jodi province
Counseling Services, PLLC

(PLEASE COMPLETE THIS PACKET WITH BLACK INK ONLY)

PATIENT PROFILE

DATE:__________________ (Office Use Only: Provider): ____

NAME:____
FIRST MIDDLE INITIAL LAST

ADDRESS:____
STREET CITY STATE ZIP

COUNTY___________DATE OF BIRTH________________AGE____________ SSN#________________

MARITAL STATUS___________________ DRIVER'S LICENSE #________________________________

HOME PHONE_______________________ WORK /CELL PHONE_________________________________

LEGAL GUARDIAN/RELATIONSHIP____

EMPLOYER OR SCHOOL ATTENDING/GRADE____

EMERGENCY CONTACT/TELEPHONE____

PRIMARY PHYSICIAN/TELEPHONE____

CURRENT MEDICATIONS____

ALLERGIES____

NATURE OF CONCERN REQUIRING

COUNSELING:____

____

____

____

INSURANCE INFORMATION

INSURANCE COMPANY:_______________________________NAME OF INSURED_____________________________

INSURED'S SSN#:__________________________________INSURED'S D.O.B_______________________________

INSURED'S POLICY #:_______________________________INSURED'S GROUP #:___________________________

INSURED'S EMPLOYER:____

INSURED'S RELATIONSHIP TO CLIENT:____

AUTHORIZATION #:____ **If your counseling is paid for through an Employee Assistance Program (EAP), please list authorization number and Number of sessions authorized:**_____________________________

1 OF 4 INFORMED CONSENT (Patient/Guardian: keep pages 1-3. Office retains page 4.)

TIME COMMITMENT: Today's appointment will take approximately 1 hour. We realize that starting counseling is a major decision and you may have many questions. This document, along with the HIPAA Information form, strives to inform you of our policies, State and Federal Laws and your rights. If you have other questions or concerns, please ask and we will try our best to give you all the information you need.
EMERGENCIES: If an emergency situation for which the client or their guardian feels immediate attention is necessary related to this office's services, please contact your counselor via their cell phone number. However, if your counselor is unavailable, you may call the office number to obtain contact info for Jodi (336-984-7591). If no contact can be made, the client or guardian understands that they are seek a natural support, contact 911 or visit a local emergency room for services as a last resort, or contact Vaya Health MCO at 1-800-849-6127 or Partners MCO 1-888-235-HOPE, or Mobile Crisis at 877-492-2785 or 336-838-9936. This agency will follow those emergency services with standard counseling and support to the client or the client's family. For any grievance you may also contact the above MCO for your covered region. If you have any grievance, you may call the number above.
In the case of a medical emergency, while you or anyone in your party is present in our office, this agency will contact 911.
RISKS AND BENEFITS: Please note there are risks and benefits to counseling. These will be discussed with you today as it relates to your case specifically. Alternative methods to treatment will also be discussed today. Each licensure board has a grievance process or system. If you wish to make a grievance, please contact the appropriate licensure board to file a complaint.
CONFIDENTIALITY: Your verbal communication and clinical records are strictly confidential except for: a) information (diagnosis and dates of service) shared with your insurance company to process your claims, b) information you and/or your child or children report about physical or sexual abuse; then, by North Carolina State Law, your counselor is obligated to report this to the Department of Social Services, as well as any report that c) you the client have an infectious disease that you will intentionally spread to harm others d) where you sign a release of information to have specific information shared and e) if you provide information that informs your counselor that you are in danger of harming yourself or others f) information necessary for case supervision or consultation and g) or when required by law.
APPOINTMENTS, PROFESSIONAL FEES, AND CANCELLATIONS: Appointments are generally 45 to 60 minutes in length. Initial intakes are $195.00, Counseling sessions varies. Other services including report writing, telephone conversations longer than 10 minutes, attendance and meetings with other professionals, court appearances/involvement, etc. can be charged at hourly rates. A $175.00 nonrefundable up-front fee is charged for any court appearances. **Letters/FMLA/Service Animal Forms/Form Completion: $50.00. No Show Fee: $85.00**

