Mosaic Counseling Center, PLLC Consent for Professional Services

92 Cornerstone Dr., #107
Raleigh, NC 27519

Name: _____ DOB: _____ Date: _____

Provider: Becky Jorgenson, MA, LPC

Receipt of Notices and Request for Services

_____ I have read the attached Professional Disclosure statement for Becky Jorgenson, MA, LPCS, NCC, CEDS, NCTM, at Mosaic Counseling Services.

_____ I acknowledge receipt of a copy of the Notice of Privacy Practices (or I have declined a printed copy).

_____ I hereby request professional services from this professional. I understand the first one or two visits are for evaluation purposes and are not a guarantee of further treatment. If ongoing treatment at this office is indicated and mutually agreeable then a treatment plan will be agreed upon at the end of the evaluation.

Financial Responsibility

_____ I hereby unconditionally guarantee payment to Becky Jorgenson at Mosaic Counseling Services, PLLC for all costs, charges and expenses incurred by said client at this office, unless separate arrangements are agreed upon in writing.

_____ I also agree to pay a service charge of $30.00 for any checks that are returned unpaid. I understand if the patient balance for services provided is not paid within thirty days of billing date, the amount due will be deemed delinquent. In the event the account is turned over to a collection agency, I agree to pay a $10.00 collection fee which will be added to the existing balance. In the event legal action should become necessary to collect an unpaid balance due for services rendered to said patient, I agree to pay reasonable attorney's fees or other such costs as the court determines proper.

Insurance/Managed Care/Third Party Payment

_____ I understand it is my responsibility to pay all costs at the time of service.

_____ I understand that Mosaic Counseling Center does not file insurance, but will provide a claims form upon request.

_____ I will accept full financial responsibility for any services the office provides.

Client Signature: _____ Date: _____

Provider Signature: _____ Date: _____