Patient Name ______________________ ID# ______________

Welcome to **Solutions!**

CONFIDENTIALITY: All counseling services are considered confidential. This confidentiality extends to the clinical supervision of your treatment. Information cannot be released to anyone outside this practice without your written permission, except as mandated by law (such as child abuse), or to prevent a clear and present danger to yourself and/or another. If more than one member of the family is receiving counseling services, each family member must agree to sign such permission. The signature of a parent or guardian is required for children who are under the age of eighteen (18). The signatures of both the patient and parent/guardian are required if the patient is 14-17 years of age. I understand that information relating to my treatment at Solutions, i.e. psychotherapy notes, may be communicated to my primary care physician, my insurance/behavioral health company, EAP and my referral source. If I received behavioral health care in the past I will contact that treatment provider and have that information forwarded to Solutions Counseling. I am aware that Health Insurance Portability and Accountability Act (HIPAA) information regarding the privacy of my health information has been made available to me.

APPOINTMENTS/CANCELLATIONS: An extended period of professional time has been set-aside for you. It is very important that you arrive at your specified time so that we can utilize as much of your scheduled time as possible. Therapy sessions are generally 45 minutes long. **Cancellations with less than 24 hours notice or missed appointments are your responsibility and cannot be billed to your insurance company. You will be billed a late cancellation fee of $50.00 for an appointment canceled if less than 24 hours notice is given. Appointments with the psychiatrist are for medication management only. The psychiatrist's time is *very limited*; if two or more appointments are missed no further appointments will be scheduled.**

ANSWERING SERVICE: Our business office hours are Monday through Friday 9:00 AM to 5:00 PM. If our office is closed and a personal emergency or crisis arises, we have an answering service available that will immediately respond to your call.

PAYMENT AND INSURANCE: Payment is expected at the time of each visit to avoid a $5.00 billing fee. We ask that you contact your insurance carrier to determine what coverage you have, specifying "outpatient psychotherapy". We will submit billing to your insurance carrier, but you are ultimately responsible for payment should your insurance company deny any claim. Your signature authorizes your insurance carrier to pay your practitioner directly. If you provide a check as payment for services, you authorize us to collect a state allowable fee through electronic fund transfer from your account if your check is returned unpaid. Records requests, report preparation, completion of disability forms and court related costs are not covered benefits; therefore, you will be responsible for any fees incurred for these services. **Nonpayment of a balance on an account may result in the use of a collection agency or possible legal action. Any accompanying fees will also be your responsibility.**

If my child is from a separated/divorced family where legal custody is shared, I agree to inform the other parent about this treatment. I understand that my signature gives permission for treatment.

______________________________ ______________
Patient signature (14 and older) Date

______________________________ ______________
Parent/guardian signature (if under 18) Date

Please complete the following as a PAYMENT OPTION: ***(OPTIONAL)***
I authorize Solutions Counseling & Consultation Services to keep my signature on file and to charge my VISA/MASTERCARD account for any unpaid charges.

______________________________ ______________
Patient/guardian Signature Date

VISA MASTERCARD______________________________ ______________
(Circle one) Card Account Number Expiration Date

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