Chart Number: ____________________

Client Name: ____________________

HEALING THERAPEUTIC SERVICES, LLC HIPAA ACKNOWLEDGMENT & AUTHORIZATION

"I hereby acknowledge that I have received a copy of the HIPAA & Privacy documents from HTS, LLC."

PLEASE REVIEW & CHECK THE FOLLOWING STATEMENTS ACCEPTING RESPONSIBILITY

[ ] I grant authorization to Healing Therapeutic Services, LLC to release PHI to my third party payer and any prior authorization that is necessary for billing or to process any claims for services provided by HTS, LLC.

[ ] I accept full responsibility for notifying HTS, LLC **IMMEDIATELY** of any changes in my insurance coverage or third party payer while receiving care. Failure to do so will result in my being responsible for any unpaid claims.

[ ] I understand that **I AM** responsible for my bill.

[ ] I authorize my therapist to act as my agent in assisting me in obtaining payment from my insurance company or third party payer.

[ ] I authorize my insurance company or third party payer to send payment directly to Healing Therapeutic Services, LLC for all services provided.

[ ] I will pay my co-payment and/or co-percentage **and** any outstanding balances owed to HTS, LLC **BEFORE** each visit.

CONSENT AND AUTHORIZATION GRANTED

PRINT YOUR NAME – FIRST, MI, LAST

First ____________________ MI ________ Last ____________________

Signature ____________________ Date ____________________

IF CLIENT IS MINOR: CONSENT & AUTHORIZATION GRANTED AS CLIENT'S REPRESENTATIVE

PRINT YOUR NAME – FIRST, MI LAST

First ____________________ MI ________ Last ____________________

Signature ____________________ Date ____________________

Relationship to Minor ____________________

INSURANCE / THIRD PARTY PAYER / SELF PAY

[ ] ____________________

[ ] ____________________

[ ] ____________________

[ ] I request **NOT** to use my insurance benefits and understand I will **SELF-PAY** the cost of services provided by HTS, LLC.

AUTHORIZATION GRANTED TO HTS, LLC TO DISCUSS BILLING RECORDS, ADMN QUESTIONS, GENERAL QUESTIONS WITH THESE PEOPLE

[ ] SPOUSE ____________________ PHONE # ____________________

[ ] PARENT ____________________ PHONE # ____________________

[ ] OTHER ____________________ PHONE # ____________________

OFFICE USE: HTS Copy of Acknowledgment & Authorization to Client: Date: ____________ Initials: ____________