Release to Bill Insurance and Responsibility of Payment

I authorize Abba's Heart Counseling Center, Inc (AHCC, INC) to release information or copies of mental health counseling records contained in my patient file to any third party payer or the representative for the purpose for obtaining payment for the services rendered by AHCC, INC. I understand I am responsible for all my bills for counseling services, including any portion of my bill not covered or reimbursed by my insurance company.

I authorize AHCC, INC to act as my agent to help assure payment from my insurance company and request and assign payments directly to AHCC, INC by all insurance carriers with whom I have coverage. If collection action is necessary, I agree to pay all costs of collection, including reasonable attorney's fees, court costs and collection agency fees associated with the collection process.

I understand that insurance companies, by contract, do not reimburse providers for missed or cancelled appointments. I will give a 24-hour cancellation notice, as set forth by AHCC, INC.'s Terms of Confidentiality, Business Practices, and Release of Liability, and also agree to pay the fees accordingly.

I understand that this consent is required in order for AHCC, INC. to bill and collect from my insurance provider, and consequently, my receiving and continuing counseling services through AHCC, INC.

Release of Confidential Information to Primary Care Physician

I, _____, born on _____ release and authorized Angie S. Mabe, LMHC of Abba's Heart Counseling Center, Inc. to disclose information to my Primary Care Physician (PCP): _____ Phone:_____all clinical information in order to allow my PCP to monitor my care, health, and well-being. Furthermore, I give consent to discuss any AIDS/HIV information by placing my initials here:_____. I may revoke this authorization in writing at any time and I understand that only the representative noted above will be disclosed with my information. I understand that a general consent form will not be sufficient in releasing information to a medical provider and it is necessary for me give proper consent for this purpose. If I wish to have a copy of this consent form, I am entitled to a copy for my records.

_____
Client Name

_____ _____
Signature (Legal Guardian or Parent) Date