



"Offering a New Vision to Meet Your Life's Destiny"

Client Information

A. IDENTIFICATION

Client Name: _____ Sex: _____ Date of Birth: ____/____/____ Age: _____
Employer/School: _____ SS #: _____-_____-_____
Home Address: _____
City: _____ State: _____ Zip: _____
Phone~ Home: (____) _____ Work: (____) _____ Cell: (____) _____
Email: _____
Which numbers/email listed above may we leave a message on? _____

If client is a minor: Names of Parent(s)/Guardian(s): _____

B. RESPONSIBLE PARTY INFORMATION: Check if the same as client (skip this section)

Guardian Name: _____ Sex: _____ Date of Birth: ____/____/____
Relation to Patient: _____ SS #: _____-_____-_____
 Same address as client: Different address than the client (Please complete address below)
Home Address: _____
City: _____ State: _____ Zip: _____
 Same home phone as client Different home phone: Home: (____) _____
Other Phones: Work: (____) _____ Cell: (____) _____ Email: _____

C. INSURANCE INFORMATION ~Please provide insurance card~ **Skip if self-pay**

Policyholder's Name _____ Policyholder's SSN: _____-_____-_____
Date of Birth ____/____/____ Primary Insurance Co. Name _____
Insurance Company's Customer Service Phone # _____ Insurance ID # _____
Policyholder's Employer: _____ Group # _____
Co-pay \$ _____ Deductible? Yes No Amount \$ _____
Authorization Required? Yes No Authorization # _____
Number of Sessions Authorized _____ Maximum Number of Sessions Allowed Per Year _____

Is the patient covered under a secondary insurance policy? Yes No

I, _____ (client or legal guardian) authorize Kristy Christopher, LPC/ New Vision Counseling Center, LLC, or any holder of medical information about me to release to my insurance company or its representative, any information needed concerning the examination or treatment rendered to me that is necessary to process the insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to be paid directly to Kristy Christopher, LPC/ New Vision Counseling Center, LLC in such amount as my benefits allow. This authorization is effective until terminated in writing by the client or their guardian.

Client or Legal Guardian Date

D. Medical History

*Please list all Physician Names& Numbers:

Medication: _____ Dosage: _____ Reason: _____ Date Started: _____

Medication: _____ Dosage: _____ Reason: _____ Date Started: _____

Allergies: _____

List any serious accidents, illnesses, operations or hospitalizations and what year. _____

E. Family of origin

<u>Relative</u>	<u>Name</u>	<u>Age</u>	<u>Illness</u>	<u>Education</u>	<u>Occupation</u>	<u>Quality of Relationship</u>
Father						
Mother						
Step-Father						
Step-Mother						
Brother (s)						
Sister (s)						

F. Marital History

Spouse's Name: _____ Years Married: _____

Previous Married? Yes No Reason for Divorce: _____**G. Symptoms****Physical Health/Symptoms**
 Headache Vomiting Diarrhea Dizziness Chest Pain Shortness of Breath
Function/Activity
 Fatigue Little/No Sleep Weight Loss Weight Gain Academic/Work Inhibition Loss of Interest/Pleasure Excessive Worry Self Injury Substance Use/Abuse (Alcohol ___ Drugs ___ Other ___)
Emotional Symptoms
 Hopelessness Panic/Anxiety Anger Tearful Suicidal Thoughts Indecisive Fearful Other
The three biggest problems in my life right now are:

1. _____ 2. _____ 3. _____

RELEASE OF INFORMATION

I, _____, do hereby authorize _____ or any related representative at New Vision Counseling Center, LLC to

release receive exchange

information concerning _____ (Name of Client, DOB)

to from with _____

I understand that such disclosure will be made for the following purposes:

- | | | |
|--|---|---|
| <input type="checkbox"/> Treatment Progress | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Child Custody / Visitation |
| <input type="checkbox"/> Treatment Planning | <input type="checkbox"/> Social History | <input type="checkbox"/> Competency to stand trial |
| <input type="checkbox"/> Medical Treatment | <input type="checkbox"/> Treatment Summary | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Reimbursement for Treatment | <input type="checkbox"/> Diagnosis | |

I understand that unless otherwise limited by state or federal regulations, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time by giving written notice to Kristy Christopher, LPC

If no prior notice of revocation is received, this consent will expire automatically two (2) years after the date indicated thereon.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

I have read, or had read to me, the above, and understand the contents.

