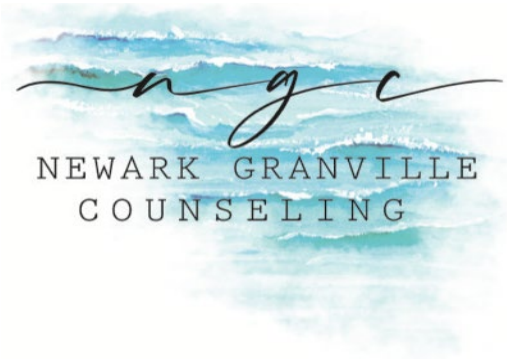

BEFORE YOUR FIRST APPOINTMENT

If you choose to use your health insurance, please note you must call your insurance company prior to your first appointment. We do not verify coverage here in this office and each of our clinicians are independently licensed. Please ask the following questions to the **Mental/Behavioral Health Division** representative so that all of the billing information is complete. If your claims are denied due to "no authorization", you will be responsible for any balance due. Payment is required on your copay, and/or unmet deductible amounts, at the time of your visit.

My appointment with _____on_____at__: _____

1. Do I need an authorization for counseling sessions? Yes____ No____
2. If so, what is my authorization number. _____
3. How many sessions are allowed for this authorization? _____
4. What is my copay amount? _____ Do I have a deductible? _____
5. What is my UNMET deductible amount? _____
6. Are these services under an Employee Assistance Program (EAP)? _____
7. What is the billing address for claims?

Please feel free to contact our office at 740.587.5252, with any questions. Thank you.

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Client Information

Client Name: _____ Date of Birth: _____

Address: _____
Street City State Zip

Sex: Male Female Social Security Number: _____

Telephone Number: Home (____) _____ Cell (____) _____

Work (____) _____ Ext: _____

Email for appointment reminders_____

If necessary, may we call you at work, if we do not identify ourselves? YES NO

Responsible Party

Name: _____ Relationship to client _____

Address: _____
Street City State Zip

Email address for payments/insurance_____

Primary Insurance Policy

Insurance Company: _____

Employer's Name: _____

Name of Insured: _____ Insured's SS Number_____

Insured's Identification Number: _____ Insured's DOB: _____

Client's relationship to insured: Self____ Spouse____ Child____ Other____

Secondary Insurance Policy

Insurance Company: _____

Employer's Name: _____

Name of Insured: _____ Insured's SS Number_____

Insured's Identification Number: _____ Insured's DOB: _____

Client's relationship to insured: Self____ Spouse____ Child____ Other____

Assignment of Benefits and Release of Information

I authorize NGC to release information necessary to effect treatment and claims payment. I also authorize payment of medical benefits be made directly to the provider.

Signed: _____ Date: _____

Telephone Consumer Protection Act (TCPA)

I authorize a representative of NGC and/or any entity authorized by NGC, including those using automated dialing systems, automated messages, email, text messaging or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address provided.

Email address: _____

Signed: _____ Date: _____

Consent to Treat

I agree to mental health and/or alcohol and drug treatment as offered by NGC for:

____Myself ____My Child ___The person for whom I am legal guardian.

I acknowledge this consent is voluntary and does not include medication/somatic (psychiatric) services.

I give consent for the use of my protected health information for treatment and payment as described in the *Notice of Privacy Practices*
.
I further acknowledge that I may revoke, in writing, this consent at any time except to the extent that action based on this consent has already been taken.

Signature: _____Reviewed by Clinician: _____

Date: _____ Date: _____

Emergency Contact

In case of emergency, contact _____

Phone number: (_____) _____

Office Policy

Welcome to *Newark Granville Counseling*. We are pleased that you have selected us to aid you to a healthier life. We want to make your visits as easy as possible by providing information that will help you with our office procedures. Feel free to discuss any concerns you have with your therapist.

Please be sure to bring these items with you for each session: ***Insurance Card & Payment (cash, check, or HSA/credit card).*** We may not be able to see you if you do not bring these items.

Are there any considerations I need to know before entering the counseling process?
The treatment process will be most helpful to you when you are honest and trust the process. We honor your presence and will work with you to make this a beneficial experience.

