

Information and Professional Services Agreement

We are pleased that you have chosen Champions Christian Counseling Center, LLC. This form gives some information about our professional relationship.

CONFIDENTIALITY

You have the right to confidentiality. No information will be released without your written consent except as required by law. Such exceptions to confidentiality include:

1. We believe you are in imminent danger of hurting yourself or others.
2. We are ordered by a Judge's order to disclose information or there is a statute requiring such disclosure.
3. If you choose to use your insurance for payment, they will typically request ongoing communication to certify the medical necessity of your continuing treatment

I acknowledge and understand that under the Health Insurance Portability & Accountability Act of 2003 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I have also been given notification of all "HIPAA" requirements concerning privacy policies. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

*Talk to your therapist about any confidentiality concerns.

RIGHTS & RESPONSIBILITIES

Rights

You have a right to be provided with professional and respectful care. You have a right to know our assessment of the problem, the recommended treatment, and the resources available to help deal with your situation. You also have the right to refuse our suggestions. You are welcome to ask your therapist any question regarding their background, credentials, professional experience or philosophy.

Responsibilities

1. To be honest, open and willing to share your concerns
2. To ask questions when you do not understand, or need clarification
3. To discuss any reservations you have about your treatment plan
4. To follow the agreed upon treatment plan
5. s. To report changes or unexpected events related to your problem
6. To keep appointments whenever possible or to call and cancel within 24 hours prior to your appointment. Otherwise you will be charged the full fee for the service.

Remember that you are responsible for your thoughts, feelings, actions and growth. We are here to help facilitate that growth to the best of, our ability.

PAYMENT INFORMATION

The average fee is \$120.00 for a 50-minute therapy session. It is the same fee for individual, couple or family therapy. Some fees are based on a sliding scale based on monthly salary.

Insurance

If you belong to a managed care program we will bill your insurance if you so direct. Co-payments or deductibles are payable at the time of service. If insurance does not pay you are ultimately responsible for the fee.

In all other instances, you will be expected to pay the full fee at the time of service. We can assist you in filing for reimbursement from your insurance company.

*There is a \$25.00 service charge for all returned checks.

Cancellations

Please give 24 hours advance notice for cancelled appointments. This serves as a courtesy to the therapist who is reserving the time for you and also to other clients who are scheduling visits. The advance notice is standard policy in our profession. Failure to give appropriate notice will result in a full charge. Champions Christian Counseling Center, LLC has a 24-hr answering service to assist you in canceling your appointment in a timely manner. Your signature below shows that you have read and accepted this policy. Failure to sign will result in a referral to another provider.

Signature: _____ Date: _____