HARMONY
Mental Health

Client name:		Client DOB:	

OUTPATIENT SERVICE CONTRACT

The law requires that our agency obtains your signature acknowledging that we have provided you with this information by the end of the first therapy session. By signing the signature page which lists this document, it will represent an agreement between you and Harmony Mental Health. You may revoke this agreement in writing at any time. That revocation will be binding on Harmony Mental Health unless there are obligations imposed on Harmony Mental Health by your health insurer in order to process or substantiate claims made under your policy, or if you have not satisfied financial obligations you have incurred.

FINANCIAL POLICY

Your signature below indicates that you have read the Financial Policy and Attendance Policy. Your signature indicates agreement with these policies and an acknowledgement that you have been offered a copy of this document..

NOTICE OF PRIVACY PRACTICES/HIPAA

Your signature below indicates you have read and understand the Notice of Privacy Practices document. Your signature also serves as an acknowledgement that you have been informed of your privacy rights, our responsibilities, and have been offered a copy of this document.

RELEASE TO PRIMARY CARE PHYSICIAN (LEAVE BLANK IF CLIENT SIGNS ROI)

If client is not authorizing release for Harmony Mental Health to communicate with client's primary care physician, please indicate one of the following:

☐ Client does not have a primary care physician at this time.

☐ Client has a primary care physician but does not want to sign a release of information at this time.

These forms have been explained to me, and I have been given an opportunity to ask questions about them. I understand that I may revoke my consent at any time with written notice.

X _____ _____

Signature of Patient/Client, Parent, Guardian or Personal Representative **Date**

If signed by a personal representative, relationship to patient: _____

Rev. 01/2025