CLIENT FINANCIAL RESPONSIBILITY STATEMENT

I hereby authorize Turning Point Psychotherapy Associates, LLC (TPPA) to release any information obtained that is necessary to support insurance claims (private and government-sponsored) on my behalf, and request that payments be made directly to TPPA and its providers. TPPA agrees to accept the reimbursement pre-determined by private and government-sponsored insurance programs and will only charge clients for their deductible, co-insurance, and/or non-covered services, as outlined below:

Individual Session Fee $140
Returned Check Fee.....$ 30
Official Correspondence (billed in 10 minute increments).....$ 20
Late Cancellation or Missed Appointment Fee.....$ 75

My signature below indicates that I agree to be responsible for any and all charges incurred by me, regardless of insurance coverage, and acknowledge that payment is expected at the time of service, unless arrangements have been made in advance.

_____ _____
Client Signature Date

NOTICE of PRIVACY PRACTICES for the PROTECTION of HEALTH INFORMATION

My signature below indicates that I have read, understand, and agree to the Policies and Practices of Turning Point Psychotherapy Associates, LLC to protect the privacy of my personal health information.

_____ _____
Client Signature Date

STATEMENT of PATIENT'S RIGHTS and RESPONSIBILITIES

My signature below indicates that I have read, understand, and agree to the terms of the Statement of Patient's Rights and Responsibilities.

_____ _____
Client Signature Date

ELECTRONIC POLICY STATEMENT

My signature below indicates that I have read, understand, and agree to the terms of the Electronic Policy Statement.

_____ _____
Client Signature Date

STATEMENT of LIMITS of PATIENT CONFIDENTIALITY

My signature below indicates that I have read, understand, and agree to the terms of the Statement of Limits of Patient Confidentiality.

_____ _____
Client Signature Date