DISCLOSURE STATEMENT AND CONSENT TO TREATMENT
~ Perspectives Therapy Services LLC ~

THERAPIST TRAINING AND CREDENTIALS:

Thank you for choosing *Perspectives Therapy Services* LLC for your emotional, mental, and relationship needs. Your therapist with Perspectives has received an advanced degree in one or more of the following fields: marriage and family therapy, social work, professional counseling, or psychology. S/he is licensed through the state of Michigan. If s/he holds a limited license or it is required by the particular insurance company, s/he will be supervised by a fully licensed clinician in the practice.

Therapeutically our staff is trained to work with individuals, couples, and families. We make up a group practice and are all independent private practitioners, not affiliated with any medical center or hospital. We are not available for emergency services, and advise that in these cases, your local Community Mental Health agency or your nearest medical center/hospital be contacted. We are not physicians and do not prescribe medications or perform medical procedures, however, with written consent, we look forward to collaborating with family physicians or psychiatrists.

THERAPY SPECIFICS:

Therapy sessions last 45-60 minutes beginning on the hour. Sessions are typically held one to two times per week. Initial sessions are dedicated to assessment, which involves gathering information about you, your family and the problem bringing you to therapy. To gain the full benefits of therapy it is strongly encouraged that you fully participate in the sessions through regular attendance and willingness to try alternative perspectives for both the problem and its solutions.

The initial assessment meeting is charged at $200. Subsequent sessions are charged based on time: 45 minute sessions are billed at **$150** and 55 minute sessions are **$175**. Obligation for payment is understood not to be dependent upon the client's receiving third party reimbursement from insurance coverage. While the practice certainly supports and encourages clients to pursue the maximum amount of financial reimbursement from third party payers (such as health insurance agencies), it is ultimately the client's responsibility to insure that s/he receives all third party payments for which s/he may be eligible. Perspectives will submit all insurance billing for health insurance companies that we are networked with. **All co-payments are due at the time of service.** There is a returned check fee of **$20.** It is our practice policy to keep a credit card on file for all clients in the practice. You may still choose to pay for your balances using another form of payment.

Session fees cover the following professional services:

- Therapy for the individual, couple, or family system
- Initial and ongoing assessment
- Treatment planning
- Time spent in consultation with other professionals

Phone contact, other than to schedule appointments, is considered a consultation and billed at $30 per 15 minutes. Report writing is charged at a rate of $150 per hour.

The therapists at PTS do not provide custody evaluations or appear in court. Additionally, evaluations for disability applications are also not completed.

CLIENT RIGHTS AND RESPONSIBILITIES:

Although you may choose to end therapy at any time, you are responsible to attend scheduled sessions. Unless a session is cancelled 24 hours in advance, you will be responsible to remit payment of $75 for a missed session. This is a strict policy with no exceptions. Please remember that if you are using insurance, charges cannot be submitted for missed sessions and you will be held responsible for the $75 charge as specified above. In cases of excessive absences it will be your therapist's discretion to terminate services at PTS and refer your care elsewhere. If a client owes on their account, payment is expected during each visit in order to continue scheduling. If a balance exists whereby no payments have been made in 30 days, PTS will attempt to contact you. If no payments are made as a result of these attempts, PTS contracts with an external collections service that will then pursue settling the amount due.

Information disclosed in session will be kept confidential and not revealed to any other person or agency without your written permission. However, there are exceptional circumstances that require your therapist to share information obtained in a therapy session without your permission. These exceptional situations include: 1) If you threaten serious bodily harm to yourself or another person, your therapist is required by law to inform the intended victim and/or the appropriate law enforcement agency; 2) If your therapist is subpoenaed by a court of law to provide specific information, s/he is obligated to comply; and 3) If you reveal information to your therapist about child abuse and/or neglect, s/he is required by law to report this information to the appropriate authority.

After you have carefully read this information and have received satisfactory answers to any questions that may have surfaced, please sign this contract below. Anyone over age 18 must sign this form in order to be treated through Perspectives Therapy Services. Parents or legal guardians must sign for persons under 18 years old.

I have read and understand the information provided in this document and agree to the procedures and conditions outlined. I understand that I may terminate therapy at any time and will be financially responsible for those sessions already completed.

Patient name (please print):_____

Patient signature: _____ Date: _____
(Parent signature for minor client)

Therapist Signature: _____ Date: _____

At times there are persons who join the therapy process who are not identified as the "patient", however are important to treatment. By signing below you acknowledge this is a health care setting. The protections in place through our practice's HIPAA policies protect you to the same degree as the primary patient. If a minor is joining the therapy process, the parent or legal guardian must consent to this participation by signing below.

Signature: _____ Date: _____

Signature: _____ Date: _____

____ Initial here to acknowledge that you have read the Notice of Privacy Practices and that a copy of the Notice has been provided to you upon your request.

