Let's Talk
Therapy and Supervision

Authorization and Guarantee

Client Name: _____

Date of Birth: _____

Insurance Benefits (if applicable): As a courtesy, we will make every effort to contact your insurance company to obtain your therapy benefits. The benefit information obtained cannot be considered a guarantee of actual benefits or insurance payment for services rendered. We encourage you to contact our insurance company to verify your benefit information.

Medicare (if applicable): "I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Administration or its intermediaries any such information needed for this or related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and coinsurance."

Guarantee of Payment (not applicable for Worker's Compensation patients): "In consideration of services rendered to me by "Let's Talk" Therapy & Supervision, Inc., I hereby guarantee payment for all services not covered or allowed by insurance. I also understand that all bills are due and payable upon receipt. I understand that the patient responsibility portion of my bill will be due and payable at the time of service. I understand that should my account with "Let's Talk" Therapy & Supervision, Inc. become delinquent and turned over to a collection agency, that I, the undersigned, will be responsible to pay all collection agency fees, court costs or any other fees/costs associated in resolving my account balance."

Fee Agreement if Not Using Insurance: "I agree to pay my private pay session fee of

$_____ at the time of service. I understand that if payment is not made, services may be suspended, and I may be referred to another provider for services."

Returned Checks: We are happy to accept your personal check, however, if your check is returned for any reason, you expressly authorize your account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. "I understand that there will also be an overdraft fee of $30 payable to "Let's Talk" Therapy & Supervision, Inc. prior to my next session being scheduled." The use of a check for payment is your acknowledgement and acceptance of this policy and its terms and conditions.

2458 W. Newell St.
Wichita, KS 67203
Angela@letstalkwichita.com
316.804.5135 v 316.847.7082 f

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Cancellations/No Shows: It is important that you keep your appointments. However, we understand that illness and circumstances require the need to cancel on occasion on your part and your clinician's part. Kindly provide 24 hours' notice, if possible, for cancellations so others can use that time. Cancellations not made at least 24 hours in advance may result in a cancellation fee of $30 and prime appointments times may no longer be available to you for excessive cancellations and/or not showing for your appointments. A $30 no show fee may be assessed if you miss an appointment without cancelling and future appointments may not be scheduled until payment of the fee.

Consent for Treatment: "I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist, may be considered necessary or advisable while a client of "Let's Talk" Therapy & Supervision, Inc."

Waiver and Release: "I hereby release, discharge and acquit "Let's Talk" Therapy & Supervision, Inc., their agents, representatives, affiliates, employees or assigns of and from all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical service, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services."

Authorization to Release Medical Information: "I consent to allow "Let's Talk" Therapy & Supervision, Inc., to use and disclose my protected health information (PHI) within "Let's Talk" Therapy & Supervision, Inc. to carry out my treatment, to obtain payment and to carry out health care operations. My PHI may be disclosed to my health plan and/or its agents as necessary to verify benefits authorize services, and process medical claims. My PHI may be disclosed to outside health agencies or institutions involved in my continuing care and/or for emergency care purposes with a specific signed release for each entity. My PHI may include medical information or any information pertaining to the evaluation, treatment and history. This may include psychiatric, HIV/AIDS, sickle cell, alcohol and/or drug information, coded medical information and charges to my health plan and/or their intermediaries. This consent is subject to revocation at any time except to the extent that action has been taken in reliance on it. Withdrawal of consent shall be addressed in writing."

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I do/do not authorize "Let's Talk" Therapy & Supervision, Inc.to exchange written and verbal information with my primary care provider to aid in coordination of care. Please circle "do or do not" as appropriate and provide primary care provider's information if you do authorize coordination of care communication:

_____

_____

_____

Assignment of Benefits: "I authorize my health plan to pay benefits directly to "Let's Talk" Therapy & Supervision, Inc. I understand that in the event my health plan or healthcare contract does not cover services, I will be responsible for payment. I understand that if my health plan does not consider "Let's Talk" Therapy & Supervision, Inc. a participating provider, charges incurred will be paid by me. I further agree to accept full financial responsibility for payment of charges rendered to the above patient.

Court Reports and/or Testimony: "I understand that insurance does not pay for "Let's Talk" Therapy & Supervision, Inc. services to complete reports for court hearings/attorneys, case management, mediation, nor for guardianship evaluations, nor for time spent testifying or waiting to testify in court. Therefore, I understand and agree that I will pay "Let's Talk" Therapy & Supervision, Inc. for time spent involved in the aforementioned activities at a rate of $50 per 15 minutes (all time under 15 minutes will be rounded up to 15 minutes)."

Confidentiality: "I understand that information shared between "Let's Talk" Therapy & Supervision, Inc. and I will be kept confidential unless that information needs to be shared with others for my protection or someone else's protection. If I am a minor/child, I further understand that information may be shared with my parent/guardian at "Let's Talk" Therapy & Supervision, Inc. discretion for my benefit and/or well-being."

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Notice of Privacy: "I acknowledge that a copy of the Notice of Privacy Practices was made available to me and for my review. Furthermore, I understand that I can request, and immediately receive, a copy of this document."- I CERTIFY THAT I HAVE RECEIVED OR HAD THE OPPORTUNITY TO RECEIVE A COPY OF THIS FORM, UNDERSTAND ITS CONTENTS AND ACCEPT ITS TERMS-

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature, if applicable Date

_____ _____
Therapist Signature Date

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