SEVEN COUNSELING

CLIENT DEMOGRAPHIC FORM

Name(s):_____

Address: _____

DL Number: _____

Date of Birth: _____ Age: _____

Social Security Number: _____-_____-_____

Please put a check in the box next to the number where you may be best reached:

Cell Phone: (____) _____-_____ Work Phone: (____) _____-_____

Email:_____

Responsible Party (Parent if Applicable): Name(s):_____

Relationship:_____ DOB:_____ DL#:_____

Phone:_____ Address (if different from above):_____

PERSON TO CONTACT IN EMERGENCIES:

Name/Relationship Phone Number: _____

Occupation/School_____

Education: Highest Level Completed _____ Any Degrees _____ Majors _____

Marital Status: _____

If ever married, how many times? _____ If ever divorced, how many times? _____

Family Physician: _____ Phone Number_____

Medications Currently Taking: _____

Medical Conditions: _____

Chief Complaint/Reason for Referral: _____

_____

OFFICE POLICY

All Payments are due at the time of service. If, **for any reason,** payment is not received at time of service, client will be allowed five (5) business days to make payment in full unless other arrangements are made.

I understand that payment due is based on a best estimate. I understand I am responsible for any fees not covered by the insurance plan. **INITIAL** _____

THIS OFFICE MUST BE CONTACTED AT LEAST 24 HOURS PRIOR TO APPOIMTMENTS TO AVOID MISSED APPOINTMENT CHARGE. **INITIAL** _____

FEE SCHEDULE

1 Hour (60 Min.) Out of Pocket.....	$150.00
90 Min. Out of Pocket.....	$170.00
Missed Appointments.....	$100.00
Comprehensive summaries, evaluations, letters or reports.....	$150.00 per Hour
On site observations, staffing, follow up conferences, court (includes travel time)	$150.00 per Hour

INITIAL _____

CONSENT FOR TREATMENT

I hereby authorize this therapist to evaluate and render appropriate counseling service to myself/my child. This consent is knowingly and freely given. I further understand that ALL INFORMATION given by myself/my child or any member of my family to the therapist is CONFIDENTIAL and WILL NOT be released except by WRITTEN client permission or as provided by law. I understand the Office Policies as stated above and accept full responsibility for payment of services rendered.

_____ _____

Therapist Client /Parent, (if Child is a Minor)

Date _____

CLIENT REFERRED BY: _____

SEVEN COUNSELING

OFFICE POLICIES AND GENERAL INFORMATION AGREEMENT FOR PSYCHOTHERAPY SERVICES

This form provides you (patient) with information that is additional to that detailed in the notice of privacy practices and it is subject to HIPAA preemptive analysis.

Confidentiality

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure were described to you in the notice of privacy practices that you received with this form.

When disclosure is required by law

Some of the circumstances where disclosure is required by the law are where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; and where a client presents a danger to self, to others, to property, or is gravely disabled (for more details see also notice of privacy practices form).

When disclosure may be required

Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by insert name of psychotherapist. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. The psychotherapist will use clinical judgment when revealing such information. The psychotherapist will not release records to any outside party unless so authorized to do so by all adult family members who were part of the treatment.

Emergencies

If there is an emergency during our work together, or in the future after termination, where the psychotherapist becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, she will do whatever she can within the limits of the law to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, s/he may also contact the police, hospital, or the person whose name you have provided on the biographical sheet.

Health Insurance and Confidentiality of Records

Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP to process the claims. If you so instruct the psychotherapist only the minimum necessary information will be communicated to the carrier. Unless authorized by you explicitly, the psychotherapy notes will not be disclosed to your insurance carrier. The psychotherapist has no control or knowledge over what insurance companies do with the information s/he submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance.

The risk stems from the fact that mental health information is entered into insurance companies' computers and soon will also be reported to the Congress-approved National Medical Data Bank. Accessibility to companies' computers or to the National Medical Data Bank database is always in question, as computers are inherently vulnerable to break-ins and unauthorized access. Medical data have been reported to have been sold, stolen, or accessed by enforcement agencies; therefore, you are in a vulnerable position.

Confidentiality of e-mail, cell phone, and fax communication

It is very important to be aware that e-mail and cell phone (also cordless phones) communication can be relatively easily accessed by unauthorized people and, hence, the privacy and confidentiality of such communication can be easily compromised. E-mails are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes can be sent erroneously to the wrong address. Please notify the psychotherapist at the beginning of treatment if you decide to avoid or limit in any way the use of any or all of the above- mentioned communication devices. Please do not use e-mail or faxes in emergency situations.

Litigation Limitation

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters that may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on the psychotherapist to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Consultation

The psychotherapist consults regularly with other professionals regarding her clients; however, the client's name or other identifying information is never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained.

Considering all of the above exclusions, if it is still appropriate, upon your request, the psychotherapist will release information to any agency/person you specify unless the psychotherapist concludes that releasing such information might be harmful in any way.

