Phone: 503.352.0240
Fax 971.279.5635
www.nhws.us

NEW HORIZONS
WELLNESS SERVICES, LLC

9400 SW Beaverton-Hillsdale Hwy.,
Suite 210, Beaverton, Oregon 97005

PATIENT INFORMATION AND INSURANCE FORM

☐ New Patient ☐ Change of Address ☐ Updated Insurance Info ☐ Returning Patient (after 3 months)

PATIENT INFORMATION

Patient Name: _____ D.O.B. _____ ☐ M ☐ F
First M.I Last

Parent(s)/Responsible Party	Phone Number(s) Home	Work	Cell	Email
Mother Name:				
Father Name:				
Caregiver Contact Information:				

Name

Address: _____ _____
Street City, State Zip Code

Parents are: ☐ Married ☐ Separated ☐ Divorced Parenting Plan? ☐ Yes ☐ No

PHYSICIAN'S INFORMATION

Primary Physician: _____ Address: _____
Phone: _____

Referring Physician: _____ Address: _____
☐ *Same as above*
Phone: _____

INSURED'S INFORMATION

Name: _____ D.O.B. _____ ☐ M ☐ F
Last First

Employer: _____ S.S.N. _____

Insurance Company: _____ I.D. #: _____

Group #: _____

Insurance Address: _____ _____ _____
Street City, State Zip

Insurance Phone Number: _____

SECONDARY INSURANCE INFORMATION

Name: _____ D.O.B. _____ ☐ M ☐ F
Last First

Employer: _____ S.S.N. _____

Insurance Company: _____ Subscriber: _____

Group #: _____

Assignment and Release: I hereby authorize New Horizons Wellness Services, LLC to release any information required by appropriate agencies or insurance companies. I also authorize my insurance benefits to be paid directly to New Horizons Wellness Services, LLC and I am financially responsible for any unpaid balance.

I declare the foregoing information is true and correct

_____ _____
Print Name Date

_____ _____
Responsible Party Signature Witness (to be signed by Staff Member)

ID Copied: ☐ Yes ☐ No

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Child/Adolescent Intake Questionnaire

Client Name: _____ Today's Date: _____
First Middle Last

Gender: M ☐ F ☐ Age: _____ Ethnicity: _____ Birth Date: _____

Parents/Guardians: 1. _____ 2. _____

Relationship: _____ _____

Address: _____ City, State, Zip: _____

Telephone(s): _____ _____
(home) (cell) (work)

E-mail 1: _____ E-mail 2: _____

May we leave messages for you? ☐ On home phone ☐ On work phone ☐ On e-mail ☐ Other ☐ No

Parents/Guardians: 3. _____ 4. _____

Relationship: _____ _____

Address: _____ City, State, Zip: _____

Telephone(s): _____ _____
(home) (cell) (work)

E-mail 1: _____ E-mail 2: _____

May we leave messages for you? ☐ On home phone ☐ On work phone ☐ On e-mail ☐ Other ☐ No

Others living in the home or siblings outside the home

Name: Age: Relationship:	Name: Age: Relationship:	Name: Age: Relationship:	Name: Age: Relationship:

Emergency contact: _____ Phone: _____ Relationship: _____

Referred by: _____

	Education	Occupation	Employer
Parent 1			
Parent 2			

	Education	Occupation	Employer
Parent 3			
Parent 4			

PROBLEMS & STRENGTHS
Describe the issues or problem(s) that brought you here today:
When did these problems begin?
What are your child's strengths? What is going well in your child's life?
How is the family functioning?
Current School:_____ How is your child's academic performance?
How is the relationship with parents or care-givers?
What are your goals for this visit?
Is there any other information that may be helpful (for example, issues of diversity, spirituality, or health)?

