THERAPEUTIC SERVICES AGENCY, INC.

220 Railroad Street SE • Pine City, MN 55063 • (320) 629-7600 • Fax (651)925-0071

Acknowledgement of Receipt of Privacy Practice Notification and Client Information and Office Policy Statement Authorization for Treatment & Payment

Name of Client: ___________________________________ Date of Birth: ________________________

By signing this document you are acknowledging the following:

1. I have been offered and/or received a copy of Therapeutic Services Agency, Inc. (TSA)'s **Client Information and Office Policy Statement** as well as the **Notice of Privacy Practices.** I understand my rights, including those related to confidentiality and its limitations.

2. I understand the service that will be provided and **I consent to treatment** for myself or for a minor child for whom I am the child's parent or legal representative. Mental health services may include diagnostic interview, psychotherapy, skills training, psychological testing (if indicated), specialized assessments (if indicated) and involvement in the treatment planning process for all services that are received through this clinic.

3. I authorize TSA to release/exchange information with my insurance company. I hereby **authorize payment** directly to TSA of the policy benefits otherwise payable to me, but not to exceed the provider's regular charges for the period of treatment. I understand that I am financially responsible to TSA for all charges not covered by my current benefits and **all co-pays are due at time of service**.

☐ Check here if you are covered by a county contract. Name of County: _________________________

☐ Check here if someone other than insurance/county is paying for services. If checked, indicate here who the responsible party is: ____

Please note, you are responsible for knowing your benefits and coverage. You are responsible for notifying TSA of any insurance change or loss of coverage. Should you secure services without coverage, it is your responsibility to pay TSA for services received. If you are covered by a county contract and that contract ends, you are responsible for paying TSA for services rendered. If payment for client responsibility is not rendered, services may be suspended until payment is received.

4. Do you wish for TSA to **notify your primary care provider** or **psychiatric provider** that you are receiving services, for purposes of coordinating care? ☐ **NO** ☐ **YES**

If YES, please complete a separate **Release of Information** form and specify what information you would like to be shared.

Client's (or Legal Representative's) Signature: ________________________________ Date: ____________

Legal Representative of client (if minor) *please print name:* ____