Acknowledgment Form

May we contact the professional person or organization who referred you? Circle Yes No
If Yes, Please list name, phone number and address: _____
_____

TELEPHONE PRIVACY: *Please answer the questions below*.
(H) May we call Yes or No May we leave messages? Yes or No
(C): May we call Yes or No May we leave messages? Yes or No
(W): May we call Yes or No May we leave messages? Yes or No

Home# _____ Work# _____ Cell # _____

GENERAL CONSENT TO COUNSELING

I consent to begin counseling, including evaluation, treatment or referral. I agree to pay for counseling services including medical, psychological or psychiatric consultation fees and testing charges. All clients will be charged the therapist's standard fee for cancellations made with less than 24 hour notice or for failure to show for an appointment. Note: This charge is not covered by insurance. Unforeseen emergency situations will be taken into account.

I have read the *Informed Consent for Counseling and our Fee Policy Agreement*, the *Notice of Privacy Practices* and I understand and agree to the policy described herein. I have also read the *Disclosure Statement* which documents my counselor's degree(s), credentials and license(s). A copy of these documents has been given to me for my records.

I agree to pay as services are rendered in the following manner:

❑ I will pay the contracted fee at each visit.

❑ I will pay the co-payment as required by my insurance company, managed care agency or HMO

I acknowledge that I have given my correct and complete insurance information below. I understand that if I have given incomplete or incorrect information that I will be responsible to pay for services.
Please fill out both primary and secondary insurance information below: *Please write neatly*.

Primary Insurance Information:

Name of Insurance Co.:_____
Name of Insured Person:_____
Primary Insurance ID#: _____
Insured's SSN: _____-_____-_____
Relationship to Insured: Self/Spouse/Parent/Guardian/Other
Insurance Group #: _____
Insured Person's Birth date: _____
Insured Person's Employer: _____

Name of Insurance Co.:_____
Name of Insured Person:_____
Secondary Insurance ID#: _____
Insured's SSN: _____-_____-_____
Relationship to Insured: Self/Spouse/Parent/Guardian/Other
Insurance Group #: _____
Insured Person's Birth date: _____
Insured Person's Employer: _____

Print Name: _____ Date: _____

Name of minor (if applicable): _____

Signature: _____