Guarantee of Payment/Cancellation Policy

Welcome to Pitts & Associates. It is such an honor to work with you and we truly value the time we spend together. This form should give you the information you need to understand our billing fees and policies. Please read through this form and feel free to ask any questions to your clinician or our team members. By signing this form, you are indicating that you agree to the policies and fee schedule as outlined below. All fees, including copays and deductibles, are due at the time of service. Please come prepared to pay before each visit. If the person responsible for payment will not attend your visits, you MUST bring payment with you. If you are not able to pay at the time of your visit, we may have to reschedule your appointment to a later time. A $5 billing charge will be added to copays/deductibles/balances not paid at the time of service.

Charges are based on length of appointment, level of care provided, and type of service provided. Pitts & Associates assumes no responsibility for collecting payment from another party, including a non-custodial parent. Any financial arrangements are the client's responsibility, and payment is due at the time of service.

If you are using your insurance benefits, Pitts & Associates requires the patient portion of the first session be paid by credit – Visa, Master Card, American Express or Discover. This is due to the high incidence of unreported deductibles and the fact that insurance may not cover certain services such as Couples Therapy, Family Therapy, and sessions lasting longer than 45 or 60 minutes.

By paying via credit card, you acknowledge that this credit card information will be automatically kept on file via PCI-compliant encrypted code used by our Practice Management software, AdvancedMD. Health Savings Account cards may also be kept on file as the primary form of payment but must still have a back-up credit card on file in case HSA funds are depleted.

You further agree and understand that if insurance does not pay the contracted rate for services, any remaining balance due that is the legal patient responsibility will be charged to this Health Savings Card or Credit Card on file. This amount typically includes co-pays, co-insurance, and deductibles that have not yet been met or were quoted incorrectly by the insurance company.

Clients with a balance of two unpaid sessions, a balance greater than $100, an unpaid missed appointment fee, or a balance of any amount that is more than 30 days old will not be rescheduled until the balance is paid in full. There will be a $30 fee assessed on all returned checks.

In order for us to service your account or to collect monies you may owe, Pitts & Associates and our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by text message or email using any information you give to us.

The duration of all sessions is typically 45-50 minutes. If you arrive late for your appointment, it is not guaranteed that we will be able to meet for the full 45-50 minutes.

Should you ever need to cancel an appointment or reschedule one, please know that sessions must be cancelled at least 24 hours in advance. Late cancellations and no show's will be billed the full session fee, this is because this prevents other clients in need from being able to make an appointment. In addition, therapists are not salaried employees and therefore lose significant revenue due to late cancellations and no shows. Note that your insurance will not cover the cost of these fees. Emergencies happen, therefore, when necessary, exceptions will be made.

Clients must provide debit or credit card information prior to first appointment via the Client Portal. Payments are automatically withdrawn between 12 - 24 hours following appointment time.

Pitts & Associates will provide access to the Patient portal where you can view your account or pay your outstanding charges.

Thank you for taking the time to read and understand our policies.

By signing my name below, I understand and agree to the fee schedule stated above, and I authorize Pitts & Associates to use my credit card as mentioned above.

THIS AUTHORIZATION EXPIRES 6 MONTHS FROM THE DATE OF OUR FINAL THERAPY SESSION

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____

Client Legal Name - First, Last

____

Signature of Client/Legal Guardian Responsible

Guarantee of Payment

(Portion below to be completed by the person responsible for payment)

____

Guarantor's name (must be 19years or older)

I will personally guarantee payment for any service fees not covered by insurance which are due on behalf of

____

Client's name

____

Signature of Guarantor

for the duration of treatment at PITTS & ASSOCIATES.

NO-SHOW & LATE ARRIVAL POLICY

This office does not double book appointments; therefore, your appointment is reserved specifically for you. Due to time-oriented appointments, this form is intended to notify you as a client that cancellation of an appointment is required 24 hours prior to your scheduled appointment time, the business day before your appointment. Appointments on the first day of the week must be cancelled on the last open business day before your appointment. If the office is closed due to a holiday, you must cancel by the last open business day before the appointment.

If you fail to keep an appointment and do not cancel at least 24 hours on the business day prior to that appointment, a no-show fee will be charged to your credit card number in our system. Missed appointments or late cancellations cannot be filed with your insurance company and will be billed to you in full. You agree to be financially responsible for this fee if you fail to keep your appointment without the required notice.

