

# Assignment of Benefits / Financial Responsibility / Telehealth Consent

I acknowledge the payment and insurance information set forth below and agree to pay for services rendered to me and/or facilitate the payment for services rendered to me by the providers affiliated with any of the behavioral health groups managed by Headway (Practice)

1. Payment of Fees: I agree to pay for charges for services as described in this agreement. I understand that:
  - Payment for sessions with providers affiliated with Practice is payable online through debit or credit card or ACH transfer, unless otherwise established
  - Payment for sessions is due after each session unless otherwise agreed upon and Practice will charge my card or bank account for my responsibility. Receipts may be provided at the time of the charge or monthly
  - I will be charged for sessions that I do not keep, unless I provide enough notice to the provider affiliated with the Practice (your treating provider will tell you how much notice is required to avoid being charged for sessions you do not keep)
  - I understand that I cannot submit bills for cancellations to my insurance company or managed care plan
2. Insurance and Managed Care Plans:

Practice participates in a number of insurance and managed care plans. If Practice participates in my plan, I agree to pay all applicable deductibles, co-payments, co-insurances and any other form of cost-sharing. If my insurance benefits run out, Practice will inform me of the ending date, and I will then be responsible for all charges dating from the end of insurance coverage. If my insurance plan denies the visit despite Practice following necessary procedures, I understand I may be responsible to pay in full for the service.
3. Assignment of Insurance Fees; Release of confidentiality for authorization of benefits and for clinical care:

I agree to allow my insurance plan or managed care plan to pay Practice directly, instead of paying me. In the event that my plan pays me directly, I will promptly turn the payment over to Practice unless I have already paid the charges myself. I authorize Practice to provide my insurance plan or managed care plan any information reasonably required to obtain insurance benefits and authorization for services. I authorize Practice to obtain at any time during my treatment here, any and all relevant clinical information from clinicians and facilities that have treated

me and to furnish relevant clinical information to providers who will continue to treat me. I will indicate in writing any exceptions to this.

4. Consent to Treatment Via Telehealth:

I consent to participate in telemental health services. I understand that I have the right to refuse telemental health services and be informed of alternative services that may be available to me. If I request alternative services, I understand that Practice may not be able to provide those services, and that I may experience delays in service, the need to travel, or any other risks associated with not having services provided via telemental health, as well as risks associated with receiving telemental health services in an off-site location. I understand that telehealth may result in certain risks that are less likely to occur with in-person services, such as technology failure, need for specialized electronic security systems, and less visibility of non-verbal cues. Telehealth can also provide benefits not present with in-person services, such as creating greater flexibility for when and where services may be provided.