ARKANSAS FAMILIES FIRST

PATIENT:_____

RESPONSIBLE PERSON:_____

RESPONSIBLE PERSON'S RELATIONSHIP TO PATIENT:_____

Insurance Authorization

I acknowledge that ARKANSAS FAMILIES FIRST, LLC (AFF) and its contracted billing company, Arkansas Therapist Connection, LLC, (ATC) will file insurance claims on my behalf. I authorize assignment of benefits and further give permission for AFF and/or ATC to release information to my insurance company if requested.

Signature_____Date_____

Patient Privacy In compliance with the state and federal requirements of HIPAA I have been provided with a copy or access to AFF's policy and procedures regarding the protection, security, and release of my Protected Health Information.

Signature_____Date_____

Scheduled Appointments

I understand and agree to pay $50 for appointments that I miss if I have not provided AFF with a notice of my intention to cancel within twenty-four (24) hours of the appointment time. I understand that my insurance coverage will not pay and will not be billed for missed appointments.

Signature_____Date_____

Billing and Payment for Services

I agree to pay for services at the time they are provided, unless I have agreed otherwise or unless my insurance coverage requires another arrangement. Further, I understand that AFF and/or ATC staff will contact insurance providers to determine benefits, however, I also understand that neither AFF or ATC can guarantee that the information provided by the insurance provider is accurate. I agree to pay for all agreed to services that **might not be** covered by my insurance plan including non-covered diagnoses or procedures (e.g., testing, group, marital counseling).

Signature_____Date_____

Treatment Coordination

I understand and give consent for AFF treatment providers to share pertinent medical records and information with my primary care physician in order to coordinate care. These may include diagnoses, regular treatment updates, evaluation reports, and other medical/mental health information. My treating physician is _____.

Signature_____Date_____