Check any of the symptoms that your child is having:			
Depression		Feelings of extreme happiness	
Extreme sadness		School problems	
Trouble concentrating		Problems getting along with friends or family	
Memory problems		Cold/Flu	
Feeling hopeless		Injuries	
Lack of energy		Chronic health conditions	
Feeling tearful		Physical complaints of pain	
Lack of enjoyment or useful activities		Sexual behavior	
Change in eating habits		Weight changes	
Loss or Grief		Substance Abuse	
Self-esteem problems		Feeling stressed	
Perfectionism		Easily irritated	
Feeling fearful		Problems with anger	
Feeling guilty		Acting violently	
Feeling nervous		Legal problems	
Obsessions or compulsions		Thoughts of hurting self or others	
Sudden feelings of panic		Thoughts of killing self or others	

MEDICAL INFORMATION	
Has your child seen a doctor within the last year?	Yes ☐ No ☐
Why did he/she see a doctor?	
Who is your child's doctor?	Phone:
Is your child taking any medications, prescription or other-the-counter? Please describe:	Yes ☐ No ☐

Medications	Dosages
1.	
2.	
3.	
4.	

Does your child have allergies to anything? Please describe:	Yes ☐ No ☐

HAS YOUR CHILD OR FAMILY EVER BEEN IN COUNSELING BEFORE Yes ☐ No ☐

If yes, please describe counseling below. Start with the most recent time first.

A. Date(s):	
Provider Name:	
Explain what happened:	

B. Date(s):	
Provider Name:	
Explain what happened:	

C. Date(s):	
Provider Name:	
Explain what happened:	

SUBSTANCE USE HISTORY

Use of tobacco (any form)?	Current ☐	Past ☐	No ☐
Use of alcohol?	Current ☐	Past ☐	No ☐
Use of caffeine (any form, including cola drinks)?	Current ☐	Past ☐	No ☐
Use of other mind-altering substances (drugs)? If yes, please describe:	Current ☐	Past ☐	No ☐

IF THERE IS OTHER INFORMATION THAT YOU THINK IS IMPORTANT, PLEASE ATTACH ADDITIONAL SHEETS

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Service & Fee Agreement

(Information Concerning the Clinic, Financial Arrangements, Confidentiality and Patient's Rights)

Welcome to New Horizons Wellness Services, LLC! We look forward to assisting you with your goals. This document (the agreement) contains important information about our professional services and business policies. **Although this document is long, it is very important that you read these policies carefully and ask for clarification when needed.** Please let us know if we can clarify any of this information and if you have any other questions. When you sign this document, it represents a formal agreement between you and New Horizons Wellness Services, LLC. You may revoke this agreement in writing at any time, and that revocation will be binding unless (1) we have already taken action in reliance upon it, (2) there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy, or (3) you have not satisfied financial obligations incurred by you.

CLINIC OVERVIEW

New Horizons Wellness Services, LLC is a private, coordinated care clinic. We help children, adolescents, adults, and families with physical, developmental, social, emotional, cognitive, and learning concerns. Our services include counseling for individuals, families, and couples; academic and social skills groups for children; academic, psychological, and neuropsychological evaluations; occupational & speech therapy; and consultation. Our clinical staff consists of licensed psychologists, licensed occupational therapists & occupational therapist assistants, and licensed speech and language pathologists. Sometimes we will have highly qualified interns/practicum students and testing technicians providing services under the supervision of a licensed psychologist, occupational therapist, or speech and language pathologist. When you call for an initial appointment we encourage you to formulate questions for us to answer or specific goals you want to accomplish. With that information we will schedule appointments for consultation, evaluation, and/or treatment with appropriate staff.

SERVICES & FEES

Clinical Psychologist

- Initial Assessment $250
- Individual Therapy $150/hr.
- Family/couples Therapy $160/hr.
- Group Therapy $70/hr (60 minute session)
- Evaluations If you are having an evaluation, we will provide you with a separate form with detailed descriptions of what evaluations involve and the cost.

Master Level Therapist

- Initial Assessment $220
- Individual Therapy $100/hr.
- Family/couples Therapy $110/hr.

Masters/Doctoral Students

- Intake $40
- Therapy sessions $25/hr.

