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### **Acknowledgement of Electronic Communication**

I understand that while every effort will be made to hold your personal information at the highest level of privacy (Federal HIPPA Standards), electronic communication is not always secure. Counseling and Mediation Solutions, LLC / Beyond the Brain Therapies Inc. have taken every step to encrypt and secure our network to meet all medical standards of compliance. Telephone, email or text exchanges will be used only for information related to treatment (including tele-medicine) and billing between yourself, your therapist/staff, your insurance carrier and the billing company we outsource to (Bell MedEx).

I authorize my therapist and those hired above to process my information as needed to cover my services. I have provided the following information for therapist-client exchanges:

Email \_\_\_\_\_ Email Address \_\_\_\_\_

Text \_\_\_\_\_ Cell Phone \_\_\_\_\_

#### **Please initial one of the following 2 options:**

\_\_\_\_\_ I authorize the release of information to my insurance or funding source. I authorize payment from my funding source for services rendered accordingly. I acknowledge and take full responsibility for amounts that are not payable by my funding source (i.e. unbillable services, deductibles and co-pays).

\_\_\_\_\_ I opt for a private pay agreement... and that insurance will NOT be billed. An agreed upon Self – Pay in the amount of \$ \_\_\_\_\_ per hour has been established. I also acknowledge full responsibility for payment at time of service.

I understand that I have the option to switch insurance billing to Self-Pay or vice versa anytime. If insurance has been billed for a specific date(s) and no payment is made, I acknowledge my responsibility to pay the remaining amount.

I have read and understand the information given regarding my rights and responsibilities and the confidential commitment of my therapist (Informed Consent and Confidential Information Form). Additionally, I understand the limitations and risks involved in tele-health services as outlined.

(Client Signature) \_\_\_\_\_ (Date) \_\_\_\_\_