Additionally, appointments can only be billed to your insurance for the time you are actually seen by your clinician. If you arrive more than 15 minutes late for your appointment without giving notice to that you are running late, it will be assumed you are not making your appointment and your appointment will be cancelled and you will be billed for the full rate of the appointment.

Reminders are made only as a courtesy to you, and it is the client's responsibility to keep track of his/her appointments. Your account will be charged for missed/late appointments even if a reminder is not received. Because of the nature of our schedule, clients that miss two appointments or repeatedly cancel appointments will be referred to another clinician's office. Dismissal of clients under age 19 will also result in dismissal of other family members. Dismissal of a client who is a guarantor of other accounts will result in dismissal of all associated clients. ALL NO-SHOW FEES MUST BE PAID PRIOR TO SCHEDULING ADDITIONAL APPOINTMENTS.

By signing below, you agree to all terms set forth in this section concerning payments and appointments.

____

Signature

____ ___________________

Printed name, Relationship to Client

Informed Consent Service Agreement

Thank you for selecting Pitts & Associates for your therapy needs. We strive to provide the highest quality and most professional services for promoting your well-being. If you ever have any questions or comments, please do not hesitate to contact our office at 205-870-3520. Our phones are generally answered Monday thru Thursday 8AM-5PM, and Friday 8AM to 4PM. If necessary, please leave a message and we will return your call as soon as possible. If you are experiencing an emergency, please call 911 or the Crisis Center line at (205) 323-7777 or go to the nearest hospital Emergency Room.

The Therapeutic Process:

You have taken a very positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and where the problem might lie, as well as to help you clarify what it is that you want for yourself.

Confidentiality: All therapy appointments, records, and identification information are kept strictly confidential and are shredded after 7 years. The limits of confidentiality apply when the clinician considers a client to be in danger of harming others or him/herself, if the records are subpoenaed, or when the client grants disclosure of information through a signed release form. Alabama law requires that child abuse be reported to the Department of Human Resources. Support staff will have limited access to information regarding clients only as is needed as they make appointments and perform ordinary business operations. Please review our Privacy Policy for more information.

Length of Session: The length of therapy sessions will be fifty (50) to fifty-five (55) minutes. The length of medication management sessions will be approximately twenty (20) minutes but vary according to your needs. Your clinician will also spend time reviewing your progress notes, evaluating assessments, making new notes, etc. If you arrive late for your session, the missed time is forfeited in order to meet the needs of all of our clients. Only the time you spend with your clinician is billable to insurance, and a late fee will be charged if you are more than 15 minutes late. Always check in with the front office when you arrive for your appointment by signing in and paying for services. If you have been waiting more than 10 minutes after your scheduled time, please inform the staff.

If you require intensive and/or inpatient care, we will be happy to refer you to another facility. If you are experiencing an emergency, call 911 or the Crisis Center line at (205) 323-7777, or go to the nearest hospital Emergency Room.

Cancellations & Missed Appointments: Keeping track of scheduled appointments is the responsibility of the client and/or guardian. Reminder calls/texts are made as a courtesy only. If you do not receive a reminder call/text, you are still responsible for keeping your appointment. If you must cancel your appointment, please contact our office by 12:00 pm noon the business day before your appointment to avoid being charged up to the full rate of the session to your credit card number in our system. Monday appointments must be cancelled by noon on Friday. This office does not double book appointments, and missed appointments or late cancellations will be billed to you. Due to the nature of our schedule, clients who miss two appointments or repeatedly cancel appointments will be subject to termination of the therapeutic relationship and referred to another clinician.

Court Appearances: In general, our clinicians do not provide court appearances. If this is a service you may need at a future point, please discuss immediately with your clinician. All court appearances must be scheduled at least one month in advance due to the clinicians' full schedules. If the clinician is subpoenaed for a court appearance, a retainer of S 1200 per day will be required two (2) weeks prior to the court date. At that time, the clinician's schedule will be cleared to accommodate the court appearance. Cancellations made within 14 days of the scheduled appearance will require forfeiture of the retainer due to the disruption in the clinician's schedule. Depositions require an up-front fee of $260 per hour, to include travel time to and from the location of the deposition. Court appearances, depositions, and other legal services are not billable to your health insurance. By signing on this page, you are agreeing to fully comply with this policy regarding court appearances. INSURANCE DOES NOT PAY FOR COURT APPEARANCES.

