Consumer Name: ______________________________	Date of Birth: _____________
Insurance Number: ______________________________	Medical Record #: __________

21st Century Counseling, PLLC

Jonadab S. Franco, MSW, LCSW, LISW-CP
Individual, Couple, and Family Counseling
304 E Greene Street, Rockingham, NC 28379
Phone: (910) 817-9181
Fax/phone: (800) 878-9353
www.21stcenturrycounseling.com

Please initial each section and sign below to indicate acknowledgment and authorization
Note: The legal representative must initial and sign the authorization in lieu of a minor child or patient. Proof of custody may be requested by the clinician and will be part of the patient's record.

_____ **Patient Payment Policy**

I have read and understood the 21st Century Counseling, PLLC Patient Payment Policy and I agree to pay for treatment rendered to me/the patient.

_____ **Notice of Privacy Practices**

I understand that 21st Century Counseling, PLLC will use and disclose my/the patient's health information for the purposes of treatment, payments, and healthcare operations, as permitted by law. Further information can be found in the Notice of Privacy Practices, which has been offered to me.

_____ **Assignment of Insurance Benefits**

I authorize the payment of mental health benefits to 21st Century Counseling, PLLC, and hereby assign to 21st Century Counseling, PLLC and the professionals involved in my/the patients care, all rights and claims for reimbursement under any private health insurance policy, Medicare, Medicaid or any other programs that I identify for which benefits may be available to pay for the services provided to me/the patient.

_____ **Consent to Treat**

I, the patient or the patient's legal representative, hereby grant permission to 21st Century Counseling, PLLC and its authorized representatives to perform examinations/treatment deemed necessary or advisable for diagnosis and treatment. ***I understand that I have the right to refuse treatment at any time either verbally or in writing***. Do not initial this section if you want to refuse treatment at this time.

_____ **Patient Rights and Responsibilities**

I understand that I have the right, and the responsibility, to participate in my/the patient's care and treatment. I understand that I have the right to be informed about the treatment being recommended, and the responsibility to ask questions if I do not understand it. I agree to provide accurate and complete information about my/the patient's health history and presenting complaint, to agree upon a treatment plan, and follow that plan. I understand that 21 Century Counseling, PLLC health care providers will treat me with respect, and I agree to do the same for them.

_____ **Consent for the provider to seek medical emergency services (911)**

I understand that 21st Century Counseling staff will contact emergency services or 911 in the event that the patient or the patient's legal representative is experiencing a life-threatening emergency.

Patient / Legal Guardian Signature: ______________________________________ Date: ______________

Relationship to patient: ____

Revised 11/12/2019