Service Agreement

Consent for Non-Secure Communication

I authorize John A. Knoerzer, LCSW to transmit the following protected health information (PHI) relating to my health records and health care treatment to myself:

☐ Yes ☐ No Information related to the scheduling of meetings or appointments

☐ Yes ☐ No Information related to billing and payment

☐ Yes ☐ No Other information. Describe: _____

BY THE FOLLOWING NON-SECURE MEDIA:

☐ My preferred email: _____

☐ SMS text message (i.e. traditional text messaging) at this number: (_____) _____

☐ Other media. Describe: _____.

I acknowledge the following risks and procedures for using unsecured forms of communication:

- That while John Knoerzer, LCSW will take every reasonable precaution to protect my personal information, I may be at risk for my personal information becoming exposed if it is transmitted to an unsecured source of my choice
- John Knoerzer, LCSW will contact me within one business day if he feels that information security or my PHI has been compromised
- I have the right to request a detailed description of John Knoerzer's LCSW digital and physical security procedures
- I understand I am not required to use non-secure communication in order to receive treatment
- I understand that I may terminate the use of non-secure communication at any time.

Sign your initials here if you agree to the terms of non-secure communication: _____
initials here

Without consent for non-secure communication, John Knoerzer, LCSW will communicate information:

- In person
- Voice phone call
- Mailed envelope (i.e. "snail mail")

Appointment reminders

☐ No, I do NOT wish to receive automatic appointment reminders

☐ Yes, I would like to receive automatic appointment reminders using the email below

Email: _____

John A. Knoerzer, LCSW (773) 234-1575
info@johnknoerzerlcsw.com www.johnknoerzerlcsw.com

Cancellations / No Show Policies

1. Appointment must be canceled at least 12 hours before the scheduled date and time or you will be charged half (50%) of your agreed session fee.

2. If you do not arrive for your session and do not contact the therapist whatsoever (i.e. "no show"), then you will be charged the full amount (100%) of your agreed session fee.

Payment Policies

3. Therapy sessions consist of a 50-minute "hour", or 25-minute "half hour". If the session lasts longer than its allotted time, you will be billed on a pro-rated basis.

4. Payment is due when services are received.

5. There will be a $30 charge for returned checks.

Insurance Policies

6. If you plan to bill insurance, all pre-authorizations or referrals needed for coverage are the client's responsibility.

7. If you plan to bill insurance, the therapist will provide extra copies of invoices or payment receipts at the client's request.

8. If insurance coverage is not obtained, you are responsible for the full amount owed for services rendered.

Notification Policies

9. If these policies change, you will be provided with a new service agreement in writing and will re-sign your consent.

I have read the above policies carefully and agree to these provisions.

_____ _____

full name date

_____

signature

☐ Check this box if the client is under the age of 18 and you are the parent / legal guardian / foster parent

John A. Knoerzer, LCSW (773) 234-1575
info@johnknoerzerlcsw.com www.johnknoerzerlcsw.com