Professional Services Agreement

Receipt of Notice of Privacy Practices, Informed Consent, Confidentiality

Release to Contact Payor(s), and Payment Agreement Form

Notice of Privacy Practices: I understand that the Genesis Notice of Privacy Practices provides information about how Genesis we may use and disclose protected health information about me.

_____I acknowledge that I have received a copy of Genesis Counseling Center, PC's Notice of Privacy Practices and that an additional copy is available upon request.

Informed Consent: This agreement indicates my commitment to enter into treatment for psychiatric and/or counseling services, and my understanding of the basic ideas and personal growth goals of treatment and/or counseling. I agree to keep my physician and/or therapist up to date about any changes in my symptoms or any 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 understand that my therapy may include periodic case consultation with Genesis' clinical staff when necessary. I acknowledge I give informed consent to begin psychiatric and/or counseling services.

Financial Agreement:

_____ Benefit Information 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 payer for payment.

_____ Genesis will submit claims to my insurance company

_____ I understand that **my payment is due at the time services are rendered.**

_____ I understand that I will be billed a **fee of $65 for appointments not canceled 24 hours** prior to 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. **Although reminders are sent, I understand they are a courtesy and I am ultimately responsible for remembering my appointments.** 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 60 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 not covered by insurance, case management fees as explained and/or court related fees should a Genesis employee be subpoenaed on my behalf. Case management activities such as written consultations or phone calls will be prorated at the therapist's hourly rate. 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 reasonable attorney fees and collection agency fees, pursuant to this course of action. My signature below represents my understanding of this payment agreement.

Credit Card on File Policy: We require keeping your credit card or debit card on file as a convenient method of payment for services that your insurance doesn't cover, but for which you are liable. Your credit card information is kept confidential and secure according to PCI standards.

_____ I authorized Genesis to charge my credit card the portion of my bill that is my responsibility.

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.

_____ _____

Client Name Date

_____ _____

Name of Guarantor and Relationship to Client ***Signature of Client or Guarantor***