As a courtesy we will bill your insurance company, HMO, responsible party or third party payer for you if you wish. We ask that at each session you pay your co-pay. In the event you have not met your deductible, the full fee is due at each session until the deductible is satisfied. If your insurance company denies payment or does not cover counseling, we request that you pay the balance due at that time. If your account has not been paid for 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure payment.
This may involve but not be limited to hiring a collection agency or going through small claims court. If that were necessary you will be responsible for all cost of litigation including attorney's fees. In most collection situations the only information released would be the client's name and address, nature of services provided, and the amount due. We sincerely appreciate your cooperation and at any time you have any questions regarding insurance, fees, balances or payments please feel free to ask. You should also be aware that most insurances companies require you to authorize us to provide them with confidential information such as clinical diagnoses, treatment plans/summaries, or copies of records. This information becomes part of the insurance company's files. All insurance companies claim to keep such information confidential, however we have no control over this information once received by the insurance companies. It is important to remember that you may always pay for services yourself to avoid the potential problems described above.

AI Assisted notes: Your therapist may use AI assisted notes in your documentation. By signing below, you consent acceptance to this model of documentation, including risks and benefits.

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2 **OF 4 INFORMED CONSENT** (Patient/Guardian: keep pages 1-3. Office retains page 4.)

PRIVATE PRACTICE SOCIAL MEDIA POLICY:

By signing below, you acknowledge that we may we contact you at the numbers you provided on your patient profile. This also allows us to leave you a message at these numbers from our office. You also consent to allow us to contact you via your email.

This section outlines our office policies related to use of Social Media. Please read it to understand how we conduct ourselves on the Internet as mental health professionals and how you can expect us to respond to various interactions that may occur between us on the Internet. If you have any questions about anything within this document, we encourage you to bring them up when we meet. As new technology develops and the Internet changes, there may be times when we need to update this policy. If so, we will notify you in writing of any policy changes and make sure you have a copy of the updated policy.

Friending: We do not accept friend or contact requests from current or former clients on any social networking site (Facebook-Meta, LinkedIn, etc). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

Fanning: Some therapists keep a Facebook-Meta Page for their private or professional use. They may allow people to share their blog posts and practice updates with other Facebook-Meta users. You are welcome to view www.jodiprovincecs.com. However, in regards to blogs or post, we do not accept clients as Fans of this Page. We believe having clients as Facebook-Meta Fans creates a greater likelihood of compromised client confidentiality and feel it is best to be explicit to all who may view my list of Fans to know that they will not find client names on that list. In addition, the American Psychological Association's Ethics Code prohibits my soliciting testimonials from clients. We feel that the term "Fan" comes too close to an implied request for a public endorsement of this practice.

Following: If we publish a blog on our website or any other social media and if you use an easily recognizable name on X (for example) and we happen to notice that you've followed us there, we may briefly discuss it and its potential impact on our working relationship. Our primary concern is your privacy. If you share this concern, there are more private ways to follow us on X (such as using an RSS feed or a locked X list), which would eliminate your having a public link to a therapist's content. Note, we will not follow you back.

In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on our working relationship. If there are things from your online life that you wish to share with me, please bring them into our sessions where we can view and explore them together, during the therapy hour.

Interacting: Please do not use SMS (mobile phone text messaging) or messaging on Social Networking sites such as X, Facebook-Meta, or LinkedIn to contact us. These sites are not secure and we will not read these messages. Do not use Wall postings, @replies, or other means of engaging with us in public online if we have an already established client/therapist relationship. Engaging with us this way could compromise your confidentiality. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart. If you need to contact us between sessions, the best way to do so is by phone. 336-818-0733 for quick, administrative issues such as changing appointment times. See the email section below for more information regarding email interactions.

Use of Search Engines: It is NOT a regular part of our practice to search for clients on Google or Facebook or other search engines. Extremely rare exceptions may be made during times of crisis. If we have a reason to suspect that you are in danger and you have not been in touch with us via our usual means, coming to appointments, phone, or email (if consented to), there might be an instance in which using a search engine (to find you, find someone close to you check on your recent status updates) becomes necessary as part of ensuring your welfare. These are unusual situations and if we ever resort to such means, we will fully document it and discuss it with you when we next meet.

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3 OF 4 INFORMED CONSENT (Patient/Guardian: keep pages 1-3. Office retains page 4.)

