POYAMA COUNSELING SERVICES
965 Liberty St. SE
Salem, OR 97302
Phone (503) 588-2004 Fax (503) 588-2415

ACKNOWLEDGMENT AND CONSENT

I understand that protected health information (phi) may be used by my Poyama therapist to carry out treatment, payment or administrative operations (e.g., making a file, setting appointments) related to my care.

I understand that I may receive a copy of the Notice of Privacy Practices for additional information about the uses and disclosures of protected health information and that I may review the Notice before signing this Acknowledgment and Consent.

I understand that I may request restrictions on the uses and disclosures of protected health information. The provider may not be required to comply with your request but if your provider does agree, the restriction is binding.

At Poyama Counseling Service we request client permission to disclose all aspects of protected health information except as required by law for the reporting of abuse, endangerment, court sanctioned disclosure for medical emergencies.

I _____ acknowledge that I have received a copy of Poyama Counseling's Notice of Privacy Practices.

_____ _____
Client Signature Date

CLIENT FINANCIAL AGREEMENT

I, _____ understand that:

1. Payment or co-payment is due at the time of service.
2. I am responsible for all fees incurred for myself and my minor children.
3. I understand that telephone consultations other than to make or change appointments will be billed at the regular rate and that they cannot be billed to insurance. I understand that I will be billed for outside consultations which are no longer covered by insurance (e.g., school counselors, attorney, court hearings, etc.)
4. Charges resulting from services outside the session must be cleared within 30 days. Outstanding bills will result in collections or Small Claims Court Action. Any fees will be added to my outstanding balance.
5. Any other payment plan must be discussed with my therapist.

I give my permission for treatment for myself and/or members of my family. I agree to the above Payment contract and I agree to pay the full fee for scheduled appointments canceled without **48** hour notice. I waive any claims against Poyama Counseling Service pertaining to client confidentiality issues, if any collection action is necessary on my account, so long as I am notified, in writing, that such action is pending.

_____ _____ _____ _____
Client Signature Date Clinician Signature Date