent to assign all payments for service rendered by this practice. I understand I am responsible for all co-payments, deductibles,, and other amounts that may be deemed my responsibility as required by my contract with my insurance plan and state regulations. These are required at the time of service. It is my responsibility to obtain information from my health plan about service coverage and any referrals that are required for services.
I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services to me at that time if I revoke this consent. The revocation does not take effect until the practice receives it.

I have read the foregoing Notice of Privacy Practices provided to me by Acorn Counseling LLC and have been given the opportunity to discuss with a member of Acorn Counseling LLC privacy practices. I understand that Acorn Counseling LLC may, at their discretion, change the terms and conditions of this Notice. Any questions I may have had have been answered to my satisfaction. **I understand the content of the Notice of Privacy Practices and I have been provided with a copy of it.**

Print Name	**Signature**	**Date**

I wish to be contacted in the following manner. (Check all that apply)

Oral Communication

___ Home telephone
___ O.K. to leave message with detailed information
___ Leave message with call-back number only
___ Other

___ Work telephone
___ O.K. to leave message with detailed information
___ Leave message with call-back number only
___ Other

Written Communication

___ O.K. to mail my home address
___ O.K. to mail my work/office address

___ O.K. to fax to this number
___ Other _____

___ I permit the Practice to discuss my PHI with and to my PHI to the following individuals
___ My spouse _____
___ My adult child(ren) _____
___ My personal representative _____
___ Other _____

Staff signature and date