GENERAL AGREEMENTS AND RELEASE	
Please initial each of the following statements and sign, date, and print your name at the bottom of the page. If you have any questions regarding these policies and agreements, please speak with Dr. Viere.	
AUTHORIZATION FOR TREATMENT	
I authorize Dr. Grace Viere to provide me with treatment.	Initial
AGREEMENT TO HIPAA PRIVACY POLICIES	
I affirm that I have read the attached notice of privacy practices and clients rights under HIPAA as applied to the therapy practice, and understand them. By signing, I agree with these policies and agree to discuss any concerns with Dr. Viere.	Initial
AGREEMENT TO CANCELLATION POLICY & FEES	
I understand that therapy is most effective if sessions are attended on a regular basis. Any cancellations must be made a minimum of 24 hours in advance. If I fail to cancel within this time frame, there will be a $35.00 charge. A failure to arrive for my appointment without cancelling prior to the appointment will result in a charge of $75.00. I am aware that insurance companies will not pay for missed appointments, and missed appointment charges will be solely my responsibility.	Initial
I am aware that my case may be closed with no liability to Dr. Grace Viere if appointments are not kept on a regular basis or cancellations are consistently not made in a timely manner.	
FINANCIAL AGREEMENT	
As a service, this office will file the insurance claim on any services you receive if Dr. Viere is in-network with your insurance plan. However, you are ultimately responsible for any payments or charges denied by your insurance company.	
Payment for counseling is required at the time of the sessions. The amount of co-payment is my portion of the payment that is stipulated by my insurance company. If my insurance company has a yearly deductible, it is my obligation to pay this amount prior to receiving any benefits.	Initial
I am responsible for payment for my sessions, regardless of insurance coverage. My insurer will assign benefits at the time claims are received. I am responsible for any amount my insurance company rejects, up to the full amount my insurance company has a contractual agreement on with my therapist.	Initial
I am responsible for notifying Dr. Grace Viere of any changes in my insurance coverage or any changes that would affect submission of my insurance claims, including but not limited to: change of name, address, phone number, marital status, guarantor, or employment. Failure to notify Dr. Grace Viere of these changes may result in denial of my claims.	Initial
There will be a $50.00 service charge for returned checks. After two (2) bounced checks within a term of 6 months I may be required to put a credit card on file with the office as a backup form of payment before I may book another appointment. Up to an additional 30% may be assessed to any unpaid account to cover costs of collecting past due balances.	Initial
RELEASE OF INFORMATION	
I authorize Dr. Grace Viere and any of her agents to release information regarding my treatment to my health insurance company to facilitate payment of benefits. I authorize my insurance company to assign benefits to Dr. Grace Viere.	Initial
I authorize Dr. Grace Viere and any of her agents to release relevant information regarding my treatment to my medical doctor and/or psychiatrist.	Initial

I agree to all statements initialed above and to abide by my rights and responsibilities as a client of Dr. Grace Viere as outlined in the HIPAA notice I have received.

_____ _____

Signature Date

_____ _____

Printed Name Date