INFORMATION AND AGREEMENT VERIFICATION

1. With my signature, I verify an understanding that I am required to pay my co-pay/co-insurance payment at the time of service and agree to do so. I understand I will be charged a fee (subject to change) for failure to do so. I understand that further sessions will not be held/scheduled after missing two consecutive co-pays until the co-pay balance is paid in full.
2. With my signature, I verify an understanding that I am required to pay my deductible payments in a timely manner, preferably at the time of service. I also understand that unpaid deductible payments may result in an interruption of services until the deductible balance is paid in full. I understand it is my responsibility to educate myself about my insurance company's deductible time of year and policies and agree to do so.
3. With my signature, I verify an understanding that I will be billed for miscellaneous (non-session or out-of-office services at the above rate provided by Dr. Hancock that he deems clinically indicated or that I request. I understand that insurance companies do not usually cover such charges. I agree to pay for miscellaneous services received as part of my therapy.
4. With my signature, I verify that I am responsible for notifying Dr. Hancock's office at least 24 hours in advance of cancellations (except in cases of illness/ emergency). I understand that failure to do so will result in a fee. I understand that after two no-shows, those fees must be paid in full in order to continue treatment.
5. With my signature, I verify that I am responsible to maintain my outstanding payment balance under $300. I agree to pay down the payment balance when it exceeds $300 within one month from the statement date indicating said balance. I understand that failure to do so will result in an interruption of treatment and that I may not schedule/retain further appointments until the balance is maintained under $300. I understand refusal to pay will result in being sent to collections and will incur a 40% collections fee.
6. With my signature, I verify that if my insurance coverage changes, if I no longer have insurance covering behavioral health services, or if Dr. Hancock elects to discontinue his professional relationship with my insurance provider, I will either have to contact my insurance about negotiating a single-case agreement, switch to self-pay rates, or be referred to a provider who is paneled with my insurance or who provides services on a sliding fee basis.
7. With my signature, I verify that I authorize Kyle Max Hancock, PhD, PC and/or its affiliates to contact my insurance company and/or myself to fulfill the completion of my claims process as identified and explained in the agreement.
8. With my signature, I acknowledge that I have received the Notice of Privacy Practices in either electronic and/or printed format. I acknowledge that my privacy rights have been explained to me in a manner that I can understand them. I also acknowledge that Dr. Hancock has given me an opportunity to discuss any questions or concerns associated with my privacy rights.
9. With my signature, I acknowledge that my mobile phone number is listed below. I authorize the use of my mobile phone number to receive scheduling and billing messages. I agree to update this office if my mobile number changes.
10. With my signature, I verify that I have read, understand, and agree to this information and agreement policy effective as dated. I understand this policy supersedes any and all former policies/statements. My signature also verifies that I was provided a full and complete electronic or paper copy of the information and agreement policy, including billing and contact information, and an opportunity to discuss any questions or concerns with Dr. Hancock.
11. My signature below affirms my complete and total financial responsibility for services provided.

Patient's Name (printed) | Mobile Phone Number

Name of Financially Responsible Person | Signature of Financially Responsible Person

Today's Date

246 E. 1260 N.
Logan, UT 84341

Phone: (435) 750-6300
Fax: (435) 753-8995

OUTSTANDING PAYMENT AUTHORIZATION

In an effort to optimize efficiency and reduce collections services (which are extremely expensive), Kyle Max Hancock PhD, PC requires each financial guarantor to consent to an outstanding payment authorization agreement. You are required to pay at least $1 toward your bill with a current credit or debit card upon your first visit. With your signature, you authorize Kyle Max Hancock, PhD, PC to charge your credit/debit card that has previously been utilized and stored by Kyle Max Hancock, PhD, PC for the total amount of any unpaid balance after it is a minimum of 60 days past due. All financial guarantors will be provided at least two separate notices of any past due balance prior to charging the card on file. If you dispute any charges billed, a written notice of dispute must be provided to Kyle Max Hancock, PhD, PC a minimum of five business days prior to the 60-day limit. All reasonable and appropriate efforts will be made to resolve any identified dispute before charging the card on file. However, Kyle Max Hancock PhD, PC reserves the right to submit charges to the card on file for any services rendered consistent with the authorized rates and charges identified in the signed contract between any financial guarantor and Kyle Max Hancock, PhD, PC provided that sufficient reasonable evidence exists that services have, indeed, been rendered for each applicable charge (e.g., patient signature on applied date of service). No other charges will be placed upon the card on file without the express consent of the responsible party. All credit card information will be stored using encryption consistent with both HIPPA and PCI DSS. This agreement does not preclude any account being submitted to collections as outlined in the signed contract. Additionally, if, consistent with this agreement, an attempt to charge the card/account identified below is unsuccessful or denied for any reason, the financial guarantor on this account will be assessed a service fee of $100 in addition to all other outstanding charges and the account may be submitted to collections as detailed in the signed contract. Finally, with your signature, you guarantee that if, at any time, you terminate the card on file, you will provide Kyle Max Hancock, PhD, PC with a replacement card within 24 business hours of card termination.

With your signature, you certify that you are an authorized user of the identified credit card/account and that you will not dispute these transactions with your bank or credit card company, so long as the transactions correspond to the terms indicated in this authorization form.

Please complete the information below:

Name of Patient: _____

Name of Responsible Party: _____ Date: _____

Signature of Responsible Party: _____ Date: _____

APPOINTMENT REMINDERS & PATIENT PORTAL

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a voice message) before your scheduled appointments. You can also enjoy the convenience of viewing your scheduled appointments, account balance, and other tools located in our secure patient portal. This is also the method we will use to send your bill to you. Simply visit www.therapyappointment.com to find your healthcare provider and set up your patient portal. Once established, you can access your patient portal by going to www.schedule.care.

Patient name: _____

Requested login name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
(letters and/or numbers only)

Requested temporary password: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
(must be at least 8 characters and contain both letters and numbers)

(After you log in, you will be asked to change this to a permanent password)

Your email address: _____

Your home phone number: _____

Your mobile phone number: _____

How would you like to receive appointment reminders? (initial one)

_____ via a text message to my cell phone (normal text message rates will apply)

_____ via an email message to the email address listed above

_____ via an automated voice message to my home phone number listed above

_____ I do not want emailed statements and agree to pay $3/monthly for a paper statement to be mailed.

NOTES: (1) If requested, appointment reminders are sent as a courtesy. Missed appointment fees still apply if, for any reason, the reminders cannot be delivered. (2) Appointment information may be classified as "Protected Health Information." By my signature, I am requesting that reminders be handled as I have noted above.

Signature _____ Date _____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, the undersigned, hereby authorize Kyle Max Hancock, PhD, PC and its affiliates the release and exchange of medical/health/psychological information of:

Name (print): _____ **Birthdate:** _____

Address: _____ **City, State, Zip:** _____

Home Phone: _____

To:

Professional/Clinic/Person: _____

Address: _____

City, State Zip: _____

Phone: _____

Fax: _____

With the following limitations or exclusions:

□

Important:

- You may revoke this authorization at any time by written request. Obviously, the revocation can't apply to information already released.
- There may be charges associated with services rendered to fulfill this release of information request.
- Your treatment is not conditional on signing this authorization.
- You are entitled to a copy of this authorization upon request.

Person Authorized to Consent: _____ **Date:** _____

Signature of Authorized Person: _____ **Date:** _____