

SALVEO COUNSELING CENTER

Family behavioral and mental health

Agreement of Office Policies and Notice of Privacy Practices

Dear Client,

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

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

If I have insurance, I understand that I am responsible to read my medical/behavioral health benefit book and understand it. I am responsible to pay a percentage of the cost of my visit at the time of treatment. I agree that I am fully responsible for the total payment of all services provided through this office. This includes services that are not a benefit of any medical or behavioral health insurance that I may have.

I agree to the above defined financial responsibilities of Salveo Counseling Center. In the case of default of payment, I am responsible for full payment of the balance, interest accrued, and any collection costs and legal fees incurred on this account.

I have read and understand the Informed Consent for Evaluation and Treatment document and agree to the terms.

I have read and understand the Client Financial agreement and agree to the terms.

Print Name _____

Signature _____ Date _____