# MAPS Counseling Services

## Signature Page

☐ 19 Federal Street
Keene NH 03431
603-355-2244

☐ 9 Vose Farm Road
Peterborough, NH 03458
603-924-2240

Fax: 603-355-2299

Today's date: _____

**Client's name:** _____ Date of birth: _____

Therapist's name: _____

**Professional Disclosure Statement:**

I have read the MAPS Professional Disclosure Statement. I understand it and agree to its provisions.

➢ Signed: _____ Date: _____

➢ Signed: _____ Date: _____

**Notice of Privacy Practices:**

I have received a copy of MAPS' "Notice of Privacy Practices" (effective June 30, 2008) brochure.

➢ Signed: _____ Date: _____

➢ Signed: _____ Date: _____

**Fees & Consent for Treatment** *(please check one)***:**

☐ I have no health insurance coverage, or I choose not to use my health insurance, and agree to pay a fee of $_____ per session.

☐ I have no health insurance coverage, and I qualify for a fee subsidy, and so I agree to pay a fee of $_____ per session.

☐ I have health insurance coverage that I wish to use to help pay my fees:

My health insurance company is: _____ My co-payment per session is: _____

Other requirements, including deductibles, are described as follows: _____

☐ Check here to receive MAPS newsletters, appeals and other episodic MAPS mailings. You may cancel at any time.

I agree that I am requesting professional services from MAPS Counseling Services (MAPS), and I authorize MAPS' staff therapists and interns to provide those services for me, for my child, or for my family.

I agree that, if I request MAPS to bill my health insurance provider(s), MAPS may provide them with the medical information necessary to authorize payment for professional services. I also understand that if my insurance does not pay for these services, or if I choose to pay for them myself, that the fee for these services is $130 for an hour of individual or family psychotherapy. (Other services may be billed at a different rate, and this will be explained to me by my MAPS staff therapist as necessary.) This fee may be subject to a negotiated reduction prior to or during the services I receive, and that a fee subsidy is available for those who cannot afford services.

I agree to pay any fee or co-payment at the time of service, unless I have negotiated an alternative plan with MAPS. I understand that services with MAPS may be postponed or terminated if my account is overdue.

I understand that many insurance plans require pre-authorization for services and I have obtained this authorization (if required) to see my MAPS therapist. I also understand that my insurance company may not pay for all services or for help with all problems and that I need to clarify this with my therapist for any services I receive. I am responsible to pay for any services that are not covered by my insurance plan and for any deductibles or co-payments that are established by my plan.

Many insurance plans place a limit on the number of sessions they will authorize. My plan will tell me this before I begin. If more sessions are needed, MAPS may need to submit a request for additional sessions. My therapist will inform me when I have used my authorized sessions, and I may choose to postpone services until further authorizations have been obtained. If I choose to continue services without authorizations in hand, I will be responsible for the cost of any services my plan chooses not to authorize and pay for.

I have informed MAPS not only of my primary insurance information, but also of all secondary insurance plans that I carry. I will also inform MAPS if there are any changes to my insurance or if I discontinue any plan.

➢ Signed: _____ Date: _____

➢ Signed: _____ Date: _____