Insurance Consent

By signing below I give permission Perspectives Therapy Services to release all required information to my insurance company to attain payment for services rendered. I understand that if my insurance company does not cover these services, I am responsible for the balance.

_____ _____
Signature of insured Date

Addendum to Consent to Treatment: Cell Phone Consent

As a contractual therapist at Perspectives Therapy Services I offer you, the client and/or guardian of the client, the privilege and ability of contacting me via cell phone. This communication includes both phone calls as well as text messaging. Know that this information is indeed a privilege that can be revoked if the therapist deems the client to be abusing the privilege. This definition of abuse is left to the discretion of the therapist and may include, but is not limited to: excessive calls and texts despite the therapist addressing the concern or attempting to contact the therapist after normal business hours.

Please know that because you call or text does not mean you will get a reply immediately or at all. Some concerns brought up in a text message are better addressed in the therapy session. Please note that the intention of receiving this therapists' phone number is primarily for scheduling purposes and to increase efficiency of communication.

Providing this number in no way indicates 24 hour access to my services, nor should it be considered an emergency resource. If you are in crisis, you are still instructed to contact your local Community Mental Health agency (listed below), call 911 or go to your local Emergency Room.

Livingston County: (517) 548-0081 Ingham County: (517) 346-8200
Oakland County: (800) 231-1127 Genesee County: (810) 257-3740

Please respect normal business hours when calling or texting.

HIPAA Privacy Disclosure:
Please be advised that communication via cell phone is not secure. While all efforts will be made to maintain your privacy, the confidentiality of cell phone calls or texts cannot be guaranteed.

By signing below I understand and accept the conditions above. Your care at Perspectives Therapy Services will not change should you decline to sign this section of the form. It is completely optional.

_____ _____
Client Signature (or Parent/Legal Guardian Signature if client is a minor) Date

Perspectives Therapy Services, LLC

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA") and regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, therapist or staff review activities, licensing, and conducting or arranging for other business activities. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of the categories of uses and disclosures permitted by HIPAA **without an authorization**. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to received reports of child or elder abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent (verbal OR written permission) or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena, court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from the U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State of medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or less the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constituted a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Office at our central business office at 120 Flint Road, Brighton, MI 48116.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you, if the information is contained in separately maintained psychotherapy notes or if your treatment involved more than one person in the therapeutic environment and a signed release is not obtained by the other party or parties. Our office will charge a reasonable, cost-based fee for copies. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you believe that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care items or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Office, Dr. Tianna Hoppe-Rooney or with the Secretary of the Health and Human Services Department at 200 Independence Avenue S.W., Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is August 1, 2015

REGISTRATION AND INTAKE FORM

CLIENT CONTACT INFORMATION

_____ _____ _____
Last Name First Name Social Security #

Address_____ City_____ State_____ Zip_____

Please check below if a message can be left at the following numbers

_____ Home phone: (_____)_____ _____ Work phone: (_____)_____

_____ Cell phone: (_____)_____ Cell phone carrier: _____

Email address:_____

APPOINTMENT REMINDERS

Appointment information is considered to be "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 requested below. Missed appointment fees will still apply if the reminder message is not received.

Where would you like to receive an appointment reminder? (check one)

___ Via text message on my cell phone (normal text message rates will apply according to your contract)
___ Via email message to the address listed above
___ Via automated telephone message to my home phone
___ None of the above. I'll remember my appointments on my own

Signature:_____ Date:_____

CLIENT PROFILE INFORMATION

Date of Birth_____ Male____ Female____ Marital Status: Single___ Married____ Other____

Household Member Name	Date of birth	Relationship to you

Emergency Contact:_____
Name Phone number Relationship

BILLING INFORMATION

Responsible Party Name (who pays the bill):_____ SSN:_____

Responsible Party Address: _____
Street City State Zip Code

Primary Insurance Company Name:_____

Subscriber/Member ID #:_____ Group #:_____

Patient relation to insured: Self_____ Spouse_____ Child_____ Other_____

Subscriber name:_____ Subscriber birthdate:_____

Secondary Insurance Company Name:_____

Subscriber/Member ID #:_____ Group #:_____

Patient relation to insured: Self_____ Spouse_____ Child_____ Other_____

Subscriber name:_____ Subscriber birthdate:_____

REFERRAL INFORMATION

How did you find out about Perspectives Therapy Services? Check appropriate box

□ Friend(s)/Neighbors □ Family Member □ Physician/Family Doctor □ Web Search/Internet
□ Social Service Agency □ Court System □ School System □ Yellow Pages
□ Other (please specify)_____

May we send a general thank-you to this referring source? □ Yes □ No
If yes, where should this be sent? _____

PREVIOUS THERAPY EXPERIENCE

Have you received mental health services (counseling/therapy) in the past? _____Yes _____No
If yes,……..When?_____Where or with whom?_____
For what reason?_____

What was *most* helpful about this therapy experience?_____
_____

What was *least* helpful about this previous therapy experience?_____
_____

MEDICAL BACKGROUND

Primary Care Physician_____ Phone Number_____

Address_____ City_____ State_____ Zip_____

Please list any medications you are taking at this time.

