Lafayette Psychology Center
www.LafayettePsychologyCenter.com
1538 W. Pinhook Rd. • Lafayette, LA 70503 • 337.234.4912

CONSENT AND OFFICE POLICIES

I understand that as a condition of my receiving treatment at Lafayette Psychology Center, my therapist and/or the responsible clerical personnel of Lafayette Psychology Center may release to my insurer, managed care company or other entity responsible for payment, relevant patient information. Such information would include, but is not limited to the following: Date of service provided, DSM-IV diagnosis, type of service provided, patient and/or insurance name, identification information, or any other information needed to obtain authorization, certification or processing of my claim. Other requests for information will require the patient or guardian to sign a Release of Information form which will require the patient's name, requesting party's name, reason for the request, and a specification as to what information will be released. Our office typically retains records up to seven years but may keep records longer depending on the reason for treatment or evaluation or according to relevant state or federal laws. Records are destroyed in a confidential manner.

If at any time I am uncomfortable with this consent, I may withdraw this consent in writing. My revocation/withdrawal will be effective except to the extent that Lafayette Psychology Center and/or my therapist has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if the withdrawal of consent limits the ability to collect legitimate fees for services rendered. I further understand that if my account is referred to an attorney or collection agency I will pay for all costs of collection. There will also be a $25 service charge made for any NSF checks.

I have been provided a copy of Lafayette Psychology Center's Privacy Notice for review. I understand that privacy practices described in the Privacy Notice may change over time and that I have a right to obtain any revised Privacy Notice by contacting the Office Manager to make such a request.

I understand that my signature below assigns and transfers benefits payable for services rendered to my therapist. I also authorize refund to the insurance company of overpaid insurance benefits. It is understood that any overpayment due will first be applied to any other unpaid balance on my account(s). I agree to pay this account of any unpaid balances, when due, in accordance with office policy.

_____ I understand that it is my responsibility to remember the date and time of each therapy appointment. **All missed therapy appointments or cancellations will be charged at the normal hourly rate unless I contact the office to cancel at least 24 hours in advance.**

_____ I understand that evaluations typically require a considerable amount of time and preparation and, as such, **I understand that I will be charged twenty percent (20%) of the fee for my evaluation if I miss my appointment or cancel my evaluation with fewer than seven (7) days notice.**

I understand that payment is due at time of service. Payments may be made in cash, by check or by credit card (Visa and MasterCard only). Should you send your child to an appointment alone, you may call in a credit card number or send a check. I understand and agree that, regardless of my insurance status, I am responsible for the balance on my account for any professional services rendered. Upon request, a standard insurance claim form will be provided on a monthly basis if I wish to file for reimbursement. I understand that a finance charge of 1.5% per month will be applied to all accounts that are overdue by 60 or more days. This will be charged even if insurance payments have not been received. In special circumstances, I may be billed for additional services such as written reports, court appearances, depositions, school consultations, phone calls, etc. I will be notified in advance of any such charges.

I, _____, (Name of Patient or Guardian, if minor) hereby request and give my consent to psychological or counseling services provided by _____ (Name of Therapist).

These services will be provided to _____ (Name of Patient).

Patient's date of birth: _____.

My signature below indicates I agree to such treatment and acknowledge that I have read and truly understand the contents of this document.

_____ _____,

Signature of Patient
(If minor, signature of Parent or Guardian)

Date