Occupational and Speech Therapy Services

- Initial Evaluation $200
- Reevaluations $125
- OT/SLP Session $40/unit (15 minutes=1 unit)

Fees for these services are billed on a clinical hour (45 minutes), quarter hour, or treatment basis and vary for each discipline. When you call for an appointment, we provide an estimate of the fee(s). We will inform you if this changes. Fees may increase during the course of treatment and, if so, you will be notified in writing 30 days in advance.

OTHER SERVICES NOT BILLABLE TO INSURANCE

Miscellaneous Fees & Hourly Rates (Pro-Rated)

Administrative Fee	$10	Professional Services (Case Management)	$100
No Show/Late Cancellation	Full Fee	Observations (School, Daycare, etc.)	$160
Insurance Reports	$100	Letter Preparation	$100
Telephone Sessions	$150	Phone Consultation	$160
Records Review	$100	Travel Time	$125

Rebilling Fee	$10	Late Payment Fee (monthly)	$40
Return Check Fee	$35	Medical Records Mailing Fee	$5
Medical Records	$30 first 15 pages $.10/additional page		
Mileage	$.57/mile		

Legal Fees & Hourly Rates (Pro-Rated)

Conference with Attorney	$180	Court Appearance/Testimony	$300
Court Preparation	$180	Deposition	$180
Legal Consult	$180	Legal Preparation	$180
Mileage	$.57/mile	Travel	$125
Evaluations	$190		

A 50% RETAINER IS REQUIRED FOR ALL LEGAL SERVICES PRIOR TO SERVICE. 10% DISCOUNT DOES NOT APPLY.

APPOINTMENTS

Appointments are scheduled following the initial evaluation. Please check with the front desk after the initial evaluation to schedule on-going treatments. **(Note: You may not be scheduled with the therapist that preformed the initial evaluation)**. Your frequency will be determined by the therapist. We will do our best to accommodate your needs but cannot guarantee your preferred day and/or time request. If we cannot meet your request, you, your child, and/or family will be placed on our waiting list and will be notified if it becomes available.

Wait List Procedure: We cannot guarantee a timeframe or when your preferred time will become available. Time slots are offered first to current patients on the therapy schedule. If we are unable to fill the time slot, calls are then placed to patients on our waitlist according to the date they were added on a first come, first serve basis.

ATTENDENCE

In order for patients to receive the maximum benefit from therapy services, it is important that all scheduled appointments be kept. It is also important that appointments are attended on time. Late arrivals reduce the amount of direct service time. We understand that there may be times that attendance is not possible (e.g., illness, family emergency).

- **Illness:** If you, your child, or one of their siblings is sick or has a fever please do not bring them to the clinic. If your child has experienced vomiting or diarrhea, please make certain they have been symptom free for at least 24 hours before bringing them to the clinic. Exceptions to the cancellation policy are made in instances of illness or emergency.

- **Cancellations and Rescheduling:** To cancel a scheduled therapy or consultation appointment, please call during office hours and give at least 48 business hours advance notice. **The full fee is charged for appointments missed and appointments cancelled less than 48 hours in advance.** Cancellations left on voicemail after business hours will be considered received as of the next business day. It is important to note that insurance companies do not provide reimbursement for missed or cancelled sessions.
  If you must cancel an evaluation appointment, please notify us **at least one week in advance**. We may elect not to reschedule evaluations cancelled without sufficient notice.

- **Late Arrivals and Pick-up:** You must arrive timely for your therapy session or evaluation. Unless otherwise indicated, counseling appointments are 45 minutes. If you arrive late for a scheduled appointment, the appointment will still end on time. Please be advised that you will be charged for the full amount of time that was allotted for the appointment. If your occupational or speech therapy session is not able to start within **8 minutes** of its scheduled start time you will be required to pay privately for the first 15 minutes of the session. The charge for this time is $40.00.