Medication	Dosage/Frequency	Reason for taking
Medication	Dosage/Frequency	Reason for taking
Medication	Dosage/Frequency	Reason for taking

Have you ever been hospitalized for reasons relevant to your attending therapy? □ Yes □ No
If yes, please describe_____

PROBLEM SPECIFICATION

Briefly describe what brings you to therapy at this time_____
_____

What would you like to see happen as a result of therapy? _____
_____

Office Use Only

Therapist initials:_____ Location: B L Hi F Diagnosis:_____ Supervisor:_____
USERNAME: PASSWORD:

Thank you for providing the information requested on this form. This is considered confidential information and will not be shared with anyone other than your therapist unless permission is granted through written consent.

PERSPECTIVES THERAPY SERVICES LLC

Child History and Symptom Questionnaire

Basic Background Information

Child's name:_____ Birthdate:_____ Present age:_____ ☐ Male ☐ Female

Name of person completing form:_____ Today's Date:_____

Relationship to Child: ☐ Biological or Adoptive Parent ☐ Guardian ☐ Other (Specify) _____

Biological Parent Information

Relationship status: ☐ Married ☐ Divorced ☐ Never married ☐ Separated ☐ Widowed

Child's age at time of divorce:_____ Child's age at time of parent death:_____

Living environment: ☐ Same home ☐ Different homes

Legal custody arrangement:_____

Physical custody arrangement:_____

☐ Child resides with neither parent Please explain:_____

Quality of biological parents' relationship: (check all that apply)

☐ Effective co-parenting team ☐ Usually on the same page ☐ Different parenting styles ☐ Poor communication
☐ Similar goals for parenting ☐ High degree of mutual respect ☐ Low levels of respect noted ☐ No contact

Parent A employment: ☐ Employed – FT or PT ☐ Unemployed ☐ Social Security ☐ Not seeking employment
☐ Enrolled in School ☐ Retired ☐ Self-employed ☐ Stay at home parent

Parent B employment: ☐ Employed – FT or PT ☐ Unemployed ☐ Social Security ☐ Not seeking employment
☐ Enrolled in School ☐ Retired ☐ Self-employed ☐ Stay at home parent

Was your pregnancy with this child: planned or unplanned (circle one)

School History

Current grade of your child:_____ Current school your child attends:_____

Has your child not passed a grade or been held back? ☐ Yes ☐ No

If yes, what grade(s) and why?_____

Does your child experience problems in the following areas? (check all that apply)

☐ Reading ☐ Math ☐ Spelling ☐ Emotional regulation ☐ Paying attention
☐ Attendance ☐ Obeying rules ☐ Making friends ☐ Following directions ☐ Fighting ☐ Teacher relationships

Is your child utilizing or being considered for special resources/services? ☐ Yes ☐ No

Has your child been tested for learning problems? ☐ Yes ☐ No If yes, when tested?_____ By who?_____

Does your child currently work with a school counselor or social worker? ☐ Yes ☐ No If yes, who?_____

Please describe any concerns or problems you have about your child's school performance:_____

_____

Please describe any concerns that your child's teachers have about your child: _____

_____

Strengths

☐ bright ☐ loving ☐ motivated ☐ good leader ☐ optimistic ☐ sense of humor ☐ open-minded

☐ creative ☐ has friends ☐ can calm self ☐ resourceful ☐ responsible ☐ adaptable ☐ compassionate/kind

☐ can ask for help ☐ establishes boundaries ☐ active ☐ good solve problems ☐ grateful ☐ patient ☐ willing to try new things

☐ able to forgive ☐ can express feelings ☐ persistent ☐ brave/courageous ☐ hopeful ☐ good listener ☐ able to say "no"

