



## Client Services Agreement Acknowledgement

I, \_\_\_\_\_, have read and understood the following documents:

- Client Services Agreement
- Notice of Privacy Practices
- Financial Agreement
- Court Policy

I acknowledge that I am aware of RCC's financial policy, which requires that payment be made at the time of the service.

*I understand that if I am using insurance for my appointments, RCC is legally obligated to collect my portion of the payment (which may be a copayment, coinsurance, or deductible amount) at the time of the service.* Failure to do so on RCC's part would be a violation of RCC's contract with my insurance company and RCC is not permitted, by law, to waive my portion of the insurance cost for my appointment(s).

I am also aware that missed appointment fees are not covered by insurance and will be added to my account for any cancellations not made more than 48 hours in advance, and for any no-shows for myself or my child. If I have a credit card on file, my card will be charged at the time of the missed appointment. Medicaid patients are not charged for missed appointments.

I have been informed that I must pay for my service at the time of my appointment or I will not be seen by my provider at that time, unless prior arrangements have been made.

I am aware that I am responsible for any collections/attorneys fees that may be assessed for failure to pay my balance in a timely manner.

I acknowledge that I have been provided with a copy of the Client Services Agreement for my immediate review and have been given the option of retaining my own copy, which contains the Notice of Privacy Practices.

I have been given the opportunity to discuss any questions or concerns accordingly with my provider.

By signing below, I agree to the conditions and terms discussed in the above documents.

\_\_\_\_\_  
Client Name (Print)

\_\_\_\_\_  
Legal Guardian (If Applicable)

\_\_\_\_\_  
Client/ Legal Guardian Signature

\_\_\_\_\_  
Date