

DESERT STREAMS, P.C.

ASSIGNMENT AND RELEASE FORM

Client Name _____ DOB _____

I, the undersigned hereby authorize the release of any clinical/medical information necessary for the processing of insurance benefits payable to myself or Desert Streams Christian Counseling including medical and/or major medical benefits. I am financially responsible to Desert Streams Christian Counseling for services not covered by this assignment. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

X _____
Signature of patient or parent or legal guardian Date

I authorize Desert Streams Christian Counseling to provide Medtec, a billing agency, with whatever demographic, insurance and clinical information is reasonable and necessary to obtain payment from both insurance carrier and the responsible party.

X _____
Signature of patient or parent or legal guardian Date

By signing below, I acknowledge that I have received a copy of Desert Streams Christian Counseling Notice of Privacy Practices.

X _____
Signature Date If signed by personal representative, relationship to patient

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Desert Streams Christian Counseling for any services furnished to me by said provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown.

X _____
Signature of patient or parent or legal guardian Date

In case of emergency, who should be contacted? _____

Phone # _____ Relationship _____

RATES AND FINANCIAL ARRANGEMENT INFORMATION ON BACK

CHARGES

(IF D.S. IS A NETWORK PROVIDER FOR YOUR INSURANCE, CHARGES MAY VARY)

- INITIAL ASSESSMENT \$195.00
- ONE HOUR SESSIONS \$130.00
- ONE HALF HOUR SESSIONS \$65.00
- (GROUPS OR TESTING - CHARGES VARY)
- \$5.00 PER MONTH FINANCE CHARGES MAY BE ADDED IF AN ACCOUNT SHOWS NO PAYMENT ACTIVITY FOR OVER 120 DAYS.
- MISSED APPOINTMENTS WITHOUT NOTIFICATION MAY BE CHARGED AT \$130.00. APPOINTMENTS CANCELLED LESS THAN TWELVE HOURS PRIOR MAY BE CHARGED AT \$65.00. (VOICE MAIL IS AVAILABLE AFTER HOURS. WE UNDERSTAND SOME CANCELLATIONS ARE UNAVOIDABLE SO PLEASE GIVE US A CALL.)

OTHER FINANCIAL ARRANGEMENTS (if applicable) - ***THERAPIST TO COMPLETE***

NO INSURANCE: CLIENT AGREES TO PAY \$ _____ PER SESSION.

THERAPIST AGREES TO WRITE OFF \$ _____ PER SESSION.

OTHER: _____

