Hicks Counseling Services

Beverly Hicks, M.Ed., LPC

2301 Stonehenge Dr. Ste. 202 Raleigh, NC 27615

Office: 919.904.4257 hickscounseling@gmail.com Fax: 866.594.1848

Service Agreement

Scope of Confidentiality: I understand that my disclosures to the staff of Hicks Counseling Services (HCS) will not be revealed to outside parties except in the following instances: 1) Where my written permission has been granted; 2) Where my physical safety or the physical safety of another person is threatened; 3) Where evidence is given of physical or sexual abuse; 4) Where records are subpoenaed by a judge. I also understand and agree that for the purpose of ensuring highest quality care, with my agreement my case may be discussed in conference or supervision with other psychologists or mental health professionals. If I should default in paying the balance of my account with HCS, then I understand that identifying information and dates of service may be disclosed if litigation or collection action becomes necessary.

Emergencies: Hicks Counseling Services uses a confidential voice mail system. However, even with a good communication system, I understand that there may be circumstances under which my therapist cannot immediately respond to my needs. If such an urgent situation arises I agree to contact the Holly Hill Hospital Respond program to obtain the support of their counselors. The Holly Hill Respond telephone number is 919-250-7000.

Authorization for Release of Psychological/Treatment Information: HCS is hereby authorized to release treatment/psychological/assessment information to my insurance carrier/HMO/PPG as required by them to determine the appropriateness of care and/or to guard against fraud and as stated in their published policies and procedures.

Assignment of Insurance Benefits: I hereby authorize payment directly to HCS of insurance benefits for provided services otherwise payable to me.

Responsibility for Payment: I agree that I am responsible for the total balance due on my account for all services rendered by HCS even though I may arrange for my healthcare plan to pay for part of it. I agree to allow HCS to use any credit card information that I provide for paying off unpaid balances on my bill. I also agree to pay a charge of $35 dollars for each occurrence of insufficient funds for an attempted check. It is my responsibility to inform HCS of my current address until my balance is paid in full.

Co-Payments: Co-payments are due at the time service is rendered unless other arrangements are made. Check, credit or debit cards are accepted.

Missed appointments, Late Cancellations, and Other Non-Co-Payment Charges: Because I will reserve appointment times in advance at HCS, I also agree to pay $75 for any scheduled appointments that I miss without advance notice. I understand that advance notice is no less than 2 BUSINESS days.

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Service Agreement Continued

If you Choose to Have Your Insurance Pay Directly: It is the policy of HCS to obtain security in the form of your credit card authorization to conveniently pay possible charges that will not be covered by your insurance carrier. These charges can include unanticipated missed appointments/late cancellations, charges for insufficient funds for check or credit card payments, unanticipated deductibles, insurance company payment discrepancies from actual fees, and changes in copayment rate and other changes that insurance plans sometimes make when contracts are renewed. Regular co-payments do not cover these charges. Whenever missed appointments, late cancellations, or insurance non-payments occur, your credit card will be charged the applicable amount and you will be notified. Regular co-payments will be made at each session and you will be able to choose your method of payment at that time.

Outstanding Balances: Any outstanding balances past 90 days will be charged in full to the credit card on file. Failure of payment will result in discontinued services with HCS.

Today's Date: _____

Name on Card: _____

Card #: _____

Card Type: _____

Expiration Date: _____

Billing Street Address: _____

Billing Zip: _____

Client Name: _____

Signature: _____

_____ By checking here, I, the patient, am stating that I fully understand and accept the terms of this consent hereby agreeing to substitute this checked box as my signature.

_____ By checking here, I, the responsible party, am stating that I fully understand and accept the terms of this consent hereby agreeing to substitute this checked box as my signature.