  If you will not be attending your child's therapy session, you must be in the lobby 10 minutes prior to the scheduled end time. We do not provide babysitting services. Our billing rate is $160.00 an hour (with a minimum $15.00 fee) is due the day of service if you fail to pick-up your child at the scheduled end time. Charges are prorated in 5 minute increments.
- **No Shows:** If you fail to keep a scheduled appointment and have not cancelled you will be charged full fee. If your child is scheduled for more than one discipline on a given day, the cancellation and or no show fee will apply to each scheduled appointment missed.

PAYMENT

We will do our best to inform you of your financial obligation when scheduling your appointment. When a child is the client, the parent/guardian seeking services is responsible for the account. A **Patient Registration** form and a **Financial Agreement** form must be completed prior to your first appointment.

- Financial arrangements between divorced parents must be handled independently of New Horizons Wellness Services, LLC. In cases of divorce, the parent seeking service is responsible for the account and must sign the **Financial Agreement** form. If the other parent holds the insurance, they, too, must sign a **Financial Agreement** form. This gives us permission to bill the health insurance. Fees are due on the day of an appointment and must be paid regardless of who brings the child to the appointment.

Payment can be made with a check, cash, MasterCard, Visa, Discover, or debit. Please make checks payable to New Horizons Wellness Services, LLC. We cannot guarantee that your HSA, HRA, or Benefits credit card will work in our office. Please call ahead to make a payment arrangement for teenagers coming on their own. There is a **$35** Non-Sufficient Funds (NSF) fee for returned checks in addition to late fees. Late charges are $40 monthly for any balance over 30 days old. If your check is denied, you will be required to utilize a different form of payment. Post dated checks are not accepted under any circumstance.

SELF PAYMENT DISCOUNT

Patients paying in full at the time of service without using insurance may receive a 10% self-payment discount. There may be other benefits of cash payment, including increased confidentiality and freedom from using mental health diagnosis. Please discuss this with your therapist.

OTHER SOURCES OF PAYMENT

Generally if your, your child's, and or family's treatment and/or evaluation are being requested by Disability Determination Services, Child Welfare, Oregon Youth Authority, Central City Concern, or Developmental Disability Services these agencies will be billed for the services rendered. However, the Appointments and Cancellations Policy still applies.

HEALTH INSURANCE

If you are receiving services under a managed care health insurance contract, your policy may limit outpatient rehabilitation and/or behavioral health coverage to **"medically necessary" procedures (for acute symptom relief)**. Your provider has an agreement with your insurance company to provide services within the limitations of these conditions. The managed care company may require a release of information about your treatment to the primary care physician. Your managed care health insurance company hires reviewers to assess the record keeping and functioning of provider offices. As part of this process, they may either send a reviewer to our office to inspect your records or request a copy of your record. If this is the case, we will follow all procedures to protect the confidentiality of your record. Your managed care insurance company may request that information regarding treatment and/or treatment authorization be transmitted via facsimile or e-mail. Some concerns you want to address in therapy may not meet the conditions of your insurance coverage. Should you want to receive treatment for a non-covered condition, your therapist will discuss options with you.

Some managed care health insurance plans require pre-authorization or they will not cover your first meeting, and may require periodic reauthorizations for ongoing treatment. If you are using health insurance benefits, you need to be aware of your policy and its benefits and limitations. You are responsible for obtaining the initial pre-authorization, if necessary. Payment is **due in full at the time of service** until insurance coverage is confirmed. Positive balance will be applied to future co-payments or refunded. It is important to remember that you remain responsible for your entire bill regardless of whether insurance covers treatment costs or whether you are the primary insured person.

Please provide proof of insurance prior to or at the time of your visit. New Horizons Wellness Services, LLC will phone your insurance company to verify that your policy is in effect and to determine if there is a deductible and/or co-payment due at the time of service. Please remember that it is your responsibility to know what your insurance plan coverage is. We will call and verify benefits and do our best to track your visits; however, it is ultimately your responsibility to know what is covered by your plan and any limitations. **We do not guarantee quoted insurance benefits.** Please remember, billing insurance is not a guarantee of payment. If your insurance plan does not cover a service, procedure, or diagnosis, you are responsible for these charges. We require a current credit card number on file.

