ANN ARBOR COUNSELING ASSOCIATES , LLC

CONSENT FOR SERVICES
SIGNATURE FORM

Please initial each:

____ I have been given an opportunity to review the Health Insurance Portability and Accountability Act (HIPAA) regulations form.

____ I have received a copy of the Professional Disclosure statement and understand its contents especially the limits of confidentiality, the cancellation fee, and my rights as a counseling client. I also understand I can ask my therapist questions about this form anytime.

____ I agree at this onset of services to pay any balance that is deemed my responsibility by my insurance company or agreement with Ann Arbor Counseling Associates, LLC including copays, deductibles, co-insurances, denied claims, “no-show” fees, or if I have opted not to use insurance, the agreed upon rate between Ann Arbor Counseling Associates, LLC and myself.

By signing below, I authorize AACA, LLC to use this signature on all of my insurance submissions, if I am choosing to use insurance, and I am also consenting to receive counseling services at this time until I revoke authorization in writing.

Client Signature (14 Years and Older):_____

Date: _____ Printed Name: _____

Legal Guardian: _____ Date: _____

Printed Name: _____

Legal Guardian: _____ Date: _____

Printed Name: _____

AVAILABLE AT http://annarborcounselingservices.com/about/resources-for-clients/forms/