

## CLIENT RIGHTS

Counseling services provided by Teresa Reichart-Vernon LSCSW are confidential and voluntary. Federal law governs the confidentiality and safe keeping of client records.

Privacy Act: The Privacy, 4U.S.C. & 552a, protects the privacy and limits of disclosure of all records maintained.

Confidentiality of Alcohol and Drug Abuse Records: Federal Law 42U.S.C.& 290dd2 limits even further any disclosure of information that identifies a client as an alcohol or drug abuser.

Disclosure of Information: Teresa Reichart-Vernon LSCSW is obligated to disclose specific information if the following conditions exhibit:

If the client consents in writing.

If the client poses a danger to self and others, or threatens to commit a serious crime.

If there is a suspicion of child or elder abuse or neglect.

If the disclosure is made to medical personnel in a medical emergency.

If there is a court-ordered subpoena of medical records and/or verbal attestation at a judicial hearing/trial.

### **Assignment of Benefits (please place X the box that applies to you)**

**[ ] Non Medicare Insured:**

In order to submit a claim for payment for services covered under your Health Insurance policy, we must have your authorization to release medical information to your Health Insurance Carrier. As a participating provider in most major Health Insurances, Teresa Reichart-Vernon, LSCSW, will accept assignment and allowable reimbursement fees from each Carrier billed. The patient will be billed for any remainder Member Responsibility in the form of copays, coinsurance and deductibles, if you do not have a Secondary Insurance. If you have a Secondary Insurance, we will bill them accordingly for the Member Responsibility in the form of copays, coinsurance and deductibles. Non Medicare and Secondary Insurance - I request the payment of authorized Mental Health Insurance Benefits on my policy that covers outpatient services to Teresa Reichart-Vernon, LSCSW.

**[ ] Medicare/Kancare Insured:**

As a KS Medicare Part B participating Provider, Teresa-Reichart-Vernon, LSCSW, will accept assignment and allowable reimbursement fees from KS Medicare Part B and Secondaries. According to Medicare guidelines, the providers will always accept the amount of Medicare's allowable, as charge owed by Medicare and Secondary Insurance. The client may be billed for Medicare copay, coinsurance and deductibles amounts in the event that there is not a secondary insurance or if the secondary insurance does not pay the Medicare deductible. Medicare-I request the payment of authorized Medicare benefits may be made to Teresa Reichart-Vernon, LSCSW. I authorize any holder of Medical information to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I hereby authorize Medicare to furnish to Teresa Reichart-Vernon, LSCSW any information regarding Medicare claims under the Title XVIII of the Social Security Act. Supplement Insurance-I hereby authorize the release of any information listed below that is necessary to file a claim with the insurance company and assign benefits to Teresa Reichart-Vernon, LSCSW.

Appointments cancelled late or not attended and not canceled will be charged to the client.

I understand that an hourly fee of \$100.00 will be charged if I request or if there is a court-ordered subpoena for attendance at court hearing/trials that is related to my case. I understand that I may be charged \$10.00 per page for any reports/summaries as needed for my Attorney and/or Judge overseeing my case.

X \_\_\_\_\_  
Client Signature (or Guardian/Durable Power of Attorney)

\_\_\_\_\_ Date

X \_\_\_\_\_  
Therapist Signature (Witness)

\_\_\_\_\_ Date

**Consent for Treatment**

I hereby voluntarily consent for Psychotherapy treatment to include assessment and week sessions as deemed medically necessary by my Healthcare Providers. This consent may be withdrawn at any time by myself, my Guardian and /or Durable Power of Attorney.

X \_\_\_\_\_  
Client Signature (or Guardian/Durable Power of Attorney)

\_\_\_\_\_ Date

X \_\_\_\_\_  
Therapist Signature (Witness)

\_\_\_\_\_ Date