Documentation: If you require documentation, such as FMLA paperwork, school forms, notes for your employer, etc., these must be requested prior to the start of your appointment and will be completed by your clinician during that appointment. If you require documentation outside of an appointment, you will be charged an average of $25 per hour, depending on the complexity of the paperwork. These fees must be paid prior to the clinician completing the requested documentation. Documentation fees are not covered by insurance.

Termination of Treatment: Treatment in this practice will be terminated immediately for non-compliance with treatment plan, abuse of staff or other clients, bringing an unlicensed weapon into our facility, repeatedly missing or cancelling appointments, non-compliance with medication policy, non-payment of account, and/or any action or attitude that causes an inability to achieve or maintain rapport between the client and clinician.

Payments and Insurance: Payment of any copay, co-insurance, deductible due, or full fees of private pay services is expected at the time of your visit and will be charged to the credit card in our system. If a client has a balance of 2 unpaid sessions, an unpaid no-show fee, a balance greater than $100, or a balance more than 30 days old, further sessions will not be scheduled nor medication refills given until the balance is paid. Our office will file primary insurance claims on your behalf as a courtesy to you for insurance carriers with which we are contracted. However, your insurance policy is a contract between the policy holder and the insurance company. It is the client's responsibility to obtain the necessary and timely referrals, coordination of benefits, or any other requirements specific to the client's policy. If for some reason your insurance does not cover a visit, or your coverage becomes inactive, you will be responsible for full payment of those charges.

By signing your name below, you are acknowledging that you have read the informed consent and agree to Pitts & Associates, Inc.'s terms of services. You further acknowledge that you have reviewed and consent to our Privacy Policy and agree to the terms and may request a copy if you wish.

____

Client Legal Name - First, Last

____

Signature of Client or Guardian

____

Date

I give permission for Pitts & Associates, Inc. to file claims on my behalf for services rendered. I also give permission, if necessary, communication with insurance or software company is needed, I give permission for release of information should communication with the aforementioned companies be necessary for account issues.

____

Signature of Client

Authorization for Electronic Communication

As a convenience to me, the undersigned, I authorize Pitts & Associates, Inc. to communicate with me regarding my treatment via electronic communications (electronic mail or text message) and to transmit my protected health information electronically as described below.

I understand there are risks inherent in the electronic transmission of information by electronic mail or text message:

- Such communication does not provide a completely secure means of communication.
- Any protected health information transmitted via electronic communications pursuant to this authorization may not be encrypted.
- Electronic transmission of information cannot be guaranteed to be secure or error-free.
- Data may be vulnerable to access by unauthorized third parties.

As such, Pitts & Associates, Inc. shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by Pitts & Associates, Inc.

I understand that Pitts & Associates may transmit my protected health information electronically as described above unless and until I revoke or amend this authorization by submitting notice to Pitts & Associates, in writing. This authorization does not allow for electronic transmission of my protected health information to third parties, and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

Placing my name in the field below acknowledges my authorization of electronic communication via text or email address on file with your office.

____

Client Legal Name – First, Last

____ _______________

Signature of Client or Guardian Date

HIPAA Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

"Protected health information" (PHI) is information about you, including demographic information that may identify you or be used to identify you, and that relates to your past, present or future physical or mental health or condition, the provision of health care services, or the past, present or future payment for the provision of health care.

Your Information ~

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with laws that may be in place now or in the Future

Your Rights ~

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health

information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health information. usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information For six years prior to the date you ask, who we shared it with, and why.
- We will include all disclosures except for those about treatment, payment, and health care operations, and certain. other disclosures (such as any you asked us to make). We'll provide one accounting a year For free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.
- File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us at [insert contact email)
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201,
calling 1-877-696-6775 or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases, we never share your information unless you give us written permission:
- Sharing of psychotherapy notes

Our Uses and Disclosures

IF you give us permission, how would we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you. Example: Your physician and I may need to coordinate your care.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
- We are allowed or required to share your information in other ways- usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with Federal privacy law.

We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
- We can share health information about you in response to a court or administrative order

Our Responsibilities ~

We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

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For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

Acknowledgement

I hereby acknowledge receiving a copy of this notice, by signing my name below.

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Signature and Date