Chris Chance, Ph.D.
connect@DrChrisChance.com

I have read Dr. Chance's Policy Statement and consent and/or 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 (if paying online). I understand my basic payment arrangement is: _____

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 emergency procedures, including the fact that texting is not available 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.

Signature: _____ Date: _____
Individual//Legal Guardian

Signature: _____ Date: _____
Additional Legal Guardian

Child's Signature: _____ Date: _____
If age 12 or older

Witness: _____ Date: _____

Please PRINT AND BRING THIS FORM to 1st session along with CLIENT INFO SHEET and
sign only after clarifying any questions about any aspects of the policies/contract with Dr. Chance.THANK YOU!