GRANGER
MEDICAL CLINIC

Consent for Treatment, Release of Information, and Assignment of Health Insurance Benefit

I hereby consent to receiving treatment for therapeutic/psychological concerns at Granger Medical Clinic (Granger). I understand that when participating in psychotherapy, there may be an initial increase in symptoms due to the need to explore and address issues related to my situation. This is normal and my therapist will work with me on navigating these issues. This agreement will remain in effect until I choose to revoke it in writing.

By signing below, I authorize Granger to disclose my protected health information and medical information to process my claim(s) (as a courtesy to our patients, we will file the claim(s) with their insurance carrier with the understanding that the patient/guarantor, not his/her insurance company, is responsible for payment of this account).

Patient (if 18 years or older) or Parent/Legal Guardian Signature:_____

Date:_____

Notice of Privacy Practices

I acknowledge that I have received a copy of Granger Medical Clinic's NOTICE OF PRIVACY PRACTICES and that it is my responsibility to read said notice to understand how my, or my child(ren)'s, Protected Health Information (PHI) may be used.

I understand that no authorization is required from me in order for Granger to use my, or my child(ren)'s, PHI for purposes of treatment, payment, or health care operations. Other uses or disclosures may require my written authorization.

Patient (if 18 years or older) or Parent/Legal Guardian Signature:_____

Date:_____

Notification of Appointments/Treatment/No-Shows

Thank you for respecting the time we have reserved for you by providing at least a 24-hour notice should you need to cancel or reschedule. For no-show visits, please be advised that you may be assessed a no-show fee for missed appointments - some may be charged at the cost of the visit or service. If recurrent no-shows become an issue, a deposit may be required to hold future appointments. You will receive a courtesy text, voice, and/or email reminder, sent out prior to your appointment. Whether received or not, please be advised that it is your responsibility to remember your appointment date and time.

Credit and Finance Charge Policy and Agreement

I agree to provide accurate, updated insurance and personal demographic information each visit. I agree to be financially responsible for costs incurred (in my, or my dependent's, care). I understand that charges for services provided shall be paid for at the time of each visit. If claims are submitted to an insurance company by Granger on my behalf, I understand that the copayment or deductible is due at the time care is rendered. I hereby authorize any benefits due to me to be paid directly to Granger (assignment of benefits). I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non-covered services, or services deemed as "non-medically necessary" by my third-party insurance carrier. I agree that I am responsible for satisfying any conditions necessary for insurance or health benefits.

All delinquent accounts may be charged an interest rate of 1.5% per month (18% per annum). In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee not to exceed 33% of the unpaid balance. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney fees in addition to the collection fee.

You authorize us to call you at any number you provide or at any number at which we reasonably believe we can contact you, including calls and/or text messages to mobile, cellular, or similar devices for any lawful purpose. You agree to any fee(s) or charge(s) that you may incur for incoming calls and/or text messages from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

In consideration for medical services rendered, I (we) acknowledge that I (we) have received notice of Granger Medical Clinic's financial policy and agree to pay for said medical services according to such terms.

Patient (if 18 years or older) or Parent/Legal Guardian Signature:_____

Date:_____