Patient Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_\_\_\_\_\_

Patient Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Age: \_\_\_\_\_\_\_\_

|  |
| --- |
| Gender: Ethnicity: Race:  \_\_\_Male \_\_\_Hispanic \_\_\_White \_\_\_Other  \_\_\_Female \_\_\_Non-Hispanic \_\_\_Black or African American \_\_\_Unknown  \_\_\_Unknown \_\_\_Unknown \_\_\_Asian  \_\_\_Transgender MtF \_\_\_American Indian or Alaskan Native  \_\_\_Transgender FtM  \_\_\_Trans\* \_\_\_Native Hawaiian or Other Pacific Islander  Primary Language\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Employment Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Is your condition related to employment? Yes | No | Employer Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is your condition related to an auto accident? Yes | No | In what state did the accident occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Is your condition related to any other accident? Yes | No | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Emergency Contact (name, relationship and phone): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contract # or ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the Insured (i.e. Parent or Spouse): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address of the Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number of the Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB of the Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Gender: Male Female Transgender MtF Transgender FtM Unknown

Insured’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contract # or ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the Insured (i.e. Parent or Spouse): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address of the Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number of the Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB of the Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Gender: Male Female Transgender MtF Transgender FtM Unknown

Insured’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Patient (14 years or older) Initial \_\_\_\_\_ Parent or Guardian Initial

# Service Contract

**Side Effects:** Counseling is not always easy and you may find yourself discussing very personal information. It is possible that you might become anxious during and after these conversations. As you learn more about yourself and your relationships you may have increased conflicts with others and may become somewhat depressed. Counseling is meant to help alleviate your problems, but at first as you delve into your problems your symptoms may become more acute. You may be asked to try new ways of doing things and we cannot promise what results or outcomes you will experience, which depend on many factors.

**Length of Session:** The intake session is schedule for 60 minutes. Counseling sessions are scheduled for 30 minutes or 45-50 minutes. Additional time (in 30 minutes increments) may be added to a session, as appropriate, with advance scheduling. Group therapy sessions are scheduled for 45-50 minutes. Your provider will also spend time reviewing your progress notes, evaluating assessments, making new notes, phone calls, etc. If you arrive late for your session, the missed time is forfeited in order remain on time for other scheduled appointments and clinical obligations.

**Late Arrival:** Insurance companies can only be billed for the time spent in session with the provider. You will be billed for the missed portion of your appointment. If you are “self-pay” you will be billed for the time scheduled regardless of your arrival time. If you have not called and have not arrived 20 minutes after your scheduled appointment time, the provider will consider you a “no show” and may not be available for any of the remaining scheduled time. Please call if you intend to keep your appointment but are running late.

**Cancelation and No-Show Policy:** If you fail to cancel a scheduled appointment, we cannot use this time for another client, and you will be billed for the entire cost of your missed appointment. **Insurance companies cannot be billed for missed appointments. A full session fee OF $145 is charged for missed appointments or cancellations with less than a 24-hour notice** unless it is due to illness or an emergency. **At the Therapist discretion, each client will be allowed one (1) sick/emergency day without being charged the full session fee. On the second cancelation with less than 24-hour notice and/or “no call/no show,”** the card you place on file will be charged at the end of the business day for any balance resulting from

**Fees:**

|  |  |  |  |
| --- | --- | --- | --- |
| Intake Session | 90791 |  | $125 |
| Individual Therapy | 90832 (16-38 minutes) |  | $70 |
| Individual Therapy | 90834 (39-52 minutes) |  | $100 |
| Individual Therapy | 90837 (53-60 minutes) |  | $145 |
| Family Therapy | 90846/90847 (45 minutes) |  | $100 |
| Group Therapy  Life Coaching  Coaching assessment  Coaching assessment | 90853  Coach (60 minutes)  Co-as  Co-as |  | $45  $125  $75  $100 |

Therapeutic phone calls $100/hour, charged in 15 minute increments with a $15 minimum or other unscheduled contact with the client or on behalf of the client. **Not covered by insurance**

Correspondence $100/hour, charged in 15 minute increments with a $15 minimum including writing letters completing forms etc.