Telephone and emergency procedures

If you need to contact the psychotherapist between sessions, please leave a message (239) 344-8420 and your call will be returned as soon as possible. The psychotherapist checks messages a few times a day (but never during the nighttime). The psychotherapist checks the messages less frequently on weekends and holidays. If an emergency arises, please indicate it clearly in your message. If you need to talk to someone right away, you can call the Salus Care at 2789 Ortiz Ave., Ft. Myers, FL 33905, the 24-hour crisis line (239) 275-4242, the Police (911), or the 24-hour suicide hotline, 988.

Payments and insurance reimbursement

Clients are expected to pay the standard fee of $150 per 60 - minute session at the end of each session unless other arrangements have been made. Telephone conversations, site visits, report writing and reading, consultation with other professionals, release of information, reading records, longer sessions, travel time, and so forth, will be charged at the same rate, unless indicated and agreed otherwise. Please notify the psychotherapist if any problem arises during therapy regarding your ability to make timely payments. Not all issues/conditions/problems that are the focus of psychotherapy are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage.

The process of therapy/evaluation

Participation in therapy can result in several benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part.

Psychotherapy requires your very active involvement, honesty, and openness to change your thoughts, feelings, and/or behavior. The psychotherapist will ask for your feedback and views on your therapy, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, and so forth, or experiencing anxiety, depression, insomnia, and so forth. The psychotherapist may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause you to feel very upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. Change will sometimes be easy and swift, but more often it will be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During therapy, the psychotherapist is likely to draw on various psychological approaches according, in part, to the problem that is being treated and his/her assessment of what will best benefit you. These approaches include behavioral, cognitive-behavioral, psychodynamic, existential, system/family, developmental (adult, child, family), or psychoeducational.

Discussion of treatment plan

Within a reasonable period after the initiation of treatment, the psychotherapist will discuss with you (client) her working understanding of the problem, treatment plan, therapeutic objectives, and view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used during your therapy, their possible risks, the psychotherapist's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that the psychotherapist does not provide, he has an ethical obligation to assist you in obtaining those treatments.

Termination

As set forth above, after the first couple of meetings, the psychotherapist will assess if she can be of benefit to you. the psychotherapist does not accept clients who, in her opinion, she cannot help. In such a case, she will give you several referrals that you can contact. If at any point during psychotherapy, the psychotherapist assesses that she is not effective in helping you reach the therapeutic goals, she is obliged to discuss it with you and, if appropriate, to terminate treatment. In such a case, she would give you several referrals that may be of help to you. If you request it and authorize it in writing, the psychotherapist will talk to the psychotherapist of your choice to help with the transition. If at any time you want another professional's opinion or wish to consult with another therapist, the psychotherapist will assist you in finding someone qualified, and, if she has your written consent, she will provide her or him with the essential information needed. You have the right to terminate therapy at any time. If you choose to do so, the psychotherapist will offer to provide you with names of other qualified professionals whose services you might prefer.

Dual relationships

Not all dual relationships are unethical or avoidable. Therapy never involves sexual or any other dual relationship that impairs the psychotherapist's objectivity, clinical judgment, or therapeutic effectiveness or can be exploitative in nature. the psychotherapist will assess carefully before entering nonsexual and non-exploitative dual relationships with clients. Southwest Florida is a small community and many clients know each other and the psychotherapist from the community. Consequently, you may bump into someone you know in the waiting room or into the psychotherapist out in the community. The psychotherapist will never acknowledge working therapeutically with anyone without her written permission. Many clients choose the psychotherapist as their therapist because they know her before they enter therapy with her and/or are aware of her stance on the topic. Nevertheless, the psychotherapist will discuss with you, her client(s), the often-existing complexities, potential benefits, and difficulties that may be involved in such relationships. Dual or multiple relationships can enhance therapeutic effectiveness but can also detract from it and often it is impossible to know that ahead of time. It is your, the client's, responsibility to communicate to the psychotherapist if the dual relationship becomes uncomfortable for you in any way.

The psychotherapist will always listen carefully and respond accordingly to your feedback. The psychotherapist will discontinue the dual relationship if she finds it interfering with the effectiveness of the therapeutic process or the welfare of the client and, of course, you can do the same at any time.

Cancellation

Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours' (1 days') notice is required for rescheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

OFFICE POLICIES AND GENERAL INFORMATION AGREEMENT FOR PSYCHOTHERAPY SERVICES

I have read the above agreement and office policies and general information carefully. I understand them and agree to comply with them:

Signature of Client or Legal Guardian:_____ Date:_____

Signature of Client or Legal Guardian:_____ Date:_____

_____ _____

Therapist Date

SEVEN COUNSELING

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I, _____, have received a copy of this office's notice of privacy practices.

Client name: _____ Signature: _____ Date: _____

Client name: _____ Signature: _____ Date: _____

It is your right to refuse to sign this document.

