Growing Bonds Counseling
5108 Broadway, Suite 226
San Antonio, TX 78209

Payment Agreement

I AGREE TO BE RESPONSIBLE FOR THE PAYMENT/COPAYMENT FOR SERVICES RENDERED BY MAILE GILES, LMFT/GROWING BONDS COUNSELING AND CHARGED AT THE RATE OF $_____ PER _____ MINUTE SESSION. I UNDERSTAND, AND AGREE THAT REGARDLESS OF MY INSURANCE I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT. I UNDERSTAND THAT APPOINTMENTS MUST BE CANCELLED 24 HOURS IN ADVANCE OR I WILL BE CHARGED FOR THE SESSION AT THE FULL RATE. I CERTIFY THAT ALL ANSWERS TO THE FOREGOING QUESTIONS ARE TRUE AND CORRECT. I AGREE TO NOTIFY YOU IF THERE ARE CHANGES IN MY INSURANCE OR DEMOGRAPHIC INFORMATION.

SIGNATURE_____DATE_____

Insurance Clients

YOUR INSURANCE COMPANY MAY REQUIRE RELEASE OF INFORMATION REGARDING YOUR THERAPY. THIS RELEASE WILL BE EITHER VERBAL OR WRITTEN AND WILL CONTAIN INFORMATION INCLUDING, BUT NOT LIMITED TO, YOUR DIAGNOSIS, PROGRESS IN THERAPY, THE CURRENT PROBLEMS BEING ADDRESSED, AND EXPECTED PROGNOSIS. IT IS NECESSARY FOR YOUR CONSENT IN ORDER TO RELEASE THIS INFORMATION. IF YOU CHOOSE NOT TO SIGN THIS FORM THERAPY MAY BE TERMINATED, AS YOUR INSURANCE WILL NOT COVER THE TREATMENT.

SIGNATURE_____DATE_____

Confidentiality

THE CONFIDENTIALITY OF WHAT YOU DISCUSS WITH YOUR CONSELOR IS PROTECTED BY THE HEALTH INFORMATION PROTETION ACT. INFORMATION MAY BE RELEASED UNDER THE FOLLOWING CIRCUMSTANCES AS PRESCRIBED BY HIPAA:

A. THE CLIENT SIGNS WRITTEN RELEASE OF INFORMATION

B. THE CLIENT IS IN IMMINENT DANGER OF HARMING THEMSELVES OR ANOTHER

C. IN CASES OF CHILD ABUSE OR NEGLECT OR ELDER ABUSE OR NEGLECT

D. IF A COURT OF LAW REQUIRES RECORDS TO BE RELEASED