

Charis Institute for Psychological and Family Services
21 South Gate court, Suite 101
Harrisonburg, VA 22801
Phone: 540-568-1876

Children's Intake Form

Where did you hear about our services or who referred you _____

General Information

Name _____ Date of Birth _____ / _____ / _____ Social Security Number _____
Mailing Address _____ City, State _____ Zip _____ School/Grade _____

Person Responsible for Account

Name _____ Social Security Number _____ () _____ Home Phone _____
Mailing Address _____ City, State _____ Zip _____ () _____ Cell Phone _____

For your comfort and assurance of confidentiality we ask that you please read over the following and check your preferences.

- I give permission for Charis to call my home and leave a message on the answering machine or with anyone who answers the phone.
- I give permission for Charis to call my work number if I need to be reached.

Signature _____ Date _____

Father

Name _____ Date of Birth _____ / _____ / _____ Social Security Number _____
Mailing Address _____ City, State _____ Zip _____ () _____ Home Phone _____
() _____ Cell Phone _____ Employer _____ () _____ Work Phone _____

Marital Status: Single Married Divorced Separated

Mother

Name _____ Date of Birth _____ / _____ / _____ Social Security Number _____
Mailing Address _____ City, State _____ Zip _____ () _____ Home Phone _____
() _____ Cell Phone _____ Employer _____ () _____ Work Phone _____

Marital Status: Single Married Divorced Separated

Person(s) Caring for Child other than Biological Parents

Name _____ () _____ Home Phone _____ () _____ Cell Phone _____
Mailing Address _____ City, State _____ Zip _____ () _____ Work Phone _____

If the child has any brothers or sisters please list, including ages. _____

Religious Background _____ Church Involvement: Active ___ Moderate ___ Inactive ___

Church Name _____

Counseling Experience Has child had previous counseling experience? Yes No

Name of Previous Counselor

Please list family history of substance abuse or mental health problems: _____

Insurance Information

Insurance Company

Cardholder DOB

Insurance Address

Address City, State

Zip Policy Number/Member ID Group Number

Medical Questionnaire

Date of Last Physical Examination

List any medical problems the child now has or has had in the past and describe them. (Also note accidents, hospitalizations, broken bones, periods of unconsciousness) _____

List all medications the child is now taking, how often, and the amount the child is taking. _____

Method of Payment: Please check the method of payment that you will be using.

Cash _____ Charge _____ Payment Plan _____ Insurance/Co-Pay or Deductible _____

We are more than happy to cooperate with individuals who are covered by insurance. We only ask that you read your policy to be sure that you are fully aware of any limitations of the benefits provided. Insurance is a contract between the patient and the insurance company for benefits. You should be aware that different insurance companies vary greatly in the types of coverage available. Be sure to check if your insurance requires you to pay a deductible before they pick up and pay a percentage of your remaining bill.

Some insurance requires prior authorization for treatment. Make sure that you find out if your insurance requires this. Most insurance companies will not go back and pick up charges if this authorization is not given prior to treatment. When prior authorization is required the insurance companies also require periodic treatment or service plans to be sent in. *If your insurance company requires these treatment plans, then you as the patient, are responsible for keeping up with them.* The insurance company will deny claims if the treatment plans are not sent in on or before the day services are rendered. Since we have no control in the selection of your insurance company (nor do we feel we should), we have no control over what they will pay or when they will pay for the services provided. Therefore, we ask that you **look upon your insurance realistically as a device which helps you pay for your care here at Charis Institute. Please understand that assisting you with your insurance claim is done willingly but that regardless of the insurance coverage, the obligation for the fee for the services rendered is yours.** All fees will be due on the day of treatment even if you have insurance unless arrangements are made in advance with our office.

Insurance companies typically limit their coverage to services that they consider medically necessary. ***In the event that you receive services and your insurance determines it did not meet their criteria, you understand that you are responsible for payment for these services.*** If you have a question about this you need to consult with your insurance company and the therapist before receiving the services.

