Spence Counseling Center PC
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Consent to Treatment, Use, and Disclose Your Health Information

This form is an agreement between you, _____________________(*client name*) and me/us Spence Counseling Center, P.C. When we use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here ___________________ (*minor child*).

When we examine, diagnosis, treat, or refer you, we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information to decide what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form, you are agreeing to let us use this information here and send to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent.

If you do not sign this Consent Form agreeing to it and what is in our Notice of Privacy Practices, we cannot treat you as permitted by Section 164.506 of the Code of Federal Regulations.

_________________________	___________________________	_________________________
Client/Guardian Signature	**Print Name**	**Date Signed**

Shortened Notice of Privacy Practices

Our practice is dedicated to maintaining the privacy of your personal health information. We are required by law to do this. These laws are complicated, but we must provide you with important information. This Notice is a shortened version of the full legally required Notice of Privacy Practices (NPP) which is available in the office, so refer to the Complete Notice for more information. Even in the Complete Notice, we can't cover all possible situations, so please talk to your provider or our Privacy Officer, Rhonda Spence about any questions or problems.

We reserve the right to change our Consent Form and Notice of Privacy Practices in accordance with Section 164.520 of the Code of Federal Regulations and clients will be notified if we change them. You are always welcome to a copy of our Consent or Notice of Privacy Practices in paper or electronic form. If you are concerned about some of your information, you have the right to ask us. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your written request. After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will comply with your wishes about using or sharing your information from that time on, but we may already have used or shared some of your information and cannot change that.

1) I hereby give consent to Spence Counseling Center for myself and/or my dependents in the evaluation and treatment regarding my therapy that may be advisable or necessary in their opinion.
2) I authorize any holder of medical information on myself and/or my dependents to release said information needed to determine benefits payable for medical services. I further authorize payments for services furnished to myself and/or my dependents be made payable to Spence Counseling Center.
3) I understand and agree that **I must notify Spence Counseling Center within 24 hours to cancel or change an appointment** for myself and/or dependents. **If not, I will be billed and agree to pay the full session fee of $170.00.**
4) I agree to notify Spence Counseling Center as soon as possible if my name, address, phone, or insurance information changes. If insurance coverage changes, I will bring in the card(s) as soon as possible.
5) **Having insurance coverage does not guarantee payable benefits. I understand that I am responsible and agree to pay for any deductibles, co-pays, co-insurances, or any amounts not covered by my insurance.**
6) **Any past due fees of balances over $200.00 and/or later than 60 days will accrue a monthly 1.5% late charge to my account.**
7) I also understand that if my account is not paid within 90 days of receiving my first bill, my account may be turned over to a collections agency. **Clients with accounts turned over to a collections agency will be responsible to pay a $75 administrative fee to Spence Counseling Center prior to seeing a therapist again.** They may also be required to pay cash at the time of each session for future appointments.
8) This consent shall hold valid for this and all future visits unless revoked in writing. My signature demonstrates that I have read, understand, and agree to the above.

_______________________________	___________________________	____________________________
Client/Guardian Signature	**Print Name**	**Date Signed**