

AGREEMENT FOR PARTICIPATION

We would like to welcome you to our office and inform you that hours of operation are by appointment from 8:00 a.m. to 5:00 p.m. Monday through Friday. Saturday hours are also available. We have a 24 hour answering service for emergency calls as well as appointment cancellations. The phone number is (616) 949-7460. If you find it necessary to cancel an appointment, we require 24 hour notice because a specific time has been set aside for you. Broken appointments, without 24 hour notice, may be charged a full fee. Please be aware that your insurance company will not pay for missed appointments.

We participate with most insurance companies and will make every effort to bill the insurance company on your behalf. However, some insurance companies may require that you file your own claim. A receipt may be given to you following your session which contains all information needed to file a claim with your insurance company. You are responsible for your portion of the charges and full payment or your co pay is expected at the time of service. Payment can be made in cash, by check or credit card. We cannot assume responsibility for accuracy in estimation of insurance benefits or for success in collection of claims.

A full counseling/therapy session typically lasts 50 minutes.

A fee of \$20.00 will be added to your account for checks returned to us from the bank. A fee of \$5.00 will be added to your account for checks that need to be redeposited.

Any unpaid balances that are sent for collection may be assessed a \$5.00 fee.

The parent or guardian of a minor child who brings that child in for counseling is responsible for any charges incurred.

Please advise us of any changes in address, telephone or insurance coverage.

CONSENT FOR PARTICIPATION

I hereby authorize Claystone Clinical Associates, P.L.C. through its staff, to provide the following services: outpatient psychotherapy/counseling, psychological testing, psychiatric evaluation, case review, and/or medication review and monitoring. I understand my participation is voluntary.

PRIVACY NOTICE/RECIPIENT RIGHTS

I have read and understand my rights as they have been written in the Privacy Notice and the Recipient Rights document. I understand that I may contact the Privacy Officer or the Recipient Rights advisor with any questions or concerns.

RELEASE OF INFORMATION

I hereby authorize _____ to release medical and other information as may be required by my insurance company and case management company utilized by my insurance company to obtain benefits for charges for treatment received by me or my dependents. I also authorize a quality-assurance review of my file contents, if required by my insurer, by an appropriate member of the clinical staff.

Initials _____.

I UNDERSTAND THE ABOVE POLICIES AND AGREE TO THE TERMS OF THESE POLICIES.

Name: (please print) _____

Signature: _____ Date: _____

Witnessed: _____ Date: _____

I UNDERSTAND THAT IF MY THERAPIST IS NON-PARTICIPATING WITH MY INSURANCE COMPANY, I AM RESPONSIBLE FOR TOTAL CHARGES INCURRED.

Signature: _____ Date: _____

Witnessed: _____ Date: _____