Rebecca K. Olander, PMHNP-BC, LLC
Amanda K. Schnee, PhD, LLC
Carrie Semke, PhD, LLC
Casey Voichoskie, LIMHP, RPT, PC
Shayla Hinrichsen, PMHNP-BC, LLC
Eryn McMaster, PhD, LLC
Alex Reznicek, LMHP, LLC

Patient/Client Name: _________________________________Patient/Client Date of Birth: _______________

Please initial each section for acknowledgment

_____Authorization for Treatment

I acknowledge that I have been given the opportunity to review the Consent to Treatment and Confidentiality Statement. I may obtain a current copy upon request. I understand that Encompass Care, LLC has the right to change the Authorization for Treatment at any time.

____Acknowledgement of Receipt of Privacy Notice

I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices for Protected Health Information. I may obtain a current copy upon request. I understand that Encompass Care, LLC has the right to change the Notice of Privacy Practices at any time. I may obtain a current copy of these upon request.

_____Patient Rights and Responsibilities

I acknowledge that I have been given the opportunity to review the Patient Rights and Responsibilities. I may obtain a current copy upon request. I understand that Encompass Care has the right to change the Patient Rights and Responsibilities at any time.

_____Appointment No-Show Fee/Billing Policy

I have been advised that this office requires a 24-hour prior notice on all appointment cancellations, and I have reviewed the Encompass Care, LLC billing policy. I have been advised that there will be a $35.00 no show fee for appointments that are canceled with less than 24-hour notice. This fee is not covered by any insurance plan. I understand that three no-show/late cancellations in one year may be cause for automatic discharge from my Provider's clinic. I understand that co-pays, if appropriate, **must** be paid at the time of visit. I understand that I am responsible for all fees not paid by my health insurance. Payment is due 30 days after receipt of statement. *Accounts not paid within 120 days of the date of the statement may be subject to a $10.00 monthly finance charge. Returned checks will be charged back the initial amount of the check plus bank fees.*

_____Office Policies

This office is open Monday through Thursday, 8am-6pm and occasionally on Friday's. Some evening appointments are available upon request. We will make every effort to return a phone call as soon as possible, but if your call is urgent, please note that with our office staff. *Lengthy phone calls may accrue additional charges. Should your phone call last longer than 10 minutes a $10.00 fee which is not covered by any insurance plan. An additional $10.00 may be charged for each additional 10-minute increment.* Seventy-two hours' notice is required for your provider to complete letters and other external documentation.

_____Coordination of Care

I acknowledge and authorize the sharing of information among the providers at Encompass Care, LLC to best serve my/my child's health care needs.

_____Assignment of Insurance Benefits

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature of this document authorizes my provider to submit claims for benefits for services rendered for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I authorize and assign payment of all/any insurance benefits to Encompass Care, LLC that is otherwise payable to me for his/her services as described on the assigned payment forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to individual providers will be credited to my account in accordance with the above assignment.

_________________________________ ____ ______________________

(Print Name of Patient) (Authorized Signature of Patient/Parent/Guardian) (Date) *Revised 8/2020*