I have Read Dr. Chance's Policy Statement and Consent and Agree that:

1. There are legal limits of confidentiality. These were outlined in Dr. Chance's Policy Statement and on the "Notice of Privacy Practices" I have read. I understand the limits of confidentiality as written and/or explained to me.

2. If using insurance, it is my responsibility to provide Dr. Chance with a minimum notice of 2 business days if my health insurance plan is changing. I understand that it is my responsibility to obtain any necessary authorizations for services *prior* to my appointment. If a notice of 2 business days is not provided, or a new authorization is not obtained, I am responsible for paying in full for any visits not covered by my insurance.

3. If using insurance, I understand clinical information (e.g., diagnosis information, a plan for my counseling appointments) will be submitted to my insurance and/or their managed care company if requested or required.

4. I will be charged $100 for appointments missed or not canceled 24 hours in advance or according to emergency exception policy. I understand that payment of this fee is required *before or at my next appointment*, as insurance does not cover these charges. I understand that if, in a period of two years, I miss or cancel three appointments with less than the required notice, I may be discharged from Dr. Chance's care.

5. Forensic and legal services, whether requested or court-ordered, are billed at $200 an hour. These services are not covered by my health insurance and are my financial responsibility.

6. Clinical time spent on the phone with Dr. Chance and the clinical time she spends with others (e.g., consultations, letters/reports), as is necessary for my care, may be billed at $40 per 15 minutes.

7. My co-payment and any other out-of-pocket payments due are due at the time of my visit or before. I understand my basic payment arrangement is:

   _____

   If I have provided debit or credit card information to Dr.Chance, she may run that card for services rendered per this agreement.

8. Any account balance left unpaid beyond 90 days may result in my being discharged from Dr. Chance's care.

9. I have received the "Notice of Privacy Practices" summarizing the uses and disclosure of my protected health information, my rights, how I may exercise these rights, and Dr. Chance's legal duties regarding my private health information, and understand my rights according to the NH Bill of Rights for Mental Health patients. I understand options to advocate for myself if I feel I am not being treated in an ethical manner. I understand that part of ethical practice includes referral to other professionals or higher levels of care if Dr. Chance's areas of competency and/or level of availability does not line up with my needs.

10. I have read and understand Dr. Chance's availability and communication procedures, including the fact that Dr. Chance does not carry an emergency line, checks voice messages on office phone only on office days (as reviewed on outgoing office phone message), texting may not be available (without special planning), and email is not appropriate for emergency communication. I will ask questions as needed on the topic of "emergencies" or other topics related to my care about which I may require additional more specific information.

11. Regarding health considerations and infectious disease, I am aware Dr. Chance exercises due diligence as directed by the American Psychological Association (APA) and Centers for Disease Control (CDC) to minimize risk of transmission of disease (e.g, available hand sanitizer, windows open as possible), but can not guarantee an infectious disease-free office environment.

12. I understand TelePsychology may be an option if practical and necessary, and have read and understand particular additional considerations if using video technology to meet. I understand the ethical and legal viability and reimbursability of TelePsychology services through insurance must be considered on a case-by-case basis before TelePsychology may be scheduled.

Signature: _____ Date: _____
Client or Legal Guardian

Witness: _____ Date: _____
Dr. Chance

1/15/21 version