Reflections Counseling
3220 E. Jefferson BLVD, South Bend, IN 46615
Phone: 574.222.2466 Fax: 574.222.2468

HIPAA Acknowledgment

I understand that I have specific rights to privacy regarding my protected health information. (Protected health information refers to information that is related to past, present, and future information about your physical and mental health.)

I understand that this information can be used to

- Obtain payment from insurance companies and other third-party payers, including secure electronic billing.
- Conduct, plan, and direct my treatment among healthcare providers who may be involved directly or indirectly in my treatment.
- Perform normal operations such as quality of care assessments and provider certifications.

I understand that it is the clinician's obligation to contact Child Protective Services (CPS) if an individual discloses abuse, neglect, or risk to a child or vulnerable adult.

I received a copy (electronic or paper) of the privacy policy and was given the opportunity to review this policy before signing this acknowledgment.

I understand that Reflections Counseling has the right to make changes the privacy practices. I have the right to contact Reflections Counseling at any time to obtain the most current copy of the privacy policy.

I understand that I may request certain restrictions related to how my protected health information is used or disclosed for treatment or payment. This request must be made to Reflections Counseling in writing. I further understand that Reflections Counseling is not required to comply with my request.

Please ask any questions you may have about this document prior to signing.

_____ I understand the certain information about me can be released to
(initial) insurance companies in order to process claims.

_____ I authorize payment of medical benefits to the provider for mental
(initial) health services delivered.

_____ I understand that co-pays are due at the time of service.
(initial)

_____ I understand that I am financially responsible for services rendered
(initial) that are not by the above-mentioned insurance company.

Reflections Counseling
3220 E. Jefferson BLVD, South Bend, IN 46615
Phone: 574.222.2466 Fax: 574.222.2468

I hereby give permission to Reflections Counseling to provide me with mental health services within the scope of the provider's license and training. My signature indicates that I have read and agree to abide by the above financial policy in exchange for mental health services.

_____

Printed Name of Client

_____

Signature of Client or Parent/Legal Guardian date