**Not covered by insurance**

Fees for consultation for legal purposes, court appearance and depositions are outlined on the next page.

\_\_\_\_\_ Patient (14 years or older) Initial \_\_\_\_\_ Parent or Guardian Initial

**Court Appearances:** In general, our providers do not provide court appearances. This is not a forensic practice, and therefore court testimony or any form of support in legal proceedings should not be the primary motivation for seeking services. If this is a service you may need at a future point, please discuss immediately with your provider.

All consultation for legal purposes, court appearances (including subpoenas to appear) and depositions must be scheduled at least one month in advance due to the provider’s full schedule. Consultation for legal purposes, court appearances and depositions are charged at a rate of $200 per hour. This hourly rate is charged for the time that the provider is unable to guarantee services to other clients, not just the time providing consultation, providing testimony or being deposed. Travel expenses will not be charged for locations within Lee County, Alabama. Outside Lee County, Alabama, the client will be billed for actual travel expenses in addition to the hourly fee for the provider’s time. A retainer of $1000 plus travel expenses will be required two (2) weeks prior to the meeting/court/deposition date. Any cancellations of such must be done two (2) weeks prior to the scheduled date. Cancellations made within 14 days of the scheduled appearance will require forfeiture of the retainer due to the disruption in the provider’s schedule. In cases where the meeting, appearance, or deposition date is revised within 14 days of the originally scheduled meeting, appearance, or deposition, a new retainer will be required to secure a new date. The expense of any non-refundable travel arrangements resulting in date revision or cancelation, regardless advance notice, will be billed.

**Appointment Reminders:** Email, text and telephone communication to remind you of your scheduled appointment is a courtesy and is NOT guaranteed. It is the client’s responsibility to attend scheduled appointments regardless of having received a courtesy reminder. You will be charged for late or missed appointments even if a reminder is not received.

**Telephone contact:** This clinic is equipped with voicemail, which is frequently checked throughout normal business hours and at least every 24 hours. Every reasonable attempt is made to respond to all messages within the same day, but it may be up to 24 hours before a call is returned. The clinic phone number does not receive text messages.

**Emergencies:** If you are in a “mental health emergency,” in which you are in need of an immediate therapeutic response, please utilize one of the following resources:

* Call 911
* Immediately go to the emergency room of the East Alabama Medical Center, 2000 Pepperell Parkway, Opelika, Alabama (334) 749-3411
* East Alabama Mental Health Crisis Line **1-800-815-0630**
* Rape Counselors of East Alabama **(334) 705-0510**
* National Suicide Prevention Hotline **1-800-273-8255**

Inform the responding clinician of your immediate mental health needs, and follow their responses. Please inform the emergency clinician of your current status as a client enrolled in treatment with this clinic, and sign any consents provided so that this clinic may receive information regarding any emergency assessments and/or treatment recommendations.

**Clinic Closure/Unavailability:** When this clinic is unavailable for more than 48 hours, the clinic will arrange a “covering clinician,” who will be available to respond to your emergency needs, either by telephone or with a face-to-face session. The clinician will be provided with your first name and very basic potential clinical emergency information, so that he/she may appropriately and sensitively assist you during this time. If you have a session scheduled in the time preceding the planned closure/unavailability, this information will be discussed with you prior the closure/unavailability of the clinic. Upon reopening/availability, the “covering clinician” will inform the providers of this clinic of any contacts (telephone or face-to-face session), and will then destroy any materials &/or information obtained. Any fees which may be charged by the covering clinician will also be discussed with you in advance.

\_\_\_\_\_ Patient (14 years or older) Initial \_\_\_\_\_ Parent or Guardian Initial

**Termination of Treatment:** Ending therapy may be initiated by you as the client, or as legal guardian of the client or the provider. In either event, a final session is strongly recommended to explore the ending process itself. This can be a useful conclusion to treatment. Referrals to other providers or other suggestions can be offered at that time.