_____ I authorize this information to be faxed to the party indicated above, and
Initial understand the limits of confidentiality which doing so creates.

_____ I have received and read the ROI, however at this time, I do not have anyone I wish to release
Initial information to. I am aware that I can make additions/changes as necessary and at anytime by completing this form.

Signature of client, parent, or legal guardian

Date

Training of Professionals:

New Vision Counseling Center, LLC is committed to providing excellent mental health services to the community. Because of this, from time to time we will engage in training interns and/or newly licensed professionals. This can result in more affordable fees to those who are in need as well as the professional growth of those we train. In order to provide this opportunity, sometimes trainees are required to sit in on sessions, record/take notes of sessions or discuss the case with a fully licensed mental health supervisor. During this, none of your identifying information is ever disclosed and your confidentiality will remain of upmost regard. If you wish to participate in this training opportunity, please sign. You can opt out at any time simply through verbal or written communication.

Signature and date

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE PROFESSIONAL SERVICES AGREEMENT AND AGREE TO ITS TERMS. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ON THE FOLLOWING PAGES.

PATIENT (or PARENTS/GUARDIANS, IF PATIENT IS A MINOR)

Signature of Patient or Parent(s)/Guardian(s)

Date

Name of Patient or Parent(s)/Guardian(s) *(Please print)*

Relationship(s) to Patient

OTHER ADULT PARTY/PARTIES INVOLVED IN TREATMENT NOT APPLICABLE

Signature of Secondary Party/Parties

Date

Name of Secondary Party/Parties *(Please print)*

Relationship(s) to Patient

Signature of Therapist

Date

Name of Therapist

PROFESSIONAL SERVICES AGREEMENT

Welcome to my practice, New Vision Counseling Center, LLC. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

Psychological Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you or your child are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you or your child will have to work on things we talk about both during our sessions and at home. Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. Before we begin working together, it is important to understand that I cannot guarantee that you or your child will benefit from therapy. No therapist can make such a guarantee because each client responds differently to this experience. Our first few sessions will involve an evaluation of needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you obtain an appropriate consultation with another mental health professional.

Sessions

I normally conduct an evaluation that will last from 1 to 2 sessions. During this time, we can both decide if I am the best person to provide the services you or your child needs in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45-50 minute session (one appointment hour of 45-50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours notice of cancellation. **Failure to cancel within 24 hours will result in you being charged the missed visit amount.**

Contacting Me

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office regular hours, I probably will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call as soon as possible. If you are difficult to reach, please inform me of some times when you will be available. If you have an emergency, leave a message for me and I will then attempt to call you as soon as possible, usually within the hour. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician, call 911, or call the nearest emergency room. If I will be unavailable for an extended time, I will always inform you and make appropriate arraignments with you.

Confidentiality

The law protects the privacy of all communications between a patient and a therapist. In most situations, I

can only release information to others about your treatment (or your child's treatment) if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this current agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel it is important for our work together. I will note all consultations in your Clinical Record (which is called PHI in my notice of psychologists policies and practices to protect the privacy of your health information)
- You should be aware that I may employ administrative staff. In most cases, I need to share protected information with these individuals for administrative purposes, such as scheduling, billing and communication with insurance companies. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement.
- If a patient threatens to harm himself / herself, I may be obligated to seek hospitalization for him/her and/or to contact family members, or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the therapist/patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all medical reports and bills.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reason to believe that a child has been abused, the law requires that I file a report with the appropriate governmental agency, usually the Department of Family and Children Services (DFCS). Once such a report is filed, I may be required to provide additional information.
- If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon him or her, other than by accidental means, or that he or she has been neglected or exploited, I must report to an agency designated by the Department of Human Resources. Once I have filed such a report, I may be required to provide additional information.
- If I determine that a client presents a serious danger to him/herself or danger of violence to another, I may be required to take protective actions. These actions may include notifying the potential victim, and /or contacting the police, and/or seeking hospitalization for the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about

potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

Professional Relationship

Psychotherapy is a professional service I will provide to you. Because of the nature of therapy, your relationship with me has to be different from most relationships. It may differ in how long it lasts, the objectives, or the topics discussed. It must also be limited to only the relationship of therapist and client. If you and I were to interact in any other ways, you would then have a "dual relationship," which could prove to be harmful to you in the long run and is, therefore, unethical in the mental health profession. Dual relationships can set up conflicts between my interests and your interests, and then the client's (your) interests might not be put first. In order to offer all of my clients the best care, my judgment needs to be unselfish and purely focused on your needs. This is why your relationship with me must remain professional in nature. Additionally, there are important differences between therapy and friendship. Friends may see your position only from their personal viewpoints and experiences. Friends may want to find quick and easy solutions to your problems so that they can feel helpful. These short-term solutions may not be in your long-term best interest. Friends do not usually follow up on their advice to see whether it was useful. They may *need* to have you do what they advise. A therapist offers you choices and helps you choose what is best for you. A therapist helps you learn how to solve problems better and make better decisions. A therapist's responses to your situation are based on tested theories and methods of change. You should also know that by law and ethically I am required to keep the identity of my clients secret. As much as I may like to, for your confidentiality I will not address you in public unless you speak me first. I also must decline any invitation to attend gatherings with your family or friends. Lastly, when your therapy is completed, I will not be able to be a friend to you like your other friends. In addition, I will not accept friend requests from social networking sites such as Facebook, LinkedIn, MySpace, Tagged or any other such kind. I will only respond to emails that are in reference to your treatment. Please note that all email correspondence will become a part of your **clinical** record. In sum, it is the duty of your therapist to always maintain a professional role. Please note that these guidelines are not meant to be discourteous in any way, they are strictly for your long-term protection.

Professional Records

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you or your child in two sets of professional records. One set constitutes your Clinical Record. It includes information about: your reasons for seeking therapy, a description of the ways in which your or your child's problem impacts on your life, diagnosis, the goals that we set for treatment, progress towards those goals, medical and social history, treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself, your child, or others or makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person (or if information is supplied to me confidentially by others), you or your legal representative may examine and /or receive a copy of your or your child's Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I require that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most situations, I am allowed to charge a copying fee. The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your records, you have a right of review (except for information provided to me confidentially by others) which I will discuss with you upon request. In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you or your child with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your or your child's therapy. They also contain particularly sensitive information that you or your child may reveal to me that is not required to be included in your Clinical Record and information supplied to me confidentially by others. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you. They also cannot be sent to anyone else, including insurance companies without your written, signed authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

Patient Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your or your child's record; requesting

restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this agreement; the attached notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

Minors & Parents

Clients under 18 years of age who are not emancipated, as well as their parents should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the child or we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is typically my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

Financial Arrangements

Professional Fees

I have a set of hourly fees (a session hour is 45-50 minutes). In addition to weekly appointments, I charge this amount for other professional services you or your child may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report and letter writing, telephone or email conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. **These services are not covered by your insurance company. No records (written or verbal) will be released to you or on your behalf if you have an outstanding balance due to NVCC.**

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party.

You will be charged the missed visit fee for any sessions missed or cancelled with less than 24 hours notice unless due to an emergency situation. You may leave a message on my voicemail on weekends or after hours to cancel an appointment or contact the scheduling department. Appointments cannot be scheduled or cancelled via email as it is not always a reliable, confidential source and not monitored 24/7. Please note that insurance companies do not pay for missed / cancelled appointments, so you will be responsible for the missed visit fee. There will be a \$25 fee assessed for all returned checks. The card on file will be charged the original amount owed PLUS the \$25 returned check fee.

