SOUTH CENTRAL HUMAN RELATIONS CENTER (SCHRC) Insurance & Agreements **Case # _____**

Policyholder Name_____ **DOB** _____ **Relation** _____

Client Name _____ **Effective Date**_____

Insurance Company Name _____ **Policyholder's Employer** _____

Group Number _____ **Insurance Number** _____

Do you have additional insurance? ❑ Yes ❑ No **If yes**, give name, address, and policy/group numbers of additional insurance carrier(s):

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I agree to inform SCHRC if my insurance changes. I also understand my insurance may not pay for psychological testing, as each plan varies. It is my responsibility to contact my insurance company to verify benefits. I hereby agree to be responsible for any charges my insurance will not cover and agree to make payment within 30 days of receipt of my statement. If payment arrangements are needed, I will contact the patient account representative. I understand SCHRC has a collection policy and will utilize a collection agency should my account become delinquent.

Initial: _____ Date _____

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*I understand that **if I miss an appointment** without notice or **cancel** without good cause less than 24 hours prior to the scheduled appointment time, I will be responsible for a charge of $45. Insurance and Medical Assistance will not pay for these charges. I understand if I fail to show for two appointments within one calendar year, my file will be closed for six months.*

Initial: _____ Date _____

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*I **authorize release of personal health information, including billing information,** to the above insurance payer(s) for processing of my claims. Access to this information will be limited to persons whose work assignments reasonably require access to it. Any other release of this information will require a separate authorization.* **This authorization expires within one year of this date or when the purposes for which it was granted have been accomplished.**

Signed _____ Date _____
Client

Signed _____ Date _____
If client is a minor or incompetent, signature of parent/guardian/personal representative/responsible party

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*I would like to receive a **___ text message or ___ telephone call** for appointment and exam confirmations and reminders, wellness checkups, and other treatment purposes. I agree that SCHRC providers, and any affiliates, or vendors, may contact me by telephone or text message at any telephone number I have provided, and any other telephone number associated with my account, including wireless or mobile telephone numbers. **I understand that message and data rates may apply.** I may be contacted at these numbers by any method, such as an Automated Telephone Dialing System (ATDS) or prerecorded message. **I will immediately notify SCHRC if I change my telephone number.** I release SCHRC and its agents, employees, directors, and officers from any and all liability under the Telephone Consumer Protection Act.* **ACCEPT ____ REJECT ____**

I hereby consent to treatment at South Central Human Relations Center

Signed _____ Date _____
Client

Signed _____ Date _____
If client is a minor or incompetent, signature of parent/guardian/personal representative/responsible party

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I hereby acknowledge that I have received a copy of the South Central Human Relations Center Client Rights Statement and Notice of Privacy Practices to review. This information is also available to view at www.schrc.com

Signed _____ Date _____
Client

Signed _____ Date _____
If client is a minor or incompetent, signature of parent/guardian/personal representative/responsible party