THE COMMUNITY COUNSELING CENTER OF MOORESTOWN VNA

Consent for Treatment

The undersigned hereby consents to any counseling services rendered to the client by the physicians, counselors/therapist employees and contracted healthcare providers.

Authorization to Release Information

The undersigned authorizes The Community Counseling Center of Moorestown VNA to release all or any part of the clinical record of the client named on this encounter form to other healthcare providers, insurance companies, organizations, or agencies as may be concerned with the diagnosis, treatment or payment of the counseling services rendered. The undersigned also authorizes other healthcare providers to release all or part of the clinical record of the client named on the encounter form to The Community Counseling center of Moorestown VNA that may be required to assist The Community Counseling Center of Moorestown VNA in client's diagnosis and/or treatment.

Assignment of Insurance

As a convenience to our Clients, The Community Counseling Center of Moorestown VNA will bill your insurance carrier directly (when appropriate). I hereby assign, transfer and set over to The Community Counseling Center of Moorestown VNA all the rights, title and interest to medical, automobile personal injury protection, or workers compensation medical insurance benefits, and all other rights and privileges otherwise payable to me for those services provided. I also understand that obtaining precertification, authorization or other requirements or conditions of my insurance coverage is my responsibility.

Receipt of Clients Rights & HIPAA Privacy Policy

The undersigned acknowledges that he/she has received a copy of Client Rights as required by the State of New Jersey and The Community Counseling Center of Moorestown VNA's Notice of Privacy Policy as required by HIPAA.

Financial Responsibility

The undersign agrees, whether signing as a Client or an agent, that in consideration of the services to be rendered to the Client, he/she hereby individually obligates himself/herself to be responsible for all or any unpaid portion of the bill incurred. I further understand the unpaid portion of the bill may be insurance deductibles, coinsurance, copayments or the entire bill, if my insurance carrier denies coverage.

The undersigned certifies that he/she has read the foregoing and understands its terms and is the Client or is a duly authorized representative of the Client and accepts the above terms.

_____ _____

Client Signature Date

_____ _____

Witness Date