CenterLife Counseling

Centerville Clinic
7039 20th Ave. S., Centerville, MN 55038
Phone: 651-288-0332 Fax: 651-288-0493

White Bear Lake Clinic
4444 Centerville Rd. Suite 235, White Bear Lake, MN 55127
Phone: 651-289-3111 Fax: 651-289-3113

IMPORTANT SIGNATURES

Please Print Your Full Name: _____

Please Print Client Name (if different): _____

FINANCIAL POLICY/MISSED APPOINTMENT POLICY
My signature below indicates that I have been provided a copy of CenterLife's Financial Policy. I acknowledge that I am responsible for any payments not billable and/or covered by insurance. I have made payment arrangements with a credit/debit card on file and/or other payment options made available to me for services rendered by CenterLife Counseling. In compliance with health insurance contracts, CenterLife Counseling cannot waive co-pays or co-insurance amounts.

NOTICE OF PRIVACY PRACTICES
My signature below indicates that I have been provided with a copy of the HIPAA Omnibus Notice of Privacy Practices. I understand that all medical records are kept confidential unless a separate release of information form is signed by me, authorizing the release of these medical records.

I hereby authorize CenterLife Counseling to release my medical records to my insurance company for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claims processing or as long as dictated by payer.

ASSIGNMENT OF BENEFITS
I hereby authorize direct payment to CenterLife Counseling of any medical benefits otherwise payable to me for services provided by a Mental Health Professional affiliated with CenterLife Counseling.

CONTACT INFORMATION
CenterLife Counseling considers your e-mail and other contact information to be confidential. We will not disclose or sell any of your contact information to outside parties or entities.

APPOINTMENT REMINDERS & FILLING CANCELLED APPOINTMENTS
☐ I hereby authorize CenterLife Counseling to send appointment reminders via email and/or text.
☐ I hereby give consent to be notified via email and/or text of appointment openings with my therapist.
☐ I elect to opt out of all email and/or text communication with CenterLife Counseling.

EMAIL ADDRESS: _____

CELL NUMBER: _____ **CELL CARRIER:** _____

My signature confirms that I have received these forms and that I have been given the opportunity to ask questions about them.

X_____ **Date:** _____
Signature of Client or Personal Representative
If Signed by a Personal Representative, Relationship to Client: _____

X_____ **Date:** _____
Signature of Therapist