Current Concerns

☐ Difficulty maintaining attention or easily distracted	☐ Sensitive to noises, fabrics, lights, temperatures, etc.	☐ Difficulty organizing tasks
☐ Seems not to listen when spoken to directly	☐ Often loses things	☐ Forgetful
☐ Fidgets with hands or squirms in seat	☐ Verbally or physically aggressive	☐ Often loses temper
☐ Bullies, threatens or intimidates others	☐ Has been cruel to animals or people	☐ Starts fights
☐ Has engaged in fire-setting	☐ Difficulty maintaining friendships	☐ Often lies
☐ Defies adult requests or rules	☐ Has stolen items from others or stores	☐ Deliberately annoys people
☐ Deliberately destroys property	☐ Actively defies rules or refuses to comply	☐ Issues w/ school attendance
☐ Often argues with adults and others in authority	☐ Blames others for his/her mistakes or misbehavior	☐ Seems easily annoyed
☐ Seems angry or resentful	☐ Specific, repetitive behaviors	☐ Excessive worry
☐ Worries something bad will happen to parent(s)	☐ Issues with impulsivity	☐ Sleep difficulties
☐ Toileting problems (including bed wetting)	☐ Issues separating from a loved one	☐ Refuses to go to school
☐ Anxiety in social situations	☐ Difficulty when routine is disrupted/issues transitioning	☐ Repeated nightmares
☐ Issues with low self-esteem	☐ Engages in self-harm behaviors	☐ Irritable
☐ Persistent feelings of sadness	☐ Withdrawal from previously enjoyed activities	☐ Cries often
☐ Has been bullied by peer(s)	☐ Feelings of hopelessness	☐ Suicidal thoughts
☐ Loss, grief or separation from loved one	☐ Suicidal attempt	☐ Perfectionistic tendencies
☐ Seems to engage in attention-seeking behaviors	☐ People pleasing behaviors	☐ Poor body image
☐ Unhealthy eating habits	☐ Desires to change weight	☐ Low energy/fatigue
☐ Experimentation with substance(s)	☐ Excessive use of electronics	☐ Sexual abuse/molestation
☐ Recent break-up with girlfriend or boyfriend	☐ Sexual orientation questions	☐ Gender identity questions
☐ Strained parent-child relationship	☐ Homocidal thoughts	☐ Intrusive thoughts

Has your child witnessed any traumatic event(s)? ☐ Yes ☐ No If yes, please explain:_____

_____

Has your child experienced any significant loss(es)? If yes, please explain:_____

_____

Is your child currently having suicidal thoughts? ☐ Yes ☐ No

Has your child had suicidal thoughts in the past? ☐ Yes ☐ No If yes, when?_____

Has your child ever been hospitalized for mental health related concerns? ☐ Yes ☐ No If yes, when and where?_____

_____

How would you describe the quality of the parent-child relationships?_____

_____

Please identify biological family members and their relationship to your child who have a history of mental health/substance abuse problems, or suicidal thoughts/attempts:

_____	_____
Family member/relationship to child	Psychiatric concern/diagnosis
_____	_____
Family member/relationship to child	Psychiatric concern/diagnosis
_____	_____
Family member/relationship to child	Psychiatric concern/diagnosis

~ Perspectives Therapy Services, LLC ~

Medical Provider Coordination of Care

(Authorization to Disclose Protected Health Information)

Client name: _____ DOB: _____

In order to provide you with the highest quality care, we ask your permission to communicate with your primary care physician (PCP) or psychiatrist. This is also a requirement of most health insurance companies and therefore part of our compliancy contract with these payors.

Please read & check the appropriate box. If you do want information to go to your medical provider, then check the "**YES"** box and sign below. If you do not want information to go to your medical provider, then check the **"NO**" box and sign below.

☐ **Yes** ☐ **No** I do hereby authorize/give my permission to exchange information with my medical provider listed below regarding my mental health treatment and medical healthcare for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health or substance abuse care and/or treatment such as diagnosis, estimated length of treatment, type of treatment to be provided and the treatment plan. I also understand that my therapist will provide my medical provider with periodic status reports of my progress during the course of treatment.

I further understand that the authorization shall remain in effect for one (1) year from the date of my signature or for the course of treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to my therapist at Perspectives Therapy Services. I also understand that my responsibility to notify my therapist if I choose to change my medical provider.

Medical Provider name: _____ Phone number:_____

Practice name:_____ Fax number:_____

Practice address:_____

_____

Psychiatrist name: _____ Phone number:_____

Practice name:_____ Fax number:_____

Practice address:_____

Client/Guardian Signature _____ Date: _____

Witness:_____ Date: _____

Credit Card Authorization

Perspectives Therapy Services LLC uses an integrated electronic medical record-keeping system for client charts and billing. This form serves as an authorization to input your credit card information into our secure system and charge it when a balance on your account exists.

The following are examples of charges that we would run on your credit card: co-payments, deductibles, document preparation/report-writing fees, costs for attendance at collaboration meetings, late cancel and no-show fees and returned check fees.

Should you choose not to pay for charges with a credit card, you may also pay using cash or check.

Type of Card (check one): ☐ MASTERCARD ☐ VISA ☐ AMERICAN EXPRESS

Type of Card (circle one): CREDIT or DEBIT

Name of Cardholder:_____

Card No._____

Expiration date:_____ Billing Zip Code:_____ CVV2 (security code):_____

Authorizing signature:_____ Date:_____

Client name (printed):_____

Therapist's name:_____