OFFICE POLICIES (SIGNATURE BELOW INDICATES YOUR AGREEMENT)
IF PATIENT IS A MINOR, ALL SIGNATURES BELOW BY PATIENT'S PARENT / GUARDIAN

NO SHOW POLICY > This office does not over-book appointments. Thus, an appointment time is offered only to you. If you do not show up, or cancel last minute, the appointment will not be utilized by anybody else. Therefore, a strict policy of billing for no show / late cancellation is in place. **If you do not cancel with at least 48 hours notice, you will be billed for the full amount of the session (not just the copay.)** Please note that insurance does not pay for no shows.

PAYMENTS > Unless a special arrangement is made, **copayments and fees are expected at the time of each visit**

ASSIGNMENT OF BENEFITS > **I authorize my insurance company to pay directly for services billed.** I understand that both I, and/or the person who signs below are ultimately responsible for all fees including copayments and fees not paid by insurance (Because you were either not covered or your insurance disagreed with and will not pay) for a treatment that you otherwise agreed with. This is in effect unless prohibited by hold harmless clause in our contract with your insurance. I also agree to pay additional fees for medical records, copies and any kind of report eg: disability.

SIGNATURE_____ DATE_____

CONFIDENTIALITY OF RECORDS AND AUTHORIZATION TO RELEASE RECORDS

I understand that my records are protected under the applicable law governing health care information that relates to mental health services and under federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 cfr part 2, cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations or in situations where my safety or the safety of others is at risk. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent will terminate one year from the date the authorization is good.

AUTHORIZATION TO DISCLOSE INFORMATION FOR INSURANCE PURPOSES

If a portion of your bill is paid by your insurance, please be aware that most managed plans require that information of your clinical condition be disclosed to your insurance in order to pay the bill or authorize further care. **If you do not want such information to be released, full fee payment for services will be required at the time of each visit, and no bills will be submitted to your insurance.**

I,_____**authorize Dr. Andrew Glatzer / Edgewater Counseling Center to release any and all information which may include addiction information requested by my insurance for the purpose of paying claims, outcomes studies or authorizing further care.**

SIGNATURE_____DATE_____

AUTHORIZATION TO COMMUNICATE WITH YOUR PRIMARY CARE PHYSICIAN

In order to coordinate care with your family doctor we may forward a copy of your records. You may refuse to allow this communication by leaving this blank and signing refusal box below. If you agree with our releasing information to your personal doctor, you must provide the doctor's name, phone and complete address in the space below.

I _____authorize Dr. Andrew Glatzer / Edgewater Counseling Center to release medical records to my primary care physician listed below for coordinating medical treatment.

NAME OF MEDICAL DOCTOR_____PHONE ( )_____

COMPLETE ADDRESS OF DOCTOR_____

SIGNATURE_____DATE_____

REFUSAL TO COMMUNICATE WITH YOUR PRIMARY CARE PHYSICIAN

I refuse information release to my PCP SIGNATURE_____DATE_____