How long does each appointment take and how long will I be in counseling?
Appointments can be anywhere from 45 to 50-minute sessions. Your individual needs are determined by you and your therapist and will dictate the frequency of appointments and the treatment duration.

How can I be assured that my records are confidential?
State and Federal laws govern that your records are confidential. We release information with your signed permission. Please be aware of several rare exceptions to confidentiality. In situations of possible harm to you or another, suspected child abuse or neglect, or when a court subpoenas your records, your therapist may be required to release confidential material. You should be aware all insurance companies require a clinical diagnosis. Sometimes we have to provide additional information such as a treatment plan or summaries, or copies of the entire record (in rare instances). This information becomes part of the insurance company files. While the insurance companies do have to follow the same practices as we do regarding confidentiality, we have no control over what they do with your records. We will be glad to share with you any information released to your insurance company. Please refer to the Notice of Privacy Practices for additional information.

What if I want to switch therapists?
We believe that you, as a consumer, need to be comfortable with the services provided. If you would like a different therapist, please discuss this in treatment. It is important that you have a therapist that meets your needs.

What if I have an emergency that can't wait until my next appointment?
If you call our office during regular business hours, we will try to have an available therapist respond to your needs. If there is not an available therapist, or if you have an emergency after business hours, please call 911, 211, or the Crisis Line 345-4357 (345-HELP) or go to the nearest emergency room.

Are there special considerations if I am bringing my child for treatment?
If the client is a minor, a custodial parent must sign a permission form authorizing services. Oftentimes the therapist will need to obtain background information from the parent to aid in the treatment process. The therapist will explain to you and your child how confidentiality works in such cases. The sessions may be divided to allow for parental consultation time. Your therapist will discuss this with you. In the case of divorce, both parents will be considered equally responsible for payment. Whoever brings the child to the office is responsible for payment at the time of the visit.

Thank you for reading this information. If you have questions about these or other matters, now or during your treatment course, please discuss them with your therapist. Dealing with these issues is often an important part of treatment. We look forward to meeting with you. If you would like a copy of these office policies for your records, please ask our Office Manager.

I HAVE READ AND UNDERSTAND THE PRECEDING INFORMATION AND AGREE TO FOLLOW THE POLICY.

_____ _____

Signature of Client or Legal Guardian Date

Financial Agreement

Welcome to *Newark Granville Counseling Ltd*. We want to make your visits as easy as possible by providing information that will help you with our billing procedures. This agreement is in place in order to prevent the financial burden of an outstanding balance. ***Please read and initial each item.***

_____***Credit/HSA cards on file***--New and existing clients are required to have a credit card on file. Copays will be charged within one week of the appointment. Any outstanding balances, after insurance payment, will also be charged to the credit card on file (i.e. deductibles and additional copay amounts). Credit cards on file that are declined will be charged $40.00 processing fee. Email receipts from charges will come from *Practice Management Bridge*.

_____ ***Insurance Authorization***--Insurance providers may require authorization prior to an appointment. This should be provided to us at your first visit. Your visit may be rescheduled, or you may be charged the full amount for the service if you do not provide this information.

_____***Returned Checks***-- An additional fee of $40.00 will be due for *checks returned* by your bank for any reason.

____***Account Balances***--Accounts may not carry a balance greater than $150.00. Additional appointments will not be rescheduled until the outstanding balance is paid.

____***Overdue Accounts***--Interest may be charged when the bill is delinquent. We reserve the right to turn the account over to a collection agency. You will receive notification from us prior to collection action with ample time to pay your bill. As is permitted under law, we will release your name, address, and the amount owed, should the delinquency continue. Once an account has been forwarded to collections you will be unable to reschedule with any member of the practice until the balance has been resolved.

____***Missed Appointments***--24-hour advanced notice is required if you need to cancel or reschedule an appointment. You may leave a message on your therapist's confidential voice mail or simply reply to the email appointment reminder you received. We reserve the right to charge $50.00 if we are not notified 24 hours in advance. If you miss an appointment without notice, a rescheduled appointment cannot be guaranteed. Repeated failure to keep your appointment may result in you being dismissed as a client. Insurance does not cover this fee and cannot be charged to your HSA card.

____***Telephone Calls***--There is no charge for the initial 10 minutes of a phone call to your therapist. After 10 minutes, your charge will be prorated at our regular hourly fee. Most insurance companies do not cover telephone calls.