- **Co-Payments:** Your co-payments are due at time of service. It is your responsibility to check in and make payment at every visit. We understand that at times the front lobby can be very busy and you may have to wait

in order to accomplish this. Effective August 1, 2012, if your co-payment is not made at time of service and we need to bill you, we will charge a billing fee of $10.00 per visit.

- **Deductible:** Most insurance plans carry a deductible. We will collect payment to **meet your deductible,** if applicable.
- **Secondary Insurance:** Secondary insurance is not billed by NHWS.

DELINQUENT ACCOUNTS

We will bill your primary insurance carrier if we are provided current and correct information. Our policy is to allow insurance carriers 30 days to pay a claim. **Accounts unpaid after 30 days will be assessed a re-billing charge of $10.00. If a payment has not been received from an insurance company within 60 days, the past due amount will be billed to your credit card.** Please notify us prior to your next appointment if you have a change in insurance. We do not re-bill insurance if you have neglected to notify us of a change.

Accounts with balances owing after 90 days will be referred for collection action. To avoid collection action and re-billing charges you will be asked to provide a credit card number. This will be kept on file and can be used to settle the balance. We make every attempt to contact you prior to charging an unpaid balance.

In the event of non-payment of charges, New Horizons Wellness Services, LLC shall be entitled to recover all costs and expenses incurred in seeking collection of such charges, including, without limitation, court costs and reasonable attorney's fees, whether such claims are pursued through court proceedings, appellate or bankruptcy proceedings, arbitration, and/or mediation.

CONFIDENTIALITY AND PATIENT'S RIGHTS

The law protects the privacy of all communications between a patient and health care provider. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- Please note that we do discuss cases internally at New Horizons Wellness Services, LLC in peer supervision and case consultation with other health and mental health professional, and by signing you give permission for these discussions. During a consultation, we make every effort to avoid revealing your identity. The other professionals are also legally bound to keep the information confidential.

As a general rule, outside of peer consultation, we will not disclose information regarding a patient unless authorized to do so by the patient in writing. There are several situations in which the Oregon State law requires clinicians to make exceptions to the confidentiality of communications between patient and clinician. These situations are:

- when there is suspected child, elder, or disabled abuse
- when there is threat of harm to self or others
- when medically relevant information is needed for emergency medical treatment
- when records are subpoenaed by order of a Judge, or if the client waives confidentiality
- when conducted at the request of an outside agency with the client's approval

HIPAA NOTICE OF POLICIES AND PRACTICES

New Horizons Wellness Services, LLC is committed to preserving the privacy of your personal health information. Additionally, we are required by Federal law (Health Insurance Portability and Accountability Act, known as HIPAA) and by State law to protect the privacy of your personal information and to give you a Notice that describes (a) how clinical information about you may be used and disclosed and (b) how you can get access to this information. Please ask for a copy of the HIPAA Notice of Policies and Practices should you wish to have a complete copy for your records.

MINORS AND PARENTS

In the state of Oregon, individuals 14 years of age and older are able to independently consent to or receive mental health services and to disclose/release information without parental permission. While privacy in psychotherapy is very important, particularly with adolescents, parental involvement is also essential to successful treatment and this may require that some private information be share with parents. It is our policy not to provide mental health services to children under the age of 18 unless he/she agrees that we can share general information about the progress of his/her treatment and attendance at scheduled sessions with parents. Before giving parents any information, we will discuss the matter with the minor if possible, and do our best to handle any objections he/she may have, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents (or other authorities) of our concern immediately and regardless of any objections the minor may have to us doing so.

PARENTS, INFORMED CONSENT AND DIVORCE

If you share legal custody and your divorce decree notes that you must inform the other parent of health appointments, please note that our services fall under this, and you may be in violation of a court order if you fail to inform the other parent of our services with your child. Also note that to provide consent for treatment for your child you must either have sole custody or have shared legal custody, and if you have no legal custody you cannot provide consent for treatment. By signing below you are stating that you have the legal right to consent for this child. In the case of separation or divorce, any matter brought to our attention by either parent regarding the child may be revealed to the other parent. Matters which are brought to our attention that are irrelevant to the child's welfare may be kept in confidence. However, these matters may best be brought to the attention of others, such as attorneys, personal therapist or counselors.