I hereby authorize treatment. I authorize Charis Institute to furnish insurance carriers with any medical information necessary to process this claim. I hereby assign to Charis Institute all payments for services rendered to my dependents or myself. *I understand that I am responsible for payment of any amount not covered by insurance and that billing the insurance company is a courtesy to me and not an obligation of Charis Institute.* I acknowledge that insurance claims pending beyond 60 days are my responsibility and I agree that I will not delay payment and that I will pay the balance if a claim is pending more than 60 days. I understand that if I make a payment and payment is received later by Charis from my insurance company, I will be reimbursed. I understand that if my account is referred to a collection agency or an attorney for collection, I agree to pay all costs of collection, including but not limited to, 35 percent, whether or not suit is filed. If a check is returned to Charis Institute, I understand that I will be responsible of paying the fee that bank charges them.

I have read and understand the Privacy Policy that is posted in the office

Signature/Guarantor

Date

Adverse Childhood Experience (ACE) Questionnaire

(Ages 0-8yrs form to be completed by parents)

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household often ...

Swear at you, insult you, put you down, or humiliate you?

or

Act in a way that made you afraid that you might be physically hurt?

Yes No

If yes enter 1 _____

2. Did a parent or other adult in the household often ...

Push, grab, slap, or throw something at you?

or

Ever hit you so hard that you had marks or were injured?

Yes No

If yes enter 1 _____

3. Did an adult or person at least 5 years older than you ever...

Touch or fondle you or have you touch their body in a sexual way?

or

Try to or actually have oral, anal, or vaginal sex with you?

Yes No

If yes enter 1 _____

4. Did you often feel that ...

No one in your family loved you or thought you were important or special?

or

Your family didn't look out for each other, feel close to each other, or support each other?

Yes No

If yes enter 1 _____

5. Did you often feel that ...

You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

or

Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Yes No

If yes enter 1 _____

6. Were your parents ever separated or divorced?

Yes No

If yes enter 1 _____

7. Was your mother or stepmother:

Often pushed, grabbed, slapped, or had something thrown at her?

or

Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

or

Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

Yes No

If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

Yes No

If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?

