Payment Agreement and Consent to Use and Disclose Your Health Information

Self-Pay Option

I understand that payment is due at the time of each session. My therapist and I have agreed that the amount to be paid based on my ability to pay, will be $_____

Payment for services is an important part of any professional relationship which is even truer in counseling. One treatment goal is to make relationships and the duties and the obligation they involve clear. You are responsible for payment of counseling services. Meeting this responsibility shows your commitment. If you have chosen to pay cash for your counseling, you and your counselor have agreed on a fee based on your ability to pay. If you have asked me to bill you insurance, I have explained that process to you. I ask that you and your counselor sign this agreement acknowledging your financial agreement.

I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged $30.00 for the missed appointment.

Client Initials	Therapist Initials

Insurance Option

I understand that billing my insurance is a courtesy provided by Michael Rosengren LMFT and that if payment is not received in 45 days, I will be held ultimately responsible for payment of services rendered and that the counselor may stop treatment until payment is received. I understand it is my obligation to pay the insurance co-payment at the time of each visit.

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian or other representative). Based on my observation of this person's behavior and responses I believe that this person is fully competent to enter into this agreement.

This form is an agreement between the client ("you") or representative and Michael Rosengren LMFT. When I treat or refer you, I will be collecting what the law calls "protected health information"(PHI) about you. I need to use this information in my office to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let me use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard my notice of privacy practices, which explains in more detail what your rights are and how I can use and share your information.

If you do not sign this form agreeing to my privacy practices, I cannot treat you. In the future, I may change how I use and share your information, and so I may change my notice of privacy practices. If I do change it, you can request a copy by email request at michaelrosengren@yahoo.com, or by calling me at 661-345-1429. If you are concerned about your PHI, you have the right to ask me not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to accept these limitations. However, if I do agree, I promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to my privacy officer. I will then stop using or sharing your PHI, but I may already have used or shared some of it, and I cannot change that.

Signature of Client or Representative _____ Date _____

Print name _____ Relationship to client _____

Counselor Signature _____ Date _____