Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Zeeland Community Counseling's "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Zeeland Community Counseling's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations Zeeland Community Counseling. The Notice of Privacy Practices for Zeeland Community Counseling is also provided on request at the waiting area of this practice and on Zeeland Community Counseling's website at www.zeelandcc.com. This Notice of Privacy Practices also describes my rights and Zeeland Community Counseling's duties with respect to my protected health information.

Zeeland Community Counseling reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing Zeeland Community Counseling's website, calling the office, and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have read and fully understand the informed consent form. All questions that I had have been answered to my satisfaction and I recognize that I have the opportunity now and in the future to discuss any question I may have with my counselor. I agree to the policies, procedures and fees explained herein. I agree to accept counseling from you and am voluntarily signing this form.

Signature of Patient or Personal Representative Date

_____ _____

_____

Name of Patient or Personal Representative

Release of Information

I authorize this clinic to release any information pertinent to my case to any insurance company, adjustor, and attorney involved in this case; and hereby release this clinic of any consequence thereof. I also give permission to discuss my condition with my physician(s) and to request medical information from my physician(s).

_____ _____

Signature of Patient Date

Important Insurance Information

Our doctor and staff desire to assist our patients in their collection of insurance assistance for chiropractic services. In order to avoid misunderstandings, please read the following statements carefully.

1. The insurance company has an obligation to the PATIENT and *NOT* to the doctor.
2. The patient alone is obligated to the doctor for payment of services. This includes insurance deductibles, co-payments, and any services rejected by my insurance company.
3. The doctor cannot state or guarantee what services the insurance company will assist with or the amounts of assistance. The patient must determine this from their insurance policy either by calling their insurance company or discussing this with their agent.
4. As a courtesy to the patient, the office will complete insurance forms and attempt to estimate insurance assistance. This does not relieve the patient of their obligation to the doctor nor does it imply that the fee for services is thereby settled.

I hereby instruct and direct my insurance company to pay, by check or electronically mailed directly to this clinic, the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic.

A photocopy of this assignment shall be considered as effective and valid as the original.

_____ _____

Signature of Patient Date

Parent/Guardian Consent Form

Your permission is requested for your child, _____ to participate in counseling at Zeeland Community Counseling.

Because counseling is based on a trusting relationship between counselor and client, the counselor will keep information shared by the client confidential except in certain situations in which an ethical responsibility limits confidentiality. You will be notified under the following circumstances:

1. The minor reveals information about hurting himself/herself or anther person.
2. The minor or another person may be in physical danger.

By signing this form, I give my informed consent for my child to participate in counseling. I understand that anything that my child shares will be kept confidential except in the above-mentioned cases.

_____ _____

Signature of Parent/Guardian Date