Yes No

If yes enter 1 _____

10. Did a household member go to prison?

Yes No

If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

Child Social History

(Child's Name) _____

(Date) _____/_____/_____

- 1) **What would you consider to be your child's major stressors?** ☐ Break-Up with Girl/Boy Friend
☐ Eating Disorder ☐ Conflict Between Parents or With Parents ☐ Housing ☐ Physical Abuse ☐ Legal
☐ Conflict With Siblings ☐ Violence in Home ☐ Neglect ☐ Death/Loss/Serious Illness of ☐ Loved One
☐ Financial Concern ☐ Sexual Abuse ☐ Parent's Separation/Divorce ☐ School ☐
☐ Work Health/Physical ☐ Religious/Spiritual ☐ No Current Stressors
- 2) **Which of the following problems do you feel the child needs help with?** ☐ Feeling Sad or Down
☐ Issues Related to Past Abuse ☐ Very Nervous or Tense Relationship Problems ☐ Problems with
Sleep ☐ Very Fast Thoughts ☐ Unexplained, Frequent Mood Changes ☐ Intense Anger/Aggressive
☐ Problems with Appetite ☐ Discipline ☐ Sexual Problems ☐ Thoughts of Harming Self or Others
☐ Abusing Others ☐ Difficulty with Memory, Concentration, or Decision Making ☐ Problems at
School ☐ Work Conflicts ☐ Reoccurring thoughts of Death ☐ Loss, Death, Divorce, Separation ☐
☐ Eating Disorder/Body Image ☐ Drug/Alcohol ☐ Compulsive Behaviors ☐ Religious
/Spiritual ☐ Hearing Voices or ☐ Seeing Strange Visions ☐ Other _____
- 3) **Who has custody of the child?** ☐ Both Parents ☐ Mother ☐ Father ☐ Relative ☐ DSS ☐ Other _____
- 4) Are natural parents married? ☐ Yes ☐ No
- 5) Have there been previous marriages? ☐ Yes ☐ No **If "yes," how many?** Mother _____ Father _____
- 6) If the child does not live with both natural parents does child see the parent that he/she does not live
with? ☐ Yes ☐ No ☐ Little Contact ☐ N/A
- 7) If parents are divorced or separated, what are the visitation arrangements? ☐ Regularly Scheduled Visits
☐ Visit with Other Parent When Child/Parent Desires ☐ Inconsistent Visitation ☐ No Visits or contact
- 8) Who lives in the child's household? ☐ Both Parents ☐ Father ☐ Mother ☐ Stepfather ☐ Stepmother
☐ Foster Parents ☐ Foster Children ☐ Brothers/Sisters ☐ Stepbrothers/Sisters ☐ Half
Brothers/Sisters ☐ Friend (s) ☐ Relative (s) ☐ Another Family ☐ Pets ☐ Other _____
- 9) How many brothers or sisters does the child have, including step/half siblings? _____
- 10) How important are religious/spiritual practices to you? ☐ Important ☐ Very important ☐ Unimportant
☐ Neutral
- 11) What is father's education? _____ What is mother's education? _____
- 12) Has either parent had serious medical problems in the past six months? ☐ Yes ☐ No
- 13) Has either parent had a history of mental health treatment? ☐ Yes ☐ No
- 14) Has either parent been hospitalized for mental health problems? ☐ Yes ☐ No
- 15) Is either parent taking medication for mental health reasons? ☐ Yes ☐ No
- 16) Does either parent have current legal charges pending? ☐ Yes ☐ No
- 17) Were there problems with pregnancy? ☐ Yes ☐ No ☐ Do Not Know
- 18) Was the child delivered full term? ☐ Yes ☐ No ☐ Do Not Know
- 19) Were there any immediate difficulties with the infant? ☐ Yes ☐ No
- 20) Were there feeding problems? ☐ Yes ☐ No
- 21) Was he/she more or less active compared to other children? _____
- 22) Was he/she well coordinated? ☐ Yes ☐ No
- 23) Were there any problems with speech development? ☐ Yes ☐ No
- 24) Does the child wear glasses? ☐ Yes ☐ No
- 25) Has the child received all of his/her current shots? ☐ Yes ☐ No
- 26) Is the Child receiving special education services? ☐ Yes ☐ No
- 27) Has the child been physically or sexually abused? ☐ Yes ☐ No