Google Reader: We do not follow current or former clients on Google Reader and we do not use Google Reader to share articles. If there are things you want to share with us that you feel is relevant to your treatment whether they are news items or things you have created, we encourage you to bring these items of interest into our sessions.
Business Review Sites: You may find our counseling practice on sites such as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums in which users rate their providers and add reviews. Many of these sites comb search engines for business listings and automatically add listings regardless of Social Media Policy whether the business has added itself to the site. If you should find our listing on any of these sites, please know that my listing is NOT a request for a testimonial, rating, or endorsement from you as my client. Of course, you have a right to express yourself on any site you wish. But due to confidentiality, we cannot respond to any review on any of these sites whether it is positive or negative.
We urge you to take your own privacy as seriously as we take our commitment of confidentiality to you. You should also be aware that if you are using these sites to communicate indirectly with us about your feelings about our work, there is a good possibility that we may never see it. If we are working together, we hope that you will bring your feelings and reactions to our work directly into the therapy process. This can be an important part of therapy, even if you decide you and your counselor or clinician are not a good fit. None of this is meant to keep you from sharing that you are in therapy wherever and with whomever you like. Confidentiality means that we cannot tell people that you are a client and we will follow our Ethics Code. But you are more than welcome to tell anyone you wish about your therapy or how you feel about the treatment, in any forum of your choosing. If you do choose to write something on a business review site, we hope you will keep in mind that you may be sharing personally revealing information in a public forum. We urge you to create a pseudonym that is not linked to your regular email address or friend networks for your own privacy and protection. If you feel we have done something harmful or unethical and you do not feel comfortable discussing it with your counselor, you can always contact the Board of Counseling for NC, which oversees licensing, and they will review the services we have provided. P.O. Box 77819, Greensboro, NC 27417.
Email: By signing our informed consent, you acknowledge and are giving us permission to email you regarding any need in your counseling as an active or inactive/closed client. You are acknowledging that email is not completely secure or confidential. If you choose to communicate with us by email, be aware that all emails are retained in the logs of your and our Internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory, available to be read by the system administrator(s) of the Internet service provider. You should also know that any emails we receive from you and any responses that we send to you become a part of your legal record.
Thank you for taking the time to review my Social Media Policy. If you have questions or concerns about any of these policies and procedures or regarding our potential interactions on the Internet, do bring them to your clinician's attention so that we can discuss them.
SCHEDULED APPOINTMENTS: Please be respectful of our time. If you must reschedule or cancel, please phone 24 hours in advance in order not to be charged for the session. A pattern of missed appointments will lead to additional charges that are not covered by insurance and may result in an end to treatment. Three no-shows (or failure to cancel without 24 hours notice) will result in termination of services at the discretion of your counselor. By signing our informed consent you acknowledge the following: Non-Medicaid clients can be charged $85.00 for sessions missed or cancelled with less than 24 hours notice. These fees are not covered by insurance and payment will be required prior to any further services being provided. All clients with three no-shows/failure to cancel within 24 hours can be terminated with this agency.
Distance Counseling: There are risk and benefits in engaging in the use of distance counseling, these include but are not limited to: technology, and/or social media; *possibility of technology failure and alternate methods of service delivery may be needed (these may be determined by you and your counselor); * anticipated response time to emergencies is within 15 minutes, please follow protocol and prompts on your counselors voicemail if your counselor can not be reached; * time zone differences may also be a consideration; * cultural and/or language differences may affect delivery of services; as well as possible denial of insurance benefits; * lastly, please review the social media policy in the informed consent.

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4 OF 4 INFORMED CONSENT (Patient/Guardian: keep pages 1-3. Office retains page 4.)

By signing below, you acknowledge receipt and agreement to "Informed Consent." You also acknowledge receipt of our "Client Rights and HIPAA Information". We are happy to provide you a hard copy of "Client Rights and HIPAA Information" at your request, or you may review these at www.jodiprovinceccs.com under "Client Information." You also acknowledge that your therapists may use AI assisted notes in your documentation and are consenting acceptance to this model of documentation, including risks and benefits.