Billing and Payments

You will be expected to pay for each session at the time it is held, unless you have insurance coverage or we agree otherwise. If you have insurance, you are required to pay your co-pay/deductible at the time of service. Payment schedules for other professional services will be agreed to when they are requested. If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

Authorization for Recording

In order to conduct business in a quick and seamless fashion, we may have to contact you or your insurance company via the telephone. These conversations are recorded by our office and records are maintained and kept in the same manner as your Clinical Record. This ensures that our office has evidence if there is ever a dispute over a scheduled appointment,

authorization of a credit card, or approval of insurance coverage. At no time will medical issues or therapy be discussed or recorded during a telephone call to our office.

Insurance Reimbursement

In order for us to set realistic goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with assistance in helping you receive the benefits to which you are entitled; however you (not your insurance company) are responsible for full payment of my fees. **It is very important that you find out exactly what mental health benefits your insurance policy provides, such as co-pays, deductibles, maximum number of sessions allowed, etc.**

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. If it is necessary to clear confusion, I, or my staff, will be willing to call the company on your behalf. Many insurance plans such as HMOs and PPOs require authorization before they provide reimbursement for mental health services. **It is your responsibility to call your insurance company and obtain authorization before your first appointment. If authorization was required and is not obtained, your insurance will deny payment and you will be responsible for the hourly rate.** I will submit the appropriate bills to your insurance company one time and try to remedy any denial or payment problem related to billing one time. If after these billing attempts, the insurance company refuses to pay the bill, it will become your (the client's) responsibility to work with the insurance company to obtain appropriate reimbursement.

If you or your child is covered by a secondary insurance plan, I will be happy to provide you with appropriate billing forms and Explanation of Benefit (EOB) forms from your primary plan. I ask that you be responsible for payment of the portion of services not covered by your primary plan and that you seek reimbursement from the secondary plan for yourself. Typical insurance plans such as HMO's and PPO's are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. It will typically be my responsibility to obtain authorization for further sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to plan to continue working with you or find another provider who will help you continue your psychotherapy. You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this agreement, you agree that I can provide requested information to your insurance carrier. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above unless prohibited by contract.

Court Attendance, On-Call, and Communication with Attorneys/Other Professionals

New Vision Counseling Center, LLC bills at the rate of \$200.00 per hour for court attendance and requires credit card information to be on file. The hourly rate begins when the therapist leaves the office location and a fee for two hours will be paid prior to court attendance, (\$400.00) and is non-refundable if less time is needed. If the court attendance exceeds two hours, your credit card will be billed for the remaining time. Payment is for the therapist's time and not necessarily their testimony. Therefore, the fees are expected to be paid regardless of whether the therapist testifies or not. If you request for your therapist to be on-call for court attendance, New Vision Counseling Center, LLC bills at the rate of \$60.00 per hour for on-call and requires credit card information to be on file for payment to be charged. The hours requested for the therapist to be on call will immediately be charged to your credit card on file and is non-refundable.

Communication with Attorneys/Other professionals/Report writing:

New Vision Counseling Center, LLC bills at the rate of \$100.00 per hour for any type of communication with attorneys/other professionals/report writing (phone calls, letter writing, email, etc). You are responsible for providing credit card information prior to any communication your therapist will have with their attorney/other outside professional. A minimum of 30 minute increments will be billed to your credit card on file and is non-refundable. **Communication fees paid by check will require bank clearance before services will be rendered.**

Agreement of Participation

I agree that I (or my child) will participate in outpatient counseling at New Vision Counseling Center, LLC (NVCC). In part of this agreement, I (or my child) make the commitment to be at NVCC at a mutually agreed upon day and time.

I also understand that if I (or my child) am unable to attend counseling for any reason, I will need to give NVCC at least 24 hours notice. I am already aware that I will be responsible for paying the missed visit fee of any appointment not cancelled with a 24 hour notice.

Lastly, I will acknowledge that if I (or my child) miss more than 2 appointments and/or do not give NVCC at least a 24 hour notice, that counseling services may be discontinued and that I will receive an appropriate referral.

I also understand that NVCC will assist me in submitting claims to all insurance coverages I provide; however, the ultimate financial responsibility for services provided by NVCC is mine. Failure of insurance to pay a claim will not mitigate any claim NVCC may have for services provided to me (or my child).