Mount Comfort Counseling Services

P. O. Box 3381, Fayetteville AR 72702
3281 W. Mt Comfort Road Fayetteville AR 72704
Glenda Davis, MSC, LMFT, LPC – Therapist

Informed Consent to Treatment & Insurance Filing

I/We indicate by signing below that I/We are authorizing, Glenda Davis and Mt. Comfort Counseling Services permission for treatment and to file for insurance claims all sessions rendered previous to this date. This does not represent additional cost to me/us. In addition, I/We give permission to file insurance claims from this point forward and agree to pay all relevant deductibles and co-payments. I/We certify that the insurance information now provided is accurate to the best of my/our knowledge and that coverage existed at the time of service.

Because an employer or other third party may have contracted for various levels of co-payment, deductible, etc. for different groups of workers we can only make an estimate of your portion of the fees when filing your insurance. **Therefore, you are responsible to verify coverage with your insurance company**. Not all information given to you by your insurance company or our staff will be accurate or reflect the final billing practices of your carrier. Not all services are a covered benefit in all contracts and some insurance companies arbitrarily select certain services they will not cover. You are responsible for the unreimbursed amount unless agreed upon in advance and noted on this form in the space provided below*.

Authorization: I/we hereby authorize Glenda Davis/Mt. Comfort Counseling Services to furnish information to insurance carriers concerning my treatment, and hereby irrevocably assign to Glenda Davis/Mt. Comfort Counseling Services all payments for services rendered when applicable excluding reimbursements to the client for advance payment or overpayment. I/We understand that on occasion insurance companies may determine that services rendered were not reasonable or necessary despite the fact that they were prescribed by a therapist and performed by professional staff with my well-being in mind. I/we understand that I/we are fmancially responsible for all charges whether or not covered by insurance beyond this date. I/We authorize the release of pertinent information to my referring physician when appropriate.

Finally, current insurance practices require that a bill is submitted in the name of one identified client. This does not permit a bill to be submitted with the name of all parties present at the time services are rendered. However, all parties in therapy must understand that each has the same right to privacy and protection from disclosure of confidential information. By signing below all parties acknowledge reading the information above and agree to not allow personal information disclosed in sessions to be released unless all parties present during a session sign a release of information. Personal information of minor children must be signed for by all relevant adult guardian and limitations of confidentiality have been discussed. Our office requests 24 hrs notice to change or cancel an appointment. Insurance companies do not allow billing for missed appointments, therefore the client is responsible for short notice cancellation or missed appointment fees.

I understand that the intake session will be billed at $110 per session and individual follow up appointments are $100 per session. All sessions are 50-60 minutes long and additional charges will be agreed upon in advance. *If I do not give* 24 *hours notice to change or cancel an appointment I understand I will be charged and will be responsible for this cost regardless of insurance.*

_____ _____

Signature of adult or child filing insurance. Date Signature of spouse when attending sessions Date

_____ _____

Signature of guardian of child or other adult Date Signature of other person attending sessions Date

_____ _____

Signature of other person attending sessions Date Signature of other person attending sessions Date

*Modifications to above:

Therapist initials _