CONTACTING YOUR THERAPIST

Please note that telephone calls are answered between 9:00 am - Noon and 1:00 - 5:00 pm, Monday through Wednesday and between 9:00 a.m. – 1:00 pm, Thursday and Friday. We are generally closed on Fridays during the summer months. Messages may be left on our voice mail system. We will make every effort to return your call on the same day you make it, or at least within 24 hours, with the exception of weekends and holidays. **ELECTRONIC COMMUNICATION (EMAIL) PRESENTS A POTENTIAL RISK TO PATIENT CONFIDENTIALITY. Email is not a replacement for office visits.** While families and patients may find this a convenient way to communicate they must be aware of the risks. If a patient/family still wishes to assume these risks and communicate with their clinician in this way, they may acknowledge this by signing below and exchanging information with their clinician within a session. We will respond should you choose to email us regarding non-clinical issues such as appointment scheduling. **Please note we will not engage in "therapy" nor respond to casual "chats" via email. If you choose to share clinical information via email, we will bill for the time reading it and discussing it with you at your next therapy session or offer to schedule a phone consultation.** Clinically relevant information exchanged by fax/email may become a part of the clinical record.

PATIENT CARE

New Horizons Wellness Services, LLC shall provide occupational and speech therapy services and materials in compliance with the orders of the patient's attending physician. Administration of treatments will be delivered as ordered by said physician.

- **Consent to Treatment:** Patient and/or patient representative acknowledge that the patient is under the medical treatment and care of said attending physician, and that New Horizons Wellness Services, LLC renders its services to the patient under the general and specific instructions of said physician. The patient and/or patient representative recognize that said physician furnishing services to the patient is an independent contractor and is not an employee or agent of New Horizons Wellness Services, LLC.
- **Restrictions and Liabilities:** New Horizons Wellness Services, LLC shall incur no liability for injuries of any kind suffered by the patient while under its care; therefore, should the patient discontinue treatment before the attending physician has so ordered, the patient and/or patient representative agrees to assume all responsibility for all results which may follow.
- New Horizons Wellness Services, LLC is not liable for injury to the patient caused by visitors attempting to assist or treat the patient in any way. For the safety of the patient and others, only the patient and the patient's guardian, if a minor, are permitted in patient treatment areas.
- New Horizons Wellness Services shall not be responsible for personal belongings left in the clinic.
-

EMERGENCIES

We do not provide emergency services. Thus you should exercise one of the following options in an emergency: contact your psychiatrist or primary care physician, call 911 or one of the local emergency services, go to the nearest hospital emergency room, and/or follow your insurance carrier's emergency procedures.

OTHER CLINIC RULES

Children must be supervised at all times while in the clinic space. It is the clinic policy that children who are not participating in therapy are not allowed in the gym or other treatment areas. Please supervise your children while they are in the waiting room area.

ALLERGY AND/OR DIETARY CONCERNS

If your child has allergies or dietary concerns, please notify the therapist and/or front desk so we may place a note on your child's chart. Because many children have allergies to animal dander, pets are not allowed in the clinic.

OCCUPATIONAL/SPEECH THERAPY OBSERVATIONS

You are welcome to observe your child's therapy session at any time. Please check with your therapist prior to the initiation of the treatment session. For adult patients, observation may or may not be appropriate by spouses or other family members. If you are not observing, you are welcome to wait in our waiting room area. If you need to leave the building for any reason, please make certain that your therapist and the front desk has a contact number where you can be reached in case of an emergency. **Therapy sessions are either 50 minutes or 30 minutes in length. We ask that parents/transportation return 10 minutes prior to the end of the schedule session.** This will allow the therapist time to review your child's progress and answer any questions you may have. Other professionals are welcome to observe your child's therapy session. Please notify your child's therapist if you wish to set up an observation.

