SERVICE AGREEMENT

Date___/___/___ Client #____________

Last Name________________________ First Name________________ Middle Initial________

Address______________________________ City____________ State__________ Zip________

County of Residence____________________ Home Phone________________ Work Phone________________

(Attach copy of county verification if outside to County Catchment Area)

Gender: ( ) Male ( ) Female SS#____________________ DOB___/___/___ Marital Status: D S M

Race____________ Ethnicity__________ Language if not English________________

Parent/Legal Guardian: ____________________________ Family Size_____ Family Income________________

Medicaid #___________________ Insurance Provider________________ Policy #____________________

Copy made of insurance Card and/or Medicaid Card ( ) Yes ( ) No

If self-pay/ sliding fee, percentage owned by client will be:_____________% based on rider string.

I, the undersigned agree that I am required to pay for services rendered to me by L&P Services, Inc. in accordance with the rate schedule applicable to my case. I further acknowledge that all information divulged by me in counseling sessions is confidential information and will be retained and held confidential by L&P Services, Inc. with the exception of those noted in the Clients Rights and Grievance Policy. I further acknowledge that in the event I do not pay those fees charged to me by L&P Services, Inc. for services rendered to me, that they me be required to take legal action including divulging to its attorneys and courts in the Local, State and Federal systems, the fact that I do owe an account to L&P Services, Inc. I specifically agree that in the event I leave and do not make the payments required by me on my account, that L&P Services, Inc. may reveal the fact that I have an account with them, the amount owned on the account the date(s) services were rendered and the amount of time involved in rendering said services to its attorneys and courts in the Local, State, and Federal systems for the purpose of collecting said account.

I understand what my personal pay obligation is and I agree to pay it at each visit. I understand that if I do not make a reasonable attempt to pay my account that L&P Service, Inc. has the right to take legal action to obtain payment. I understand insurance will not pay for CSP services and I may have to pay for this service based on income. I agree to contact L&P Services, Inc. if I obtain insurance coverage or if my financial condition changes including my family size or monthly income. I agree to allow L&P Services, Inc. to contact me at a later date to find out if I am satisfied with the services received. I agree that any time I am unable to keep a scheduled appointment I shall notify L&P Services. Notification should be made 24 hours prior to the scheduled appointment, except in emergency situations. I authorize L&P Services, Inc. to accept payment from any and all third party payers. I affirm all information above is true and accurate. I understand and agree to all statements contained in this agreement.

I have received L&P Service Client Hand Book which includes the agency rules and expectations, client rights and grievances process, and HIPAA Privacy Practices. I understand who the Client Rights Officer is and I understand how to contract Crisis Intervention services.

I understand that as a part of my health care at L&P Services, Inc., L&P Services, Inc. creates and maintains records describing my physical and mental health history, symptoms, examination and test results, diagnoses, treatment, and plans for future care or treatment. I understand that this information serves as: A basis for planning my care and treatment; a means of communication among the staff at L&P Services, Inc. who contribute to my care; a means for verification of services to an insurance provider; and a tool for health care operations, such as assessing quality and reviewing competence of health care professionals.

I understand that as a condition of receiving treatment from L&P Services, Inc., L&P Services, Inc. may use or disclose my personally identified health information for such treatment, payment and operations purpose. These uses and disclosures are more fully explained in the Privacy Notice that has been provided to me and which I have had the opportunity to review.

I understand that the privacy practices described in the Privacy Notice may change over time, and that I have a right to obtain any revised Privacy Notice by contacting L&P Services, Inc., PO Box 4006, Marietta, Ohio 45750 to make such a request. I also understand that I have the right to request L&P Services, Inc. to restrict how my health information is used or disclosed by completing a Disclosure Restriction Request form. L&P Services, Inc. does not have to agree to my request for the restriction, but if it does agree, it is bound to abide by the restriction as agreed.

Finally, I understand that I have the right to revoke/withdrawal this consent, in writing, at any time. My revocation will be effective expect to extent that L&P Services, Inc. has taken action in reliance on my consent for use or disclosure of my health information. Provision of future treatment may be withdrawn if I withdraw my consent for treatment, payment, or operation.

X____________________________ ____/____/____ ________________________

Client/Guardian Signature Date Staff Signature

L&P Services, Inc. will not deny services to anyone for the INABILITY to pay. L&P Services, Inc. does reserve the right to deny or discontinue services for REFUSAL to pay and to increase fees based on failure to report TOTAL FAMILY income.

☐ Copy given to client