Agreement to Informed Consent and Acknowledgement of receipt of Client Rights, HIPAA Information & AI assisted notes, as well as acknowledging our after-hours emergency policy with emergency contact numbers:

____

Signature of Client or Guardian **Date**

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS:

I/We consent that ____ (minor's name) may be treated as a client at Jodi Province Counseling Services, PLLC. Please be aware that the law may provide parents/guardians the right to examine treatment records. It is our policy to provide parents/guardians access to information about treatment. However we also ask parents/guardians to trust us and allow us to keep your confidences on specific information and we will provide them with general information about your treatment sessions. At times it may be necessary to schedule appointments during school hours. We ask for your cooperation to provide the timeliest treatment for you and your children.

____

Signature of client or guardian **Date**

Your counselor's professional disclosure statement is located on jodiprovincecs.com, under the 'Counselors' section. By signing below, you acknowledge that you have read and understand this document.

Client and/or Guardian Signature:________________________________Date:______________

AUTHORIZATION FOR RELEASE OF INFORMATION

I (We) authorize Jodi Province Counseling Services, PLLC to release and disclose information from the clinical record

of:____ ______________________________
Name of client/recipient of mental health services Date of birth

to, and allow such information to be inspected and copied by:____
Facility/Provider/PCP

____
Facility/Provider/PCP Address

Nature of information to be disclosed:____
State specific nature of information to be disclosed

For the purposes of ____
State specific purpose of information to be disclosed

Information to be released and/or exchanged includes any available substance use/abuse or HIV/Infectious disease information as verified by **CLIENT INITIALS**: yes____________ no______________

I understand that have the right to revoke this authorization, in writing, at any time by sending notice to Jodi Province Counseling Services, PLLC office. I understand that a revocation is not valid to the extent that Jodi Province Counseling Services, PLLC office has acted in reliance on such authorization. This authorization is valid One Year from date signed unless written notice is given stating otherwise.

A copy of this release shall have the same force and effect as the original. By signing below I acknowledge that I have been notified that release/disclosure of information may only occur with a consent unless it is an emergency or for other exceptions as detailed in the General Statutes or in 45 CFR 164.512 of HIPAA.

______________________________________ ____
Client Signature 12 yrs. or older Date **Parent/Guardian Signature Date**

______________________________________ ____
Witness Date **Relationship to Client**

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.

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UCLA PTSD REACTION INDEX FOR CHLDREN/ADOLESCENTS - DSM-5©

Robert S. Pynoos, M.D., M.P.H. and Alan M. Steinberg, Ph.D. All rights reserved.

Child/Adolescent Name: ______________________________ Sex: □ Girl □ Boy Date (*month, day, year*) ____/____/____

TRAUMA/LOSS HISTORY SCREENING QUESTIONS:
Place a check mark in the box on the left for each type of trauma /loss experience that has occurred. ***Sometimes people have scary or violent things that happen to them where someone could have been or was badly hurt or killed.***

□ **Serious Accidental Injury**: Have you ever been in a bad accident (like a serious car, bus, train or bicycle accident or a bad fall) where you or someone else was or could have been badly hurt or killed?
Have you ever seen a bad accident where someone was badly hurt or killed?

□ **Illness/Medical Trauma**: Have you ever been so sick that you and your parents (or people taking care of you) were scared that you might die? Did you have a medical treatment that was very scary or painful? Did you ever see someone you really care about get so sick that you were scared they might die?

□ **Community Violence**: Did you ever see a bad fight or shooting in your neighborhood, like between gangs? Were you afraid of getting badly hurt or killed? Have you seen someone mugged, robbed, stabbed or killed in your neighborhood?

□ **Domestic Violence**: Have you ever seen adults you live with get in a bad fight with each other, where someone got punched, kicked or hit with something? Have adults you live with threatened to hurt each other? Have you ever seen an adult you live with forced to do something sexual by another adult you live with?

□ **School Violence/Emergency**: Were you ever at school when something really scary happened, like a shooting, a stabbing, a fire, where you or someone else got badly beaten up or someone attempted or committed suicide?

□ **Physical Assault**: Have you ever been badly physically hurt (punched, kicked, stabbed) by someone outside of your family or who was not taking care of you? Have you ever been badly hurt by someone outside your family, like someone in your neighborhood, a boy or girl friend or a stranger?

