Kathleen B. Stringer, PhD, LPC(S), NCC

215 East Bay Street; Ste. 201D

CHARLESTON,SC 29401

Patient Name _____ M F Date of Birth _____

SSN _____ Single Married Other Spouse's Name _____

Address: _____

Home Ph: _____ Work Ph:_____ Cell Phone: _____

Emergency Contact _____Phone: _____

E-Mail Address _____ May we contact you via e-mail? Yes/No

**Consent for Services**

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

I understand that as a courtesy to me, this office will accept insurance payments directly from the primary insurance company provided eligibility can be confirmed. I agree to handle the estimated portion that insurance is not expected to pay when treatment is started. If for some reason my insurance has not responded or paid within 60 days from the date of service, or my insurance has paid less than expected, I am responsible for the balance.

A service charge of 1 ½% per month ($18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days from the date of service, unless previously written financial arrangements are satisfied. This office does not report defaulted accounts to collection agencies.

I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I ALSO ACKNOWLEDGE THAT WE MAY NEED TO USE "SKYPE" AND THAT IT MAY NOT BE CONSIDERED HIPPA COMPLIANT DUE TO THE NATURE OF THE MEDIA.

_____ Date _____

*Signature of patient, parent or guardian*

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**Authorization to Bill Insurance**

Insurance Company _____ Group # _____ ID#_____

Name of Guarantor: _____ Date of Birth _____

Patient's Relationship to Guarantor: Self Spouse Child Other _____

I, the undersigned certify that I (or my dependent) have insurance coverage with the insurance company as indicated above and assign directly to **Dr. Kathleen B. Stringer** all insurance benefits, if any, otherwise payable to me or services rendered. I understand that I am responsible for all charges wheterh payable or not payable by insurance. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize this signature on all insurance submissions.

_____ Date _____

*Signature of patient, parent or guardian*

**Notice of Privacy Practices**

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). Additional information is available on the website from the U. S. Department of Health and Human Services at www.hhs.gov/news.

**Acknowledgement of Receipt of Notice of Privacy Practices**

I have been informed of this office's Notice of Privacy Practices and aware that a copy of the said Notice is located on the website.

_____ Date _____