Client Name:________________________

ASSIGNMENT OF BENEFITS FORM:

I hereby authorize my insurance company(s) to pay directly to Alarus Healthcare, LLC, any and all benefits due to me for claims submitted for myself or any member of my family for any services rendered.

I also authorize Alarus Healthcare, LLC to release such information as may be necessary during or after the course of treatment for the efficient processing of an insurance claim. I also permit a photographic or other facsimile reproduction of this authorization to be used in place of the original.

Client Signature___________________________________Date_____________________

FINANCIAL POLICY:

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy. You are required to read and sign prior to any treatment.

COPAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE

Our staff will call and check your benefits prior to your first session. This is not a guarantee of benefits as insurance companies only quote benefits. I understand if I am a self-paying client, all payments are due at the time of service. We accept Cash, Checks, Visa/MasterCard, and Discover.

Client Signature___________________________________Date___________________

REGARDING INSURANCE:

We will submit all claims to your insurance company, however the balance is your responsibility whether or not your insurance company pays. Your insurance policy is a contract between your and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all of the services may be non-covered services and not considered reasonable and customary under your medical insurance policy.

Alarus Healthcare, LLC requires that you make us aware of all changes to your insurance on or before the changes take place. If you do not bring your insurance card along with you at the time of service, or do not make us aware of any changes to your insurance and your insurance denies your claim, you will be responsible for paying the charges. If the change took effect more than 3 months ago, you will be responsible for paying the services and you will need to bill your insurance company. If you need to get

authorization prior to seeking services, and have not done that and your insurance denies your claim, you will be responsible for that charge.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Client Signature___________________________________Date___________________

MINOR PATIENT:

The adult accompanying a minor (the parents or guardians of the minor) will be responsible for copayments and deductibles not met at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless the copayment and/or deductible is sent along.

Client Signature___________________________________Date_____________________

TREATMENT ATTENDANCE POLICY:

We strongly encourage you to discuss this policy with your treatment provider to help ensure that you understand our treatment policy. Please let us know if you have questions or concerns. We care about providing the best treatment services that we can. One of the things we know is that regular attendance to treatment is important. Studies show that clients that make all of their appointments generally benefit from treatment to a greater degree.
Alarus Healthcare, LLC has the following attendance policy. It is OK to cancel an appointment 24 hours or more in advance. We can use that time slot for other patients. We understand that things come up and that unexpected events occur from time to time.
Alarus Healthcare, LLC will charge patients a $40.00 fee for missed appointments under the following circumstances:

1. Failure to cancel appointments 24 hours prior to the scheduled appointment time.
2. Failure to show for your scheduled appointment.

We offer reminder calls as a courtesy, but it is the patient's responsibility to remember their appointment.

If there are two failed appointments or late cancellations, you must talk directly with your therapist or doctor to address the issues that may be keeping you from attending consistently.

If there is a third failed appointment or late cancellations within 12 months, your treatment at Alarus Healthcare, LLC may be terminated.

This policy is to help us provide our clients the best care possible. Making a serious commitment to improve your health is one of the best things we can do. Attending scheduled appointments consistently is part of that commitment. Please contact us at 262-377-6276 if you have any questions or concerns regarding this policy.

Client Signature____________________________________Date______________________

Client Name:________________________

INFORMED CONSENT:

The benefits of psychotherapy have been well documented. Most people report feeling better or much better after their first session. There is a wide-range of medication useful in the treatment of anxiety, depression or other conditions. The benefit of these medications has been demonstrated in controlled studies.

There are alternatives to professional psychotherapy and psychotropic medication, such as exercise, community support groups and over-the-counter supplements. These alternatives vary in effectiveness. Talk to your therapist about alternatives to treatment that may be helpful for you personally. There may be consequences of not receiving treatment, such as increased symptomatology, including the possibility of suicidal thinking or behavior. Clients meet with their therapist once a week to once a month.

Unless therapy is court-ordered, you have the right to withdraw your consent to treatment at any time. Typically, consent remains in effect for 15 months.

It is important that you receive specific, complete and accurate information about the services you will be receiving. Please review your personal treatment goals with your therapist.

Client Signature___________________________________Date_______________________

PRIVACY NOTICE & GRIEVANCE PROCEDURE:

I acknowledge that I have received and understand a copy of my rights and responsibilities as a patient at Alarus Healthcare, LLC. Due to confidentiality laws we want to make you aware that we will give reminder calls only with your permission.

Client Signature__________________________________Date_________________________

TREATMENT PLAN:

I give permission to Alarus Healthcare, LLC to develop a treatment plan and provide treatment, which may consist of individual, family and/or group therapy. It is understood that is consent shall remain in force for no longer than 12 months. It is further understood that I may withdraw my consent to treatment at any time, but that it is assumed that this consent continues unless I inform Alarus Healthcare, LLC otherwise. If I am court ordered to treatment, I realize that some of my rights may be affected in terms of consent to treatment/services. If that is the case, I agree to discuss these issues and consequences fully with my therapist.

I have read the Financial Policy, Treatment Attendance Policy, and Treatment Plan Consent and have received the Patient's Privacy Notice and Grievance Procedure. I understand and agree with these policies.

Client Signature_______________________________Date___________________

Witness Signature _____________________________Date_____________________