□ **Disaster**: Have you ever been in a natural disaster, like a hurricane, tornado, earthquake, flood or wildfire where you were hurt or could have been hurt or killed? Have you been in a natural disaster where you saw someone badly hurt or killed? Have you been in a place where there was a chemical spill or explosion?

□ **Sexual Abuse**: Did someone who was taking care of you ever force you to do something sexual? Did someone taking care of you ever make you watch something sexual?

□ **Physical Abuse**: Have you ever been badly hurt (punched, kicked, stabbed, shaken) by someone who is in your family (like a parent, brother or sister) or someone who was taking care of you? Have you seen another child in your family being badly physically hurt by a parent, caregiver or legal guardian?

□ **Neglect**: Has there ever been a time when someone who should have been taking care of you didn't, like they didn't take you to a doctor when you were really sick, they left you alone for too long, didn't make sure you were going to school or didn't do their best to keep you healthy or safe?

□ **Psychological Maltreatment/Emotional Abuse**: Did anyone in your family ever keep telling you that you are no good, keep yelling at you or keep threatening to or send you away?

Good Faith Estimate for Health Care Items and Services **Patient Information**		
Patient First Name:	Middle Name:	Last Name:
Patient Date of Birth:		
Contact Information		
Street or PO Box		Apartment
City	State	Zip Code
Phone		
Email Address		
Patient's Contact Preference:	☐ By phone ☐ By mail	☐ By email
Patient Diagnosis & Estimated Charges		
Primary Service or Item Requested / Schedules		
Patient Primary Diagnosis	Primary Diagnosis Code	
If scheduled, list the date(s) the Primary Service or Item will be provided: ☐ Check this box if this service or item is not yet scheduled		
Date of Good Faith Estimate	/ /	
Intake: Hour session	Provider Name	Estimated Cost $195.00
Individual / Family Therapy: 45 Min to hour	Provider Name	Estimated Cost Per Session $175.00
Individual/Family Therapy: 30 Min session	Provider Name	Estimated Cost Per Session $175.00
Total Estimated Cost: $		

The above is a detailed list of expected charges per Therapy session. The estimated costs are valid for 12 months from the date of the Good Faith Estimate. Note: Policies for late cancellation fees and missed session fees have been reviewed. There is a cancellation fee from $55.00 up to the full fee if the therapy session is not cancelled within 24 hours of the scheduled time.

Disclaimer This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $30.00 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call the No Surprises Help Desk at 1-800-985-3059. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 1-800-985-3059. **Keep a copy of this Good Faith Estimate in a safe place or take pictures of it.**

Signature_________________________________ **Date**________________

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Financial Agreement. Payment (if not covered by insurance) is due in full on the morning of your appointment (new and returning patients) and will be drafted by our billing team from the credit card on file that you sent with your intake information. If you are having financial difficulties, please let us know at least one week prior to your next appointment.

o Please visit www.jodiprovincecs.com for our Fee schedule for patients not using insurance or if insurance rejects your claim. Please be advised, rates are subject to change at any time.

o You are required to pay any remaining balance/past due in full prior to your next appointment. Should you no show or cancel less than 24 hours of your scheduled appointment, your credit card will charged a no show fee.

o If you are a new patient and not using your health insurance, we may run your credit card the day prior to your appointment, please review our no show policy in our informed consent.

o If you have a history of not paying your bills in a timely manner with our practice, you will be required to pay for your upcoming appointment in advance.

o Under circumstances of unusual and demonstrated financial hardship, we may establish payment installment plans. If an account is more than 60 days past due, without an established payment agreement, agreement will be remanded to a collection agency or small claims court.

o Clinical messages requiring more than 5 min of your clinicians' time (including reading your message, review of your chart, and responding to your message) will be subject to our most current fees and/or billed to your insurance company as a digital evaluation.

o Crisis phone and tele assessments by our therapy interns or another clinician in the office will be billed to your insurance or subject to out-of-pocket fees.

o **You waive your right to dispute credit card transactions from Jodi Province Counseling Services, PLLC through your bank.** If you have questions or concerns about your transactions or would like a copy of your bill, please contact our office first by calling the office. If you believe we made a billing error, please notify us, and we will review your account and directly refund your card if there was an error. If you choose to dispute a legitimate transaction with your bank/credit card, you agree to authorize Jodi Province Counseling Services, PLLC to release confidential information about your appointments/fees charged to the bank and credit card software as part of the dispute process. You will also be sent to a collection agency for unpaid appointments/transactions, even if the bank rules in your favor. Additionally, you will be charged a fee for the credit card dispute (similar to a bounced check) as we are charged by our credit card processor.

