New Client Signature Page

Name (Printed): _____DOB: __/__/__

1) The information provided on the registration paperwork is true to the best of my knowledge.
2) By the signature below, I authorize independently contracted therapists who are contracted with Verna Dority, MSW, CCSW Inc, to treat myself or the above named family member.
3) I have received, read, and understand the Bill of Rights for Medicaid and Tricare, CCS Office policies and Patient's Rights.
4) I hereby acknowledge that I have received and have been given an opportunity to read Carolina Counseling Service's Notice of privacy practices. I understand that if I have any questions regarding the notice or my privacy rights. I can contact the owner of Carolina Counseling Services.
5) I understand that if I am experiencing an emergency or am in crisis, I can contact my therapist 24-hours a day (I have been given a card with the contact information of my therapist.), call or go to the nearest crisis and assessment center, call 911, or go to the nearest Emergency Room. Also, if available, I can call the 24-hour Access and Information Line provided by my insurance. (Contact information is provided on Patient Rights and Office Policy forms)
6) I acknowledge that I have received a card containing the contact information of my individually contracted therapist.
7) In the event of an emergency, my signature below grants permission for the employees and/or contracted therapists to seek emergency medical care on my behalf from a hospital or physician.

_____ **Client Signature** _____ **Date**

_____ **Parent/Guardian signature** _____ **Date**

_____ **Parent/Guardian printed name**

Client refuses to acknowledge receipt of Notice of Privacy Practices. _____ Staff Member signature

If you don't understand the following, please discuss with Administrative staff before you sign.

1) Verna Dority, MSW, CCSW, Inc is the corporation that does business as Carolina Counseling Services
2) Each individual therapist is independently contracted with the above corporation. They are **not** *employees* of the above corporation
3) **It is our intention at CCS that you get the help that YOU need.** It is important, therefore that your therapist is a good fit for you (or your family member). Please let your independently contracted therapist know exactly what your expectations are and the changes you are looking for. Do this during your first session. If you believe at some point that it is not a good fit, we encourage you to speak to your therapist about this first-to see if adjustments can be made. If you discover it is still not a good fit, please ask your therapist for a referral to another therapist who is independently contracted with CCS who may be a better fit. You may also contact the main office to request this referral.

I have read and understand the above.

_____ **Signature** _____ **Date**

Please sign under one of these choices:

FOR SELF-PAY CLIENTS ONLY:

As a self-pay client, I agree to pay the current rate set by my independently contracted provider..
I attest that:
a) I do not have insurance coverage, OR
b) I have insurance coverage but choose not to use it, and understand that in doing so I am waiving any right to reimbursement, OR
c) I have insurance coverage, but understand that my services are not covered by the plan.

_____ **Signature** _____ **Date**

FOR INSURANCE CLIENTS ONLY:

I authorize any insurance benefits to be paid directly to CCS (Carolina Counseling Services), Verna Dority, MSW, CCSW, Inc, or any of it's independently contracted therapists who provide services to me or my family members. I understand that I am financially responsible for any balance. I also authorize CCS (or the entities listed above) and/ or insurance company to release information required to process my claims.

_____ **Signature** _____ **Date**