Journey…..counseling and consultation

Financial Policy and Confidentiality Statement

Payment is expected after each session unless other arrangements have been made. In the event of insurance coverage, the co-pay is due at each session, or to be paid within 15 days of receiving monthly statements.

"No show" appointments will be billed at a rate of $25.00. I understand that I must give a 24 hour notice for appointment cancellation. [An insurance company will not be billed for the "no show" fee, so client will be responsible for the entire amount.]

I understand that what is discussed is kept confidential; however, there are certain exceptions to this policy. These exceptions include issues of child abuse/neglect, dependent adult abuse/neglect, or when safety concerns are present in regard to the potential for suicide or homicide. Any other disclosure of information will only be done with my written consent.

I hereby authorize the release of information to **Pam Nerness (Billing Agent)** for the purpose of insurance filing and patient billing. Only information pertaining to billing will be released and will be held in the utmost confidence.

My signature below authorizes the release of information necessary to process claims (Section 12 of the HFCA 1500 form). My signature below authorizes payment of medical benefits to be paid to **Edward Ruppert, LISW** for services rendered.

I agree to be financially responsible, with or without the benefit of insurance, for all charges. I understand the above stated terms and agree to the financial liability. [If the client is a minor, the parent or guardian accompanying them is responsible for payment.]

I have received a copy of ***Journey Counseling and Consultation*** "Notice of Privacy Practices".

Signed: _____ Date: _____

Witness: _____ Date: _____