

**Financial Agreement and Receipt of Privacy Policies
and Informed Consent**

Insurance Carrier:

Your Deductible:

Your Copay's:

Your Visit Limit

Self Pay Rates:

Initial Session:

Counseling Sessions:

Family Sessions:

Missed Appointment Fee of \$40 applies to all. Insurance companies do not pay this fee

I authorize Bethlehem Counseling Associates, P.C. to release any information obtained during examinations or treatment of this client which is necessary to expedite and support any insurance claims account. **I understand that I am financially responsible for all charges, regardless of insurance coverage.** I authorize the payment of benefits otherwise payable directly to this provider. Medicare regulations may apply.

If you are using insurance coverage, the financial information listed above has been provided by your insurance company. At times, insurance benefits have been stated incorrectly to BCA as we check your coverage. So, if you have any questions about the stated benefits or wish to check the benefits yourself, please feel free to contact your insurance company personally.

Client Name

Date

Responsible Party Name

Date

Client/Responsible Party Signature

Date

I have received a copy of BCA Privacy Policies and Procedures and the BCA Informed Consent to Counseling and have asked questions about anything that is not clearly understood. I agree to comply with the policies and information presented.

Print Name

Date

Client/Responsible Party Signature

Bethlehem Counseling Associates, P.C.
2045 Westgate Drive, Suite 304
Bethlehem, PA 18017

Phone: 610-865-8177
FAX: 610-865-2764

**Authorization to Disclose Information
To Primary Care Physician**

I understand that my records are protected under the applicable state and federal laws governing health care information that relates to mental health services and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

I, _____ hereby authorize _____
(Please Print Client Name) *(Please Print Treating Clinician Name)*

Please Check One of the Following:

- _____ Release any applicable information to my Primary Care Physician
- _____ Do not release information to my Primary Care Physician
- _____ Do not currently have a Primary Care Physician

(Client or Client Responsible Party, please sign) _____
(Date)

(Please print the name signed above)

Primary Care Physician's Name, Address, & Phone

Maintain Original in Client's Behavioral Health File