**Non-voluntary Discharge from Treatment:** A patient may be terminated from treatment non-voluntarily if: (A) the patient exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or (B) the patient refuses to comply with stipulated practice rules, refuses to comply with treatment recommendations, and/or (C) failure to comply with our financial policy and/or (D) failure to comply with no show policies and fees. (E) frequently cancels. Reschedules or missed appointments, and/or (F) is chronically late for scheduled appointments, and/or (G) demonstrates repeated inappropriate use of afterhours/emergency contact/emergency coverage services. The patient will be notified of non-voluntary discharge by letter. Referral to another provider can be made as appropriate. The patient may appeal this decision with the program owner or request services at a later date.

**Referrals to Other Providers:** Providers at this clinic have experience in various areas of practice utilizing specific treatment approaches. In the event the patient presents with, develops, or reveals a problem that is outside the scope of the treating provider, a referral to another provider will be discussed with the patient in session (when possible) and a letter will be provided. The patient has the right to refuse the recommended referral. Doing so does not guarantee that services will continue at this clinic. In accordance with ethical standards of professional practice, providers at the clinic will not work to treat problems for which they lack competency. Additionally, providers at this clinic will not utilize treatment approaches for which they lack competency.

My signature below indicates that I have read and understand the following documents AND that I have received a copy of the following documents:

* Service contract
* Financial Policy
* Notice of patient confidentiality
* Notice of privacy practices
* Filing of complaints against HIPAA-covered entities believed to be non-compliant with HIPAA privacy rule.
* Social media policy

My signature below indicates my consent to have a copy of this authorization to be used in place of the original.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Date Parent/Guardian Date**

# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witness Date**

**Consent to Treat ADULT:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the undersigned, hereby attest that I have voluntarily entered treatment at Soul-Affirming Counseling. Further, I consent to have treatment provided by a psychiatrist, psychologist, social worker, or counselor. The rights, risks, and benefits associated with the treatment have been explained to me in a language I can understand. I understand that the therapy may be discontinued at any time by either party. The clinic encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Date Witness Date**

|  |
| --- |
| **Consent to treat CHILD:**    Child’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    I certify that I am the (circle one): Father Mother Legal Guardian of the above child/adolescent    I certify that I have the legal custody of the above-named child/adolescent.    If there is a legal shared custody arrangement, please identify by name WHO shares custody and explain the legal arrangement. This information allows our providers to understand who is legally involved in the child’s life and who has authority to make decisions regarding care/treatment:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the undersigned, give my authorization and consent for  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (child’s name) to have treatment at Soul-Affirming  Counseling. The rights, risks, and benefits associated with the treatment have been explained to me in a language I can understand. I understand that the therapy may be discontinued at any time by either party. The clinic encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.    **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Patient Date Parent/Guardian Date**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Witness Date** |

Financial Policy

This form must be completed before future sessions can be scheduled.

Charges for all services are due in advance or at the time of service.

Our office will file insurance on your behalf as a courtesy to you. However, insurance policies and requirements vary greatly by policy and it is the client’s responsibility to understand the requirements and benefits of his/her policy. Our office will assist you as much as possible in understanding your insurance policy and meeting its requirements. The client is responsible for obtaining and maintaining referrals from their physician and/or insurance authorizations required by insurance (when applicable). If for some reason insurance does not cover a visit, the client will be responsible for the charges.

Accounts with a balance for any portion of two or more sessions may result in cancelation of pending future appointments and/or suspension of scheduling future appointments until the balance is paid in full. Failure to follow this financial policy may result in discharge from treatment.

Legal Guardians: The parent/guardian bringing a child/adolescent to our office for treatment is responsible for payment at the time services are rendered. He/She will be responsible for making prior payment arrangements with the child’s/adolescent’s other parent or responsible party. This clinic assumes no responsibility for collecting payment from the other parent or responsible party with whom you may have financial arrangements for the child’s/adolescent’s medical care.

