Stronghold Counseling Services, Inc.
Treatment and Financial Contract

1 – INFORMED CONSENT

I hereby request & consent to psychological care and other procedures, which will include therapy performed on me ________________(**please print name**) (or the minor named below for whom I am legally responsible) by any clinician, therapist, or counselor who provides services on behalf of Stronghold Counseling Services. I understand that I will have the opportunity to discuss the nature and purpose of counseling procedures with the therapist. I understand that results of psychological care and therapy are not guaranteed.

There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition of mine as a result of treatment in this clinic. It is my intention to rely on the counselor to exercise professional judgment during the course of therapy, which she/he feels at the time to be in my best interest.

I understand and am informed that, the practice of psychotherapy includes some treatment risks. I do not expect the therapist or agency be able to anticipate and explain all risks and complications, and I wish to rely upon the therapist to exercise judgment during the course of therapy which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest. I will have an opportunity to ask questions about its content, and by signing below I acknowledge that I understand and agree to the foregoing. I intend this consent form to cover the entire course of treatment at/with Stronghold Counseling Services for my present condition and for any future condition(s) for which I seek treatment.

2 – CONSENT FOR TREATMENT OF A MINOR

I, the undersigned, as parent or guardian of_______________, (**please print name**) a minor child, hereby authorize the counselor and whomever he/she designates as his/her assistants, to administer treatment to my child as necessary. I also acknowledge and agree to the terms set forth in Section 1 and Section 3 on behalf of the minor child.

3 – HIPAA

By signing below, I acknowledge I am in receipt of the Stronghold Counseling Services HIPAA notification and fully understand it and my rights (or my minor child's rights) per the document.

4 – COMMUNICATION WITH FAMILY AND FRIENDS

Stronghold Counseling Services may share ☐ medical ☐ billing ☐ scheduling information with the following individuals, at their request, who are involved with the client's care. Such disclosure shall expire upon the event which renders this contract no longer enforceable. The client for which this Treatment and Financial Contract is binding upon may revoke this authorization in writing, subject to certain exceptions. Stronghold Counseling Service may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs this authorization. This information subject to this disclosure may be subject to redisclosure by the recipient and will no longer be protected by Part 164, Subpart E of the regulations interpreting the Health Insurance Portability and Accountability Act.

Release to: _________________________________ Relationship: ____________________________________

Release to: _________________________________ Relationship: ____________________________________

5 – FINANCE POLICY

Payment for all services is due at the time that services are rendered. We accept payment in the following forms: cash, check, credit card, or check card (personal or HSA cards). As a courtesy to you, we will submit claims to your health insurance. While we may accept assignment of insurance benefits, you must understand the following:

A. Your insurance policy is a contract between YOU, possibly your EMPLOYER, and the INSURANCE COMPANY (Insurance Company meaning any of the following: personal health insurance, workers' compensation insurance, personal injury insurance, automobile, or other liability insurance and/or Medicare). We are NOT a party to those contracts. We will assist you with understanding your benefits but we are not guaranteeing them since your contract is with your insurance company, not us. **IF YOU HAVE MORE THAN ONE INSURANCE POLICY YOU MUST LET US KNOW NOW.**

B. All charges are your responsibility whether your insurance company pays or not. Not all services we provide are covered benefits under every insurance policy. Some insurance companies select certain services they will not cover. Fees for these services along with unpaid deductibles and co-payments are due at time of treatment, except as provided below in Subsection C.

C. If your insurance company does not pay for your balance in full within 30 days, we ask that you contact the carrier to help speed things up. If the insurance company does not pay your balance in full within 45 days, we will require you pay the balance in full.

D. **UNLESS YOU NOTIFY STRONGHOLD COUNSELING SERVICES OF CANCELLED THERAPY SESSIONS AT LEAST *24 HOURS IN ADVANCE*, YOU WILL BE CHARGED A $60.00 LATE FEE FOR THE LATE CANCEL OR MISSED SESSION.**

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E. We reserve the right to forward an overdue account to a collection agency in the event you do not pay your balance in full. The collections agency we use is Express Collections, Inc. Accounts forwarded to collections will be subject to a collection service fee, which can vary between 25% - 47% of the original overdue balance prior to late payment and/or interest charges. This rate is based on the amount due.

F. Any changes made to this contract will only be effective with respect to all future services provided by Stronghold Counseling Services. However, any changes made to this contract will **NOT** be effective with respect to services you have previously received from Stronghold Counseling Services. Therefore, any changes to your insurance, including but not limited to changes in carrier, the terms of the policy, or the specific policy used, will not be applied retroactively.

I, the undersigned, hereby acknowledge and agree to the above and that this signed Treatment and Finance Contract will endure for the lifetime of all my treatment(s) (or my minor's treatments) at Stronghold Counseling Services, regardless of whether my insurance policy or carrier changes or if the payer is a workers' compensation carrier or personal injury carrier.

6 - TELEHEALTH

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services. Patients are permitted to make reasonable requests for receipt of communications containing protected health information by alternative means or at alternative locations.

7 – ASSIGNMENT AND RELEASE OF BENEFITS

I, the undersigned, certify that I (or my dependent) have insurance coverage as indicated with the card I presented today and assign all such insurance benefits, if any, otherwise payable to me for services rendered, to Stronghold Counseling Services. Per the financial policy in Section 5 above, I understand that I am financially responsible for all charges whether paid or not paid by insurance. I hereby authorize Stronghold Counseling Services to release all information necessary to secure the payment of benefits. I authorize this signature to apply to all future insurance submissions.

CONSENT TO TREATMENT

I consent to treatment from Stronghold Counseling Services.

Printed Name: ____

X____ __________________________

SIGNATURE *DATE*