- 28) Have parents or other family members been investigated for allegations of physical or sexual abuse? ☐ Yes ☐ No
- 29) Has Child Protective Services been involved with the child's family? ☐ Yes ☐ No
- 30) Has the child ever been accused of abusing another child? ☐ Yes ☐ No
- 31) Has the child ever been placed outside the home? ☐ Yes ☐ No
- 32) Has the child seen hitting or hear threats to hit within the home? ☐ Yes ☐ No
- 33) Have there been separations of parents? ☐ Yes ☐ No
- 34) Has the child seen much conflict/fighting between parents and/or other household members? ☐ Yes ☐ No
- 35) Has the child had other traumatic experiences? ☐ Yes ☐ No
- 36) Has the child been held back from any previous grades? ☐ Yes ☐ No
- 37) What kind of grades does the child make? _____
- 38) Was there any difficulty getting the child to go to school when he/she first started? ☐ Yes ☐ No
- 39) Is there now a problem getting the child to go to school or stay at school? ☐ Yes ☐ No
- 40) Where does the child go after school? ☐ Home ☐ Babysitter ☐ Daycare ☐ Relatives ☐ Work ☐ Not Supervised
- 41) Is he/she involved in any after school activities? ☐ Yes ☐ No
- 42) Does the child participate in team sports? ☐ Yes ☐ No
- 43) Does the child have interests outside of school? ☐ Yes ☐ No
- 44) Does the child like his/her teacher? ☐ Yes ☐ No
- 45) Has there been a history of conduct or behavior problems at school? ☐ Yes ☐ No
- 46) Has the child ever been suspended? ☐ Many times ☐ Few Times ☐ Once ☐ Never
- 47) Does the child have a best friend? ☐ Yes ☐ No
- 48) Is the child a leader with other children? ☐ Yes ☐ No ☐ At Times
- 49) Is the child a follower with other children? ☐ Yes ☐ No ☐ At Times
- 50) Who does the child prefer to spend time or play with? ☐ Children of the Same Age ☐ Younger Children ☐ Older Children ☐ Adults ☐ Parents/Guardians ☐ Prefers to Be Alone
- 51) Have there been any changes in the child's relationships with friends? ☐ Yes ☐ No
- 52) Does the child have a lot of difficulty with one or more brothers and sisters? ☐ Yes ☐ No
- 53) Have brothers or sisters been treated for similar emotional or behavior problems? ☐ Yes ☐ No
- 54) Are there indications of similar problems with any brother or sister? ☐ Yes ☐ No
- 55) Are there any children living outside of the family? ☐ Yes ☐ No
- 56) **The Following Questions Are to Be Answered About the Child's Mother**
- Number of brothers and sisters... _____
- Did mother grow up with both parents present? ☐ Yes ☐ No
- How were mother's economic conditions growing up? ☐ Below Average ☐ Above Average ☐ average
- What was mother's religious affiliation growing up? ☐ Protestant ☐ Jewish ☐ Catholic ☐ Other
- Please check any of the problems that the mother experienced: ☐ Alcohol/Drug Abuse ☐ Physical Abuse ☐ Mental or Emotional Illnesses ☐ Sexual Abuse ☐ Financial Problems ☐ Marital Problems/Divorce ☐ Physical Illnesses ☐ Legal Problems ☐ Other _____
- Does mother currently use alcohol or other drugs? ☐ Yes ☐ No
- Has mother had any legal consequences as a result of alcohol or drug use? ☐ Yes ☐ No
- 57) **The Following Questions Are to Be Answered About the Child's Father**
- Number of brothers and sisters: _____
- Did father grow up with both parents present? ☐ Yes ☐ No
- How were father's economic conditions growing up? ☐ Below Average ☐ Above Average ☐ average
- What was father's religious affiliation growing up? ☐ Protestant ☐ Jewish ☐ Catholic ☐ Other
- Please check any of the problems that the father experienced: ☐ Alcohol/Drug Abuse ☐ Physical

- Abuse ___ Mental or Emotional Illnesses ___ Sexual Abuse ___ Financial Problems ___ Marital Problems/Divorce ___ Physical Illnesses ___ Legal Problems ___ Other _____
- 58) Does father currently use alcohol or other drugs? ___ Yes ___ No
- 59) Has father had any legal consequences as a result of alcohol or drug use? ___ Yes ___ No
- 60) How long did parents know each other before they began living together? _____
- 61) Were there any specific problems in the relationship? ___ Financial ___ Religious ___ Sexual ___ Drugs/Alcohol ___ Personality ___ Violence/Abuse
- 62) **As things are now in the relationship, parents generally agree on:** ___ Raising Children ___ Family Finances ___ Partner's Employment ___ Recreational Activities ___ Seeking Help for Children ___ Nothing
- 63) Are both parents involved in the child rearing? ___ Yes ___ No
- 64) Which of the following are problems in the household? ___ Conflicts With Parents ___ Conflicts with Stepparent ___ Conflicts with Grandparents ___ Conflicts with Parent Dating
- 65) Has the child used alcohol or drugs? ___ Yes ___ No
- 66) Has the child been placed on probation as the result of alcohol or other drug use? ___ Yes ___ No
- 67) Is the child on probation now? ___ Yes ___ No
- 68) Has the child been suspended, expelled, or absent from school because of alcohol or other drug use? ___ Yes ___ No
- 69) Has the child had school grades drop because of alcohol or drug use? ___ Yes ___ No
- 70) Have there been any health problems as a result of alcohol or drug use? ___ Yes ___ No
- 71) Does child have friends who are "users of alcohol or drugs"? Yes ___ No ___
- 72) Has the child recently had problems with bed wetting or soiling pants? _____
- 73) Has there been a change in the child's daily activities? ___ Yes ___ No
- 74) Does the child have a set time for: ___ Bed Time ___ Meals ___ Bath ___ Homework
- 75) Where does the child sleep? ___ Alone ___ With Other Children ___ With Parents
- 76) The child can: ___ Bathe Self ___ Dress Self ___ Comb/Brush Hair

Psychologist Signature

Date

Charis Institute for Psychological and Family Services
21 Southgate Court, Suite 101
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Fax: 540.574.6076

Client Information

We would like to take the opportunity to let you know about some very important aspects of the services we will be providing for you at Charis. We would also like you to signify your acceptance of these arrangements by signing this form.

