SERENITY & HOPE, LLC
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PLEASE READ THE FOLLOWING SECTION CAREFULLY IF YOU PLAN TO USE YOUR HEALTH INSURANCE

Please initial each item to indicate that you have read and understand it:

1. I understand the follow information regarding my/my child's mental health benefits:

   a. My deductible is $______________. Initial: _____
   b. My co pay or co insurance/copay amount is __________. Initial: _____

2. I understand that if my/my child's insurance company does not pay, I will be responsible for the balance owed to my therapist/ my child's therapist. The therapist **charges $100.00 per 45 minute session.** Initial: _____

3. I understand that when I elect to use my or my child's health insurance benefits to pay for psychotherapy services, that my/my child's diagnosis, symptoms and substance abuse (if any) issues and history will become part of my/my child's permanent health insurance records. My/my child's insurance company has retained the right to access and copy any and all of my record. Initial: _____

4. Your therapist may be required to fax treatment plans and diagnostic reports to your/your child's insurance carrier. In some instances, this information may be submitted to insurance databases and/or employers when they are the purchasers of your/your child's medical/mental health benefits. You have most likely waived your rights of confidentiality when you signed up with your insurance company. Initial: _____

5. If I do not understand any of the above items I will ask for clarification. Initial: _____

____

Client Name (Please print) DOB

____

Signature of Client or Parent/Guardian Date

____

Kathleen Hurley Med, LPC, NCC Date