CORE Professional Services, PA Insurance / Telehealth Disclosure

Client Name: _____ DOB: _____

The client portion of your bill is due on the date of service, unless other arrangements are made and agreed upon by the business office. Although we will bill insurance, it is the client's responsibility to check with their insurance company regarding any co-payment, deductible, or percentage of fee for which the client may be responsible. If it has been verified that you have an unmet deductible, staff will notify you of the amount of payment needed prior to or on the date of the appointment. This payment will be applied to any balance due, and you will be refunded for any overpayment. If your commercial insurance carrier denies payment, you are completely responsible for payment in full. You can appeal this decision for nonpayment with your insurance carrier. In some circumstances, grant funding may be utilized to cover eligible services. By signing this form, you authorize payments to be made on your behalf. If fraudulent payments are made on your account, any fees associated with this will be assessed to you as the client.

If your insurance does not pay for services, you may have to pay. Not all insurances pay for every service. Your insurance may not pay for the following reasons: Insurance may determine service is not "medically necessary;" it may be a non-covered service; the diagnosis code may not be covered under policy provision; court-ordered services are not covered under policy provisions; etc.

This form authorizes the release of any medical or other information needed to process your medical claims or to comply with insurance requirements. By signing this notice, you understand and agree that regardless of your insurance status, you are ultimately responsible for the balance on your account for any professional services rendered per insurance contract limitations. You will be charged 18% APR interest or 1.5% per month with a minimum fee of $1.00 on all balances over thirty days old. You will be legally responsible for all collection costs involved with the collection of this account, including court costs, reasonable attorney fees, and all other expenses incurred with collection if you default on this account. By signing this notice you agree to receive services.

Signature:_____ Date: _____
(Client or Authorized Person and Relationship)

Do you have a Health Care Directive? _____ YES _____ NO
*If no, do you wish to receive information on this? _____ YES _____ NO

Primary Care Physician: _____ Practicing Location: _____
*If you wish for records to be sent to your primary care physician, please request to sign a release of information.

Mental health services are available by two-way interactive video or audio communications, referred to as "telemedicine" or "telehealth," which means that you may be evaluated and treated by a health care provider or specialist from a different location.

1. You will inform your provider if anyone is required to be present with you at your location, and you may give your verbal permission prior to the start of a session authorizing additional personnel to be present in the room with your provider, such as another provider, intern, etc. You may request that nonessential personnel leave the room(s) at any time to allow a private consultation with your provider
2. The therapist for whom the on-site examination or treatment is performed will keep a record of the encounter in your medical record.
3. If you participate in sessions through telehealth, you understand that you must be alone in a private location for this to occur. If there is any instance of breaking confidentiality of other participants, you may be immediately terminated.
4. You are not allowed to audio record or videotape any virtual group or individual session.
5. You must participate from a location within the state lines.

Noting all the above, you understand that your participation in telehealth services is voluntary and constitutes a waiver of the usual right to physician-patient privacy and may possibly increase the risk of disclosure of my medical data. By signing this form, you acknowledge that the providers involved have explained the telehealth encounter in a satisfactory manner and that all questions that you may have about the telehealth encounter have been answered satisfactorily. Understanding the above, I consent to the telehealth process described above.

Signature:_____ Date: _____
(Client or Authorized Person and Relationship)