Confidentiality

Your identity and any information shared by you will be held in the strictest confidence. The right to release information about you belongs to you. No information, including the fact that our office is seeing you, will be released to anyone without your written or verbal permission. Exceptions to this confidentiality policy are made as a result of legal requirement to report any of the following:

- The abuse or neglect of a child or dependent adult.
- Imminent danger of hurting yourself or someone else.
- In the case of court involvement, if the court would order it.
- Information regarding your involvement in treatment (i.e. Dates of treatment and billing records) if legal collection action becomes necessary by our office.
- Information regarding your treatment, dates of service, diagnosis, and treatment plans if you submit claims for these services to your insurance company and your insurance company requires such information.
- For the purpose of ensuring quality services, our staff is involved in on-going training and supervision. For this reason, confidential information will be shared among staff to enhance therapeutic effectiveness.
- For the purpose of scheduling appointments and receiving notice of cancellations when necessary, you give permission for us to leave a message at your home or work with numbers to call.
- Unethical or illegal practices of other psychologist that have provided care to you.

Appointments and Fees

- You will see your therapist on an appointment basis. You should check with the office before your session or before you leave to confirm your next appointment.
- **Please notify us at least 24 hours prior to your appointment if you cannot keep your scheduled time. If we do not receive a 24 hour notice for a cancellation or if you do not show up for your appointment, you will be charged a \$35 fee and we will remove any future appointments you have scheduled.** After two cancellations with insufficient notice or two "no shows," you may be given a referral elsewhere. Insurance will not pay for "no show" fees, and you are responsible for payment.
- **There is a charge of \$200.00 for your first session** (which involves various intake procedures.) **Subsequent sessions are \$150.00 for 40-45 minute sessions** (other session fees available upon request). You agree to pay in full for services not covered by your insurance and for your portion of covered services. We will file insurance claims for you if you wish. If you file your own claim, and pay in full at the time of service we will give you a 25% discount. We will also give the same discount for those who do not have insurance and wish to pay cash at the time of the visit.
- You may be billed for additional services, reports and telephone contact that are not covered by your insurance.
- **We will provide you with a regular statement on your account. You agree to pay 1.5% interest (18% per year) on a balance that is 120 days or more past due. We understand that due to conditions of employment, health, or other factors, a payment plan or other necessary arrangement will need to be made. If this should occur please bring this to the attention of the Accounts Manager to avoid collection action. If collection is necessary you will be charged the collection fees in addition to your account balance.**

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Emergency

- If I need professional help between sessions, you agree to call the Charis office at 540.568.1876. If you should need assistance and are unable to reach the therapist, you agree to go for help to the Rockingham Memorial Hospital Emergency Room, or to a Hospital Emergency Room near you. If you are unable to do so, you agree to call 911 for assistance.

Release of Information/Records

- You may request copies of your notes, reports, or any other information that we have concerning your records. At times it is necessary for the clinicians to write reports concerning your treatment. Please know that there will be a small fee for processing any of the above.
- In the event of unplanned or planned retirement of the psychologist or closure of the practice, your records will be maintained for the amount of time determined by state law. If you need to access them, you should be able to contact your psychologist by sending a message through the Charis Institute Facebook page (to be developed at that time) or Linked In or the psychologist's cell numbers (used for emergencies only at this point). You may be billed for the cost of providing your records.

Termination, Legal, Court Issues

- If you should be dissatisfied with the services you receive, you agree to discuss this with your therapist and express the extent of your dissatisfaction.
- You understand that you may terminate treatment at any point, and may request a referral to another qualified therapist.
- In the event that you should make an ethical or legal complaint to any source regarding treatment rendered, and it is determined that the therapist is not found in error, you understand that you are liable for reimbursement of any costs incurred and income lost by the therapist in pursuing the matter.
- The psychologist will not participate in legal proceedings except under very limited circumstances. If the psychologist is required to respond to court proceedings or requests related to your records or your care, you are responsible for these costs and this time, even after your therapy has terminated. The usual fee for court-related activities is typically a different higher rate.