o **This practice reserves the right to charge your card on file for all qualified charges, unpaid fees, past due balances, same day cancellations, no-show fees and administrative processing fees without notice.** We welcome you to request a copy of your bill/itemized list of transactions and we will send this to you over the patient portal.

o This practice reserves the right to refer patients or their guarantor with unpaid bills over 60 days to a collections agency.

o By entering treatment with Jodi Province Counseling Services, PLLC, you are aware that you will be discharged from the practice if you decline to put a working credit card on file and/or if your credit card is declined and you choose not to pay your bill or not to respond to our attempts to contact you to address your balance.

Credit Card / HSA / Bank Card on File. To remain in treatment with our practice, you are required to have an active payment card on file. We will default to the card you gave in your intake form unless you contact us with a different card. If you choose not to comply, you will be asked to transfer your care to another practice.

By signing this document, you consent to having a working credit card or health savings account card on file in your HIPAA secure electronic medical record and you consent for us to charge your card automatically for any balance not paid by your insurance company (including unpaid claims that were submitted 90+ days earlier and

remain unpaid) as well as no show/late cancellation fees. You acknowledge you are waiving your right to dispute any qualified charges made to your credit card on file.

o If you place a credit/bank/HSA card on file with a different individual's name (such as a parent or spouse), by signing this document, you legally authorize that the credit card holder is aware of and agrees to charges related to your care at Jodi Province Counseling Services, PLLC. Providing someone else's card to our agency without their permission is fraud and may be prosecuted. If the cardholder questions legitimate charges from Jodi Province Counseling Services, PLLC, you authorize the billing and administrative team at Jodi Province Counseling Services, PLLC to contact the cardholder regarding these charges and release your information about your bill. If they dispute the charges, you are responsible for paying the balance due in full immediately with a different payment method.

Insurance. We file your insurance for you as a courtesy to you. It is very important that you find out exactly what mental health services your insurance policy covers, what providers are credentialed under your plan, and that you obtain appropriate authorizations. We do our best to estimate your financial responsibility at the time of service. However, we cannot guarantee your accurate out of pocket responsibility until we submit your claim to your insurance company and they process the claim. Occasionally, it can take several months to hear back from insurance companies regarding claims, especially if there is an initial denial. Should we receive a refusal from your insurance company due to delinquency in premiums by you, we will not schedule a subsequent appointment, or you may opt to pay out of pocket for the appointment. Should your insurance process your claim and you have made a payment, we will reimburse you for the duplicate claim.

○ **We request that you verify and understand your insurance coverage. You are responsible for charges not covered by your insurance. You are responsible to ensure that the provider you choose is in network with your insurance plan.**

○ It is the sole responsibility of the patient (or patient guardian) to ensure the practice has the most current demographic, financial, and insurance information on file. We require a driver's license to file insurance.

○ If our team does not estimate your financial responsibility accurately based on information given to us by your insurance plan, your provider is not covered under your insurance, or your insurance denies the claim, you will be responsible for unpaid fees associated with your appointment, even if it is months later as we will often appeal the insurance denial or contact you for additional insurance information.

○ If you do not provide your insurance information to us PRIOR to your appointment, we cannot guarantee that we can file it retroactively. You may have to pay our current out-of-pocket rates at the time of service. You are responsible for getting your most up to date insurance information to us via the portal, text message, or you can present a copy of your card in the office at least one week prior to your appointment.

○ Failure to update your insurance in advance of the first appointment at which it applies will result in a fee for each claim that must be re-submitted by our billing team.

○ You should be aware that your contract with your health insurance company requires that we provide them with clinical diagnoses and your medical records in the event of an audit.

○ It is ILLEGAL on a federal level and considered insurance fraud for the practice to waive any patient insurance fees including copayments and deductibles.

I have read the above and consent to the financial arrangement with Jodi Province Counseling Services

Patient &/or Legal Guardian Signature:____ Date________________________

Relationship to patient:____