Credit/Debit Card Payment Authorization

Name\*

DOB\*

\_\_\_\_ I understand that payment is due at the time of service, including treatment expenses that are not covered by insurance, such as missed appointments, late cancelations, deductibles, and co-payments. I will have the option with paying with check, cash, or credit card at the time of service.

\_\_\_\_ I recognize that for all credit or debit card transactions, Accepted Therapy Services charges a $2.00 transaction convenience fee. This fee will be applied to each credit card transactions that occurs after April 4, 2022.

\_\_\_\_ If I do not cancel at least 24 hours before my appointment or I do not show up to my appointment, I recognize that Accepted Therapy Services will charge my card a late cancel or no-show fee of $75. If there are unforeseen circumstance, I will contact my therapist and inform them and I recognize that the late fee will be at their discretion in the event of these circumstances.

Name on Card\*

Card Type

* American Express
* Discover
* Mastercard
* Visa

Last 4 of Card Number\*

CCV\*

Expiration Date\*

Billing Zip Code\*

Email Address for Receipt

I [text box] verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing and initialing I recognize that if my payment is not received Accepted Therapy Services reserves the right to use an attorney or collection agency to secure payment.

Signature

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Non-Secure Release

**Consent for Release of Protected Health Information by Non-Secure Means**

Name

DOB

I [text box] authorize Accepted Therapy Services to transmit to me by non-secure media the following types of protected health information related to my health records and health care treatment:

* Information related to the scheduling of meetings or other appointments
* Information related to billing and payment

I understand that if I contact my therapist through non-secure means (text messages, email, or other phone apps) my therapist reserves the right to not respond to protect my confidentiality.

**Termination of Consent**

I understand that this authorization will expire 60 days from the termination of my therapy services.

I can also revoke this authorization in writing at any time by sending written notification to my therapist at 423 Weathersby Road Suite 240 or by email to acceptedtherapy@gmail.com. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive you written request to revoke authorization.

Signature

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Sliding Scale Fee Application

Name\*

DOB\*

Sliding scale rate is based on family size and annual income. This form will be help me to figure out which level of the sliding scale you qualify for. This application will be reevaluated every six months or in the event of financial change in the household. The sliding scale rate is not applicable to anyone with insurance coverage that is in network with Accepted Therapy Services.

# Household Members

Please list all dependent members of your household and their date of birth. If you have a dependent who is over the age of 18, additional information may be requested.

|  |  |  |
| --- | --- | --- |
| **Name** | **Relationship to you** | **Date of Birth** |
|  | Self |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

# Household Expenses

This is a list of all of your monthly household expenses. I will take these expenses into consideration when determining your sliding scale fee rate.

|  |  |
| --- | --- |
| Rent/Mortgage | $ |
| Electricity | $ |
| Water/Sewer/Gas | $ |
| Car Payment(s) | $ |
| Phone | $ |
| Insurances (car, home, renter) | $ |
| Other (Explain) | $ |

# Household Income

Total all sources of income for each box and place the total amount in the second column. Then denote whether the income is received monthly or annually.

|  |  |  |
| --- | --- | --- |
| **Source of Income** | **Amount** | **Frequency** |
| Wages, salaries, or tips | $ | Monthly  Annually |
| Unemployment  Worker’s comp.  Social Security Disability  Public assistance  Survivor benefits Pension or retirement | $ | Monthly  Annually |
| Child Support  Rent  Royalties  Alimony | $ | Monthly  Annually |
| Any other income sources | $ | Monthly  Annually |

(Please be available to provide supporting documentation of your income upon request.)

I [text box] understand that I am being considered for a sliding scale fee at Accepted Therapy Services. I also understand that I may not meet criteria for a sliding scale. I further understand that that if my financial situation changes, I am expected to notify Accepted Therapy Services prior to my next session so that my sliding scale rate can be reassessed for need.

Signature

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Release of Information

This form is to be completed in the event that you wish to include other angecies or people previous therapists, medical providers, testing results, parent providing payment, or anyone else you would like for Accepted Therapy Sercies to have access to.

I [Text box] whose date of birth is [text box] authorize Accepted Therapy Services to disclose and/or obtain information from [text box]

The following information (initial each item to be disclosed)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Assessment |  | Presence/Participation in Treatment |
|  | Diagnosis |  | Progress in treatment |
|  | Psychosocial Evaluation |  | Demographic information |
|  | Treatment Plan |  | Recommendations |
|  | Current Treatment Updates |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

*\* Psychotherapy notes will not be released without discussion and approval from individual therapist.*

This information may be used or disclosed in connection with mental health treatment or payment. If the purpose is other than as specified above, please specify [text box]

## Termination

Unless sooner revoked, this authorization expires 60 days from the termination of my therapy services I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification my therapist at 423 Weathersby Road Suite 240 or by email to acceptedtherapy@gmail.com. I further understand that revocation will not apply to actions taken by the requesting person/entity prior to the date they receive you written request to revoke authorization.

## Conditions

I further understand that Accepted Therapy Services will not condition my treatment on whether I give authorization for the requested disclosure.

Signature

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Telehealth Treatment Consent

**Information and Informed Consent for Telehealth Treatment**

Telehealth is live two-way audio and/or video electronic communications that allows therapists and clients to meet outside of a physical office setting.

# Client Understanding

\_\_\_\_ I understand that telehealth services are completely voluntary and that I can withdraw this consent at any time.

\_\_\_\_ I understand that none of the telehealth sessions will be recorded or photographed.

\_\_\_\_ I agree not to make or allow audio or video recordings of any portion of the sessions.

\_\_\_\_ I understand that the laws that protect privacy and the confidentiality of client information also apply to telehealth, and that no information obtained in the use of telehealth that identifies me will be disclosed to other entities without my consent.

\_\_\_\_ I understand that telehealth is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet-based communication is not 100 % guaranteed to be secure.

\_\_\_\_ I agree that my therapist and Accepted Therapy Services will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

\_\_\_\_ I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

\_\_\_\_ I understand that I or my therapist may discontinue the telehealth sessions at any time if it is felt that the video technology is not adequate for the situation.

\_\_\_\_ I understand that if there is an emergency during a telehealth session, then my therapist may call emergency services and/or my emergency contact.

\_\_\_\_ I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to telehealth services.

\_\_\_\_ I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for recontact. My therapist may choose to use a different means of technology (Zoom, FaceTime, Google Meets) for completion of my session; however, these other means may not be HIPPA compliant.

\_\_\_\_ I understand my therapist will advise me about what telehealth platform to use and she will establish a video conference session. I also recognize that if I am more than 10 minutes late to a telehealth session, I will be charged the standard no-show fee.

\_\_\_\_ I understand a “no show” or late fee will be charged if I miss an appointment or do not cancel within 24 hours of scheduled appointment. I understand credit card or other form of payment will be established before the first session and that insurance is not responsible for any late or no-show fees accrued.

Client Consent

I [Text box] hereby give my informed consent for the use of telehealth in my care.

Signature