NPP ACKNOWLEDGEMENT OF RECEIPT FORM

This form, when completed by you, acknowledges that you have had the opportunity to review the HIPAA Notice of Privacy Practices. I understand that if requested I may have a copy to keep.

I, (print full name) _____, acknowledge that I have reviewed a copy of the Notice of Privacy Practices for New Horizons Wellness Services, LCC on this date _____(mm/dd/yyyy).

_____ _____
Signature of Patient (14 years+) Date

_____ _____
Signature of Personal Representative (if different) Date

If the acknowledgment is signed by a personal representative of the patient, the name of the patient and a description of such representative's authority to act for the patient must be provided.

_____
Patient's Name (Printed)

_____
Authority to act for patient (e.g., parent or legal guardian) - (Printed)

THERAPIST-PATIENT SERVICE AGREEMENT

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ AND UNDERSTOOD THIS DOCUMENT AND AGREE TO ABIDE BY ITS TERMS DURING OUR PROFESSIONAL RELATIONSHIP. Please ask for clarification of any information you are unclear about.

I have read and understand the Mental Health/Rehabilitation Service and Fee Agreement. I agree to the statement herein and terms of payment, to include payment of fees listed for court testimony. This agreement was reviewed with me and any questions I had were discussed as well.

_____
Patient's Name (Printed)

_____ _____
Signature of Patient (14 years+) Date

_____ _____
Signature of Personal Representative (if different) Date

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Special Notice for Divorced Parents Concerning Insurance Billing

Child's Name: _____

Often when a child from a divorced family is brought in for treatment numerous concerns can arise. It is important to recognize that the parent initiating services is considered the **RESPONSIBLE PARTY**, and will be financially responsible for your child's account overall. The parent who holds the insurance benefits will be considered the **INSURED**; sometimes these are the same person, but not always.

Below are important aspects of our office policies:

1) Copayments are expected **at the time of service** and we expect that the parent who has brought the child to treatment that day will pay for those services. We will not bill separate balances for each parent.

   For example if a child is brought to treatment by her mother but her co-pay is not paid at the time of service, that balance will be reflected in the child's overall account. Ultimately, the **RESPONSIBLE PARTY** will be responsible for that balance unless both parents can agree otherwise. This also includes any missed appointment fees incurred by either parent.

2) When a provider meets individually with either parent (not the child) these sessions are considered "family therapy." Some insurance policies provide coverage for family sessions. If that is the case, parent-only sessions can be billed under your child's benefits. If family sessions are not a covered benefit under the insurance plan, parent sessions can be billed under each parent's individual benefits (rather than under the child's) or the parent can elect to pay cash for the session. Parents are invited to speak with their child's provider about the need for parent-only sessions.

I have read this information and understand that I am responsible for my child's copayments **at the time of service whenever I transport my child**.

Parent Name: _____ Date: _____

Parent Signature: _____

Parent Name: _____

Parent Signature: _____ Date: _____

PLEASE CHECK AND SIGN THE APPROPRIATE STATEMENTS BELOW:

As the **RESPONSIBLE PARTY** I understand that I am financially responsible for the overall balance reflected on my child's account.

☐ I am not the RESPONSIBLE PARTY

☐ RESPONSIBLE PARTY'S SIGNATURE:_____

As the **INSURED**, I understand that my ex-spouse may want to participate in treatment and that my provider may suggest some individual, parent-only sessions.

☐ **I DO** give consent for my ex-spouse to participate in my child's treatment under my child's benefits as a family session.

☐ **I DO NOT** give consent for my ex-spouse to participate in my child's treatment under my child's benefits as a family session.

INSURED SIGNATURE: _____

☐ **I am not the INSURED**, but understand that if the INSURED does not provide consent, parent sessions would be billed **under my individual benefits or at a cash rate.**

NON INSURED SIGNATURE: _____