Initials

I understand it is my responsibility to notify ***ReDiscover*** of any change in my status such as: _____

a) Insurance coverage
b) Medicaid or Medicare coverage
c) Income and/or employment
d) address and/or phone number

I authorize my payor source(s) to pay ***ReDiscover*** any benefits due for services rendered and understand that ReDiscover will release my information as necessary to process my claims. _____

I understand I am financially responsible for any charges not covered by my payor(s) including co-pays, deductibles, or co-insurance as determined by my Insurance Plans. _____

I understand if I do not keep my account current, ***ReDiscover*** has the right to suspend my treatment until my account is made current. I further understand that if I choose to discontinue treatment, I am still responsible for the full balance due, and that my unpaid balance may be referred to a collection agency. _____

I acknowledge ***ReDiscover*** has the right to release any information acquired during my assessment and treatment (including alcohol/drug use or HIV testing or status, if applicable) that is necessary to process payment for my services. _____

I understand that my information and treatment records are strictly confidential, and will only be released with my written permission or as specified by law. _____

I authorize ***ReDiscover*** to provide the treatment deemed necessary to improve the emotional well being of the client named below. _____

I acknowledge receiving a copy of ***ReDiscover's*** Client Handbook which includes: _____

a) My Rights and Responsibilities as a client. b) Notice of Privacy Practices
c) the process for filing/resolving concerns/ grievances

I have an Advance Healthcare Directive: ☐ Yes ☐ No ☐ N/A ☐ Unknown _____

Client or Authorized
Representative Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Client Name _____ MR #_____

White = Medical Record Yellow = Client

ADMISSION INFORMATION Page 3

ReDiscover