Informed Consent to Treatment

I give my consent for the provision of psychotherapy and/or psychological evaluation services to **myself/my child** _____. I have read the policies and procedures on the preceding pages and I have discussed with my therapist any area(s) I do not understand. I agree to these provision. I understand that this consent will continue in effect as long as the individual noted above continues in treatment, unless I should notify my therapist in advance in writing that, as of a certain date, I am no longer consenting to further treatment, or any of the provisions listed above. I may request a copy of this form for my own records.

My therapist will discuss with me the specifics of my treatment plan in our intake session. I understand and am satisfied with my therapist's qualifications to treat the difficulties for which I am seeking help. I understand that my therapist will conduct him/herself in a manner consistent with ethical, legal, and professional standards of practice. If I have any concerns, it is my responsibility to communicate these to my therapist.

(Client/Guardian Signature)

(Date)

(Psychologist Signature)

(Date)

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**Authorization to Disclose Information
to Primary Care Physician**

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. Until I revoke my consent, this authorization is valid.

I hereby authorize on behalf of myself/my child _____

Please Check One:

_____ To release or to exchange any applicable information with my Primary Care Physician.

_____ To release or to exchange medication information only with my Primary Care Physician.

_____ Not to release or exchange any information to my Primary Care Physician.

(Patient or Patient's Guardian, please sign)

(Date)

(Please print the name signed above)

(Date)

(Therapist Signature)

(Date)

Primary Care Physician's Name, Address & Phone

(Please Print Physician's Name)

(Street/Mailing Address)

(City)

(Zip)

(Area Code)

(Phone)

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Release/Exchange of Information

I, _____, authorize Charis Institute regarding myself /child

_____ to
(Name of self and child)

_____ Release information including medical, psychiatric, alcohol and /or drug abuse, HIV testing, and /or AIDS information to
_____ Receive information, excluding medical, psychiatric, alcohol and/or drug abuse, HIV testing, and/or AIDS information from
_____ Exchange information on an ongoing basis with:

(Name of individual or agency) Phone

(Name of individual or agency) Phone

(Name of individual or agency) Phone

(Name of individual or agency) Phone

(Name of individual or agency) Phone

(Name of individual or agency) Phone

This information will be released for the purpose of:

- _____ obtaining information
- _____ exchanging information with the above agencies
- _____ evaluating service needs
- _____ developing and maintaining a treatment plan
- _____ ongoing service coordination
- _____ continuity of care
- _____ psychological evaluation

The specific records/reports to be disclosed shall include:

- _____ Complete Records (including progress notes)
- _____ Discharge Summary
- _____ Psychological Evaluations
- _____ Psychological Records
- _____ Medical Records
- _____ Psychiatric Evaluation
- _____ School Records
- _____ Other -Specify type: _____

I understand that the records and information released/exchanged shall be regarded as confidential communication except when public safety is threatened or when a release of such information is court ordered. I further understand that the purpose of this release is to assist the staff of Charis Institute to plan, implement, and to conduct follow up evaluations on the outcome of the counseling program. I know that I may request to receive a copy of this authorization. I agree that this authorization shall be valid for two years from the date in which I sign it and that a photographic copy of this authorization shall be as valid as the original. I understand that I may revoke this release exchange of information in writing.

Alcohol, drug, HIV, ARC, and /or AIDS information, if present, will be disclosed from records whose confidentiality is protected by Federal Law which prohibits any further disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. Copies or faxes of this authorization are acceptable. I understand I may be charged a service fee for requesting copies of any records.

Patient signature (if over 14 years of age)

Print name of person who released information

(Patient/Guardian, or authorized signature if patient is a minor)

(Date)

Therapist Signature

(Date)

Credit Card Authorization Form

Credit Card Information

Cardholder Zip Code (from credit card billing address):

Date _____