Hippa Acknowledgment and Consent

I acknowledge that I have read and received copies of a professional disclosure statement from Martha R. Durham, PhD, LLC and Clients Rights under Hippa. My signature confirms that I understand and accept the information in these documents. I further consent to treatment with Martha R. Durham, PhD and understand that participation in treatment and / or psychological assessment / testing is voluntary and I can terminate services at any time. While I expect benefits from treatment I understand that these cannot be guaranteed. I also understand that I am financially responsible for these services and for any portion of the fees not reimbursed or covered by my health insurance or third party payer.

Signature of Client: _____ Date: _____

Assignment of Insurance and Release of Information

Please remember that insurance is considered a method of reimbursing the patient for fees paid directly to the provider of the service and is not a substitute for payment. Some companies will pay fixed allowances for certain types of service and others pay a percentage of the charge. They do not pay at all for some services. It is the patient's responsibility to pay any deductible amount, insurance co-payment, or any other balance not paid for by his/her insurance company. If we are filing your claim we will allow 45 days from the billing date for the insurance company to process your claims and make payment accordingly. If payment from your insurance carrier is not received within that time frame we will notify you and expect you to pay the balance of your account and seek reimbursement for yourself directly from your insurance company. Any other arrangement must be made in advance and in writing with your individual therapist.

Your signature below certifies the following: I have read and understand fully this billing policy and agree to make payment in full and/or satisfactory arrangements if asked to do so as specified above. I understand that I am financially responsible for any amount of unpaid deductibles, all charges and/or co-payments whether or not paid by my insurance company. I specifically grant permission for Martha R. Durham, PhD or her representative to contact me at home or work for the purpose of resolving my bill. Should my account be referred for collection to an attorney or collection agency, I shall pay reasonable attorney's fees, court fees and collection expenses. I hereby authorize Martha R. Durham, PhD or her representative to release all information necessary to secure payment. I hereby assign all benefits to which I am entitled, including private insurance, Worker's Compensation, Victim's Compensation, etc. This assignment applies to all charges outstanding as the date of signature and will remain in effect for all current and future charges until revoked in writing. A photocopy of this assignment is to be considered as valid as the original.

_____

Patient Name-**Please Print**

_____

Name of Responsible Party-**Please Print**
(*If different from patient)

_____

Signature of Patient or Responsible Party

_____

Date