Lauren Rose, LCSW

Acknowledgement of Receipt of Financial and Privacy Policies

Client Name: ____

Date of Birth: ____

Welcome to my office! Please read these policies and let me know if you have any questions.

Payment is due at each session. You will receive a receipt which can be mailed to your insurance company and any reimbursement will be mailed directly to you. Your policy is a contract between yourself and your insurance company. I am not a party of that contract. If necessary, it is your responsibility to obtain any referrals or preapproval prior to beginning treatment.

Cancellation Policy: I would appreciate at least 24 hours notice of your need to cancel an appointment. You will be billed for a regular session for all appointments missed or cancelled with less than 24 hour notice.

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I have read and understand the above policies, and I have been given opportunity to ask for clarification. I also acknowledge that I have been provided a copy of the Notice of Privacy Practices, and have therefore been advised of how health information about me or my child may be used and disclosed by Lauren Rose, LCSW, and how I may obtain access to and control this information.

____

Client Signature   Date

____

Guardian's name and relationship to client (if client is under 18 years of age)

____

Guardian Signature (if client is under 18 years of age)   Date

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