ACKNOWLEDGEMENT AND CONSENT:
TO THE PATIENT SERVICES AGREEMENT & TO THE NOTICE OF PRIVACY

I have read and understand the information in Lee Welch, LCSW' "Information & Patient Services Agreement." This includes information pertaining to Professional Services, Appointments, Fee Policy & Insurance Reimbursement, Emergencies, and Minor & Parents.

I am aware I have the right to choose the best treatment and provider. I also have the right to refuse or stop treatment at any time and for any reason. I have the right to a detailed explanation of any and all treatment procedures provided by Mr. Welch. If I am not getting the treatment I require, I have the right to raise this concern with Mr. Welch and can expect him to work with me to revise treatment or to refer me to other professionals who may better serve my health care needs.

If health care insurance or a third party payor is being used, by signing below, I also agree to have Mr. Welch, and his staff, submit claims to my insurance companies for reimbursement of services provided. I acknowledge I, and not my insurance company, am responsible for full payment of all fees incurred. Payments can be made directly to Mr. Welch.

I understand and agree Mr. Welch may use and disclose health information about me. I understand my health information may include information both created and received by Mr. Welch, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, prescriptions, and similar types of health-related information.

This information may be used and disclosed in order to:

- make decisions about, and plan for my care and treatment
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my healthcare, and
- perform various office, administrative and business functions that support Mr. Welch's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

By signing below, I acknowledge I have received a copy, reviewed, understand, and agree to the information above and in both the Patient Services Agreement (dated Aug.2020) and the Notice of Privacy (dated Aug.2020).

_____ _____

Signature of Patient Date Signed

_____ _____

Signature of Patient Representative (parent, legal guardian) Date Signed