MidValley Healthcare

Adult Behavioral Health and Addiction Recovery (+18 yoa)
Print Clearly
Use Black or Blue Ink

Office Policy 2020

Please read and initial each statement.

Please DOWNLOAD and complete forms in Acrobat (not in the web browser), save, email to Admin@midvalleyhealthcare.com , RoxanneH@midvalleyhealthcare.com , and gillies.katie@midvalleyhealthcare.com.
Note: By printing your name on the signature line, you consent to treatment.

1. I understand that if my account receives **more than three 'late cancellations' or 'no show/no calls' that my services will be terminated** and my care referred elsewhere, without exception**.** _____
2. I understand there is a **fee related to 'late cancellations' (less than 24 hour notice) and 'no show/no calls'**. I am aware that, per office policy, any appointments that are cancelled late (without 24 hour notice) or deemed a 'no show/no call' will incur a fee of $55 per appointment. I also understand that this fee will be my responsibility and not that of my insurance. _____
3. I understand that in the event I request a personal copy of my records or need documentation to be filled out by the provider, **that there is a charge for this service and that an appointment may be required**. _____
4. I understand that it is my responsibility to contact my insurance company to verify benefits, provider contracting status and authorization for treatment guidelines prior to my appointment. **Although our providers do contract with many insurance plans, they may not be contracted with yours.** _____
5. I understand that authorization of services from my insurance company does not guarantee payment and if my insurance denies my services, **I am ultimately responsible in full for payment.** _____
6. I authorize this office to release to my insurance company any information concerning the illness and treatment necessary to expedite insurance payment. _____
7. I give my consent to the office of MidValley Healthcare, PLLC to fax labs/medication prescriptions to the pharmacy or lab of my choice. _____
8. I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. _____
9. I have reviewed a copy of the Office Payment Policy and understand that all payments are due at time of service. No exceptions. If I would like a copy for my records, I may request one from the front desk. _____
10. I have received a copy of the Client Rights and Responsibilities, and Complaint Procedure. _____
11. I understand that while counseling and/or medication may provide significant benefits, it may also pose risks. Counseling may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications may have unwanted side effects. Though these services, provided by licensed providers, can lead to improvement for my specific problems, there is no guarantee of what I will experience. _____

I have read, understood, and agree with all of the above listed consents and disclosures.
~ **Regardless of signature/initial on this page, ALL office policies will still be enforced** ~

_____ _____
Print Patient Name DOB

_____ _____
Signature of Patient Date

Updated 11/27/2019