_____ _____

Therapist Date:

FOR OFFICE USE ONLY:

The reason that a standard acknowledgment (such as the above) of the receipt of the notice of privacy practices was not obtained:

____ Patient refused to sign

____ Communication barriers prohibited obtaining the acknowledgment.

____ An emergency situation prevented this office from obtaining it.

____ Others: _____

SEVEN COUNSELING

CONSENT TO USE OR DISCLOSE INFORMATION FOR TPO

Patient Name_____

Federal regulations (HIPAA) allow me to use or disclose PHI from your record to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (known as “health care operations”). Nevertheless, I ask your consent to make this permission explicit. The notice of privacy practices describes these disclosures in more detail. You have the right to review the notice of privacy practices before signing this consent. We reserve the right to revise our notice of privacy practices at any time. If we do so, the revised Notice will be posted in the office. You may ask for a printed copy of our notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke thus consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my PHI as specified above.

Signature of Client or Legal Guardian: _____ Date: _____

Signature of Client or Legal Guardian: _____ Date:_____

_____ _____

Therapist Date

SEVEN COUNSELING

HIPAA NOTICE OF PRIVACY PRACTICES (NPP)

I. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

II. It is my legal duty to safeguard your protected health information (PHI).

By law I am required to ensure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this notice about my privacy procedures. This notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this notice.

Please note that I reserve the right to change the terms of this notice and my privacy policies at any time as permitted by law. Any changes will apply to PHI already on electronic file with me. Before I make any important changes to my policies, I will immediately change this notice, and you may request a copy from me.

III. How I will use and disclose your PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

A. Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent

I may use and disclose your PHI without your consent for the following reasons:

1. For treatment: I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI to coordinate your care.

2. For health care operations: I may disclose your PHI to facilitate the efficient and correct operation of my practice. Examples: Quality control—I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

3. To obtain payment for treatment: I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. Example: I might send your PHI to your insurance company or health plan to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.

4. Other disclosures: Examples: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

B. Certain Other Uses and Disclosures Do Not Require Your Consent

I may use and/or disclose your PHI without your consent or authorization for the following reasons:
(Note to therapists: The following list is a compilation of federal and California laws.)

1. **When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or law enforcement** Example: I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel, and/or in an administrative proceeding.

2. **If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.**

3. **If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.**

4. **If disclosure is compelled by the patient or the patient's representative pursuant to California health and safety codes or to corresponding federal statutes of regulations,** such as the privacy rule that requires this notice**.**

5. **To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public** (i.e., adverse reaction to medications).

6. **If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.**

7. **If disclosure is mandated by the California Child Abuse and Neglect Reporting law.** For example, if I have a reasonable suspicion of child abuse or neglect.

8. **If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law.** For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.

9. **If disclosure is compelled or permitted by the fact that you tell me of a serious/ imminent threat of physical violence by you against a reasonably identifiable victim or victims.**

10. For public health activities. Example: In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.

11. **For health oversight activities.** Example: I may be required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider.

12. **For specific government functions.** Examples: I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the president of the United States or assisting with intelligence operations.

13. For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.

14. For Workers' Compensation purposes. I may provide PHI to comply with Workers' Compensation laws.

15. Appointment reminders and health-related benefits or services. Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options or other health care services or benefits I offer.

16. If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena *duces tectum* (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.

17. If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by U.S. Secretary of HHS to investigate or assess my compliance with HIPAA regulations.

18. If disclosure is otherwise specifically required by law.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object

I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization

In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

IV. The rights you have regarding your PHI

1. The Right to See and Get Copies of Your PHI.

In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed.

If you ask for copies of your PHI, I will charge you not more than $0.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

2. The Right to Request Limits on Uses and Disclosures of Your PHI

You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

3. The Right to Choose How I Send Your PHI to You

It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via e-mail instead of by regular mail).

I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

4. The Right to Get a List of the Disclosures I Have Made

You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, that is, those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, disclosures to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for 6 years.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous 6 years (the first 6- year period being 2003–2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than 1 request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

5. The Right to Amend Your PHI

If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

6. The Right to Get This Notice by E-mail

You have the right to get this notice by e-mail. You also have the right to request a paper copy of it.

V. How to complain about my privacy practices

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

VI. Person to contact for information about this notice or to complain about my privacy practices

If you have any questions about this notice or any complaints about my privacy practices or would like to know how to file a complaint with the Secretary of the DHHS, please contact me.

VII. Effective date of this notice: This notice is in effect as of April 14, 2003.

HIPAA NOTICE OF PRIVACY PRACTICES (NPP)

I acknowledge receipt of this notice.

Client Name: _____ Date: _____ Signature: _____

Client Name: _____ Date: _____ Signature: _____

Therapist: _____ Date: _____

SEVEN COUNSELING

Payment Authorization Form

Credit card and insurance information may be used for the purposes of billing: Professional Services, Deductibles and Copayments, Additional Services (Court Testimony and reports required for legal proceeding, letters or reports for government services, telephone calls)

Client Name _____

Name of Card holder as it appears on card: _____

Billing Address: _____

Credit/Debit Card Number: _____

Expiration Date: _____

CCV Code: _____

I authorize Seven Counseling – Dr. Anamaria Ryan, PhD, MA, LMHC, CAP to keep my signature on file and to charge my credit card listed above for any balance applied to my account that is not covered by my insurance. Client agrees to provide information on any credit card or insurance changes within 30 days.

Client Signature: _____ Date: _____