Consent to Receive Billing Statements by Email

Billing statement information is considered “Protected Health Information” under HIPAA.

□ By my signature below, I am waiving my right to keep this information completely private, and requesting to receive non-encrypted billings statements to the following email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Date Parent/Guardian Date**

# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witness Date**

□ I decline to receive non-encrypted billing statements by email. I understand this will prevent my ability to pay statements online.

Financial Policy continued

**To facilitate the handling of cancelations with less than 24 hours-notice and/or “no call/no show,” all clients are required to provide a credit/debit card that will be saved on file. In rare cases, the client may not have a credit/debit card, a check or cash in the amount of the missed full session will be expected on the following appointment.**

I understand that Soul-Affirming Counseling is NOT responsible for keeping up with insurance company’s deductible, co-pays and/or the number of visits authorized by my insurance or referring physician. I also understand that my insurance company is NOT responsible for my bill, but that I am. If my insurance company does not pay in a timely manner, I will pay the bill in full.

I, the undersigned, hereby agree to pay all amounts and charges for services rendered by Soul-Affirming Counseling no later than 30 days of the rendering of said services unless other specific arrangements are made. I am aware of the cancelation, no show, and late arrival policy.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Date Parent/Guardian Date**

# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witness Date**

|  |
| --- |
| For office use:  Paid by \_\_\_\_\_\_ Cash in the amount of $\_\_\_\_\_\_\_  \_\_\_\_\_\_ Check in the amount of $\_\_\_\_\_\_\_ check # \_\_\_\_\_  Staff Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Financial Policy continued

In the event your card fails to process, you will be notified by phone, email, and/or mail and provided an opportunity to update your billing information. Balances that remain past 30 days will accrue a service fee of $10 a month every month the balance remains.

Feel comfortable knowing this document is locked and secured at all times. You are welcome to change credit cards at any time by completing and signing a new form.

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Amex \_\_\_\_\_Visa \_\_\_\_\_ MasterCard \_\_\_\_\_ Discover

Name on the Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exp Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Security Code: \_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Soul-Affirming Counseling or representative of Soul-Affirming Counseling to charge my credit/debit card based upon the provisions listed above.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Date Parent/Guardian Date**

# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witness Date**

**Appointment Reminders**

**Online Appointment Scheduling**

You can receive an appointment reminder to your email address **OR** your cell phone (via a text message) **OR** your home phone (via a computer-generated voice message) the day before your scheduled appointments.

You can also enjoy the convenience of online scheduling at any time. Once your account is established, you simply visit **www.therapyappointment.com** and click on ‘Find Your Therapist’ in the upper right-hand corner of the screen to schedule or reschedule your appointments. You may continue to schedule appointments in person or by telephone, but if you have internet access, you are sure to enjoy the convenience of this online system.

This service is provided as a courtesy. A 3rd party is used to handle these reminders, and although the delivery rate is at 99%, there are circumstances where messages will not be successfully delivered (if users are on the phone, out of service, etc.). It is YOUR responsibility to record and keep any appointments that have been made, as we cannot guarantee you will successfully receive a reminder every time.

Your name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Online Scheduling Set Up**

Requested login name: |\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_| (letters or numbers only)

Requested temporary password: |\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_|\_\_| (Letters or numbers only. Must contain one letter and one number. 8-35 characters.)

**Appointment Reminders**

Where would you like to receive appointment reminders? (check ONE)

\_\_\_\_\_ Via a text message on my cell phone (normal text message rates will apply)

Your cell phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Via an email message

Your email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Via an automated telephone message to my home phone

Your home phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ None of the above. I’ll remember my appointments on my own (Missed appointment fees will still apply).

Appointment information is considered “Protected Health Information” under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Date Parent/Guardian Date**

# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Witness Date**