BRIGHT HOPE
Christian Counseling Center, PLLC

Serving Individual Adult, Adolescent, Children and Couples

270 North Main, Logan, UT 84321 – Phone: 801-317-4410 – Fax: 435-227-0401 – Email: karen@bhccc.org – Web: https://bhccc.org

PAYMENT & INSURANCE RELEASE AUTHORIZATION

Client Name: _____

Date of Birth: _____

Father's Name (if client is a minor): _____

Mother's Name (if client is a minor): _____

I/we authorize the following method of payment (Choose one):

☐ Direct Pay (Out-of-pocket; No insurance). I/we hereby agree to the session rate $_____ per session.

☐ Bill insurance

Insurance Company Name & Type: _____

Insurance Rate: _____ Copay Amount: _____

☐ No-show fee. I/we hereby agree to be billed for **$75.00** per session when I/we do not show up for the appointment without giving BHCCC a 24-hour notice. I understand BHCCC will not charge my card without my permission/knowledge. I understand this fee will be waived in the case of emergency or illness.

In compliance with HIPPA and PHI privacy and confidentiality rights, I/we authorize **Bright Hope Christian Counseling Center, PLLC**, as the Provider, to only disclose pertinent mental health treatment information and records obtained in the course of my psychotherapeutic treatment to my insurance company, including -

1. Name and date of all sessions
2. The relevant DSM 5-TR / ICD-10 Diagnostic Criteria(s)
3. Treatment Plan
4. Social History
5. Progress Notes/Case Summary/Update

The therapist will notify me if more information will be required by a third party. At such time, I/we will discuss with the Therapist about the release of such information.

This Client disclosure of information and records authorization is required for the purpose of billing and receiving reimbursement for the services rendered. Client understands that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPPA Privacy Rule, although applicable Utah law may protect such information. *This authorization shall remain valid unless revoked by the Client.*

I/we understand that -

1. I/we have the right to receive a copy of this authorization.
2. Any modification or cancellation of this authorization must be reflected in writing. At such time, I will discuss my decision with my Therapist/Provider.
3. I/we have the right to revoke this authorization at any time. At such time, I will discuss my decision with my Therapist/Provider.
4. I/we have to pursue such revocation in writing. At such time, my Therapist/Provider should receive the written revocation in a timely manner for the revocation to be deemed effective.
5. I/we have the right to refuse to sign this authorization form. The therapist shall not condition treatment upon Client signing this authorization.

Acknowledgment & Signature:

I have read and agreed to the terms outlined in this document, **PAYMENT & INSURANCE RELEASE AUTHORIZATION**. I acknowledge that I am the Client, or a legal representative of the client. I agree that my e-signature below is a legally binding equivalent to my handwritten signature.

Client Name (Print): _____

Client Signature: _____

Today's Date: _____

Father's Name (Print): _____

Father's Signature: _____

Today's Date: _____

Mother's Name (Print): _____

Mother's Signature: _____

Today's Date: _____