____***Additional Costs***--Time spent on your behalf outside of counseling sessions (e.g. school consultation, court appearances, court preparations, hospitalization arrangement, etc.) result in an additional prorated billing. Routine letter writing or reports on behalf of the client will be subject to $80/hr. fee. Court related time, as outlined in "Court Related Services", constitute additional fees. **Payment is expected prior to the court appearance and/or any documents being released.** Please allow 10 business days for turnaround time for reports, forms and letters written on your behalf.

____***Billing***--Paumier Medical Management Group (PMMG), our outside billing agency, submits insurance claims on your behalf and may send bills for outstanding balances.

FEES

Initial Office Visit -$185
Ongoing appointments, Individual, 50 minutes $170
Ongoing appointments, Family, 45 minutes $160
Ongoing appointments, Individual, 45 minutes $145

I HAVE READ AND UNDERSTAND THE PRECEDING INFORMATION AND AGREE TO FOLLOW THE POLICY.

Client Name: _____Reviewed by Clinician: _____

Signature: _____Date: _____

Newark Granville Counseling, Ltd
PO Box 481•945 River Rd., Granville, OH 43023-0481
Phone (740) 587-5252 Fax (740) 587-2571
www.ngcohio.com Email: office@ngcohio.com

Notice of Privacy Practices

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, that patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment, or to a collection agency if necessary.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and discloses will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information. **Protected health information** covers any identifiable information in the file, information compiled in reasonable

anticipation of, or for use in a civil, criminal, or administrative action or proceeding, and certain information used for research situations. You can exercise your rights by presenting a written request to the Privacy Officer*, McKenzie Povlinko*, LPCC-S, MFT, (740) 587-5252.

You have the right to:

- Request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- Reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- Inspect and copy your protected health information.
- Amend your protected health information.
- Receive an accounting of disclosures of protected health information.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Any individual or others filing a complaint will not be intimidated, coerced, threatened, or discriminated against, provided the individual(s) is acting in good faith, believe the practice opposed is unlawful, and the manner of opposition is reasonable, involving the disclosure of protected health information.

Please contact us for more information:

McKenzie Povlinko, LPCC-S, MFT
Privacy Officer
Newark Granville Counseling, Ltd
945 River Rd
Granville, OH 43023-9169
740.587.5252

For more information about HIPAA or to file a complaint:

The US Department of Health/Human Services
Office of Civil Rights
200 Independence Ave., SW
Washington, DC 20201
(202) 619.0257
Toll Free: 1.877.696.6775

Notice of Privacy Practice Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and certifications.

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____

Client Name: _____

Relationship to client: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the client's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below.

Date:	Initials:	Reason:

Revised 12/2023

Court Related Services (minor)

It is understood that I am ethically bound to not give my opinion about either parent's custody or visitation suitability. Per the OAC 4732-17-01 General rules of professional conduct:

"License holders in treatment role with one or more adults involved in a contested parenting time or custody dispute shall anticipate being asked to participate in conflicting roles. License holders shall clarify and document as early as feasible that his/her role is restricted to providing therapeutic services and shall take appropriate action to avoid role conflicts."

"License holders in a treatment role with one or more adults involved in a contested parenting time or custody dispute shall not render verbal or written opinions to any person or entity, including but not limited to the client, any court, attorney, guardian ad litem, or other professional about a child's access or other person's access to, or parenting time with, any child."

"License holders in a treatment role with one or more children shall not render verbal or written opinions about any adult's access to or parenting time with the child client(s)."

If required to testify in court or at a deposition involving your therapy or the therapy of your child(ren), regardless of who initiates my involvement, a non-refundable retainer of $1500 is due within 24 hours of the subpoena being served, to block out my schedule in order to ensure my availability. If the subpoena is received without a minimum of 10 business days' advance notice, there will be an additional nonrefundable express charge of $500. You will be responsible for the retainer fee whether I testify or not; further, the cause of cancellation, whether it is initiated by the court or by one of the interested parties is irrelevant.

When it comes to court actions the retainer will take care of the following:

- Preparation time
- Phone calls
- Preparing and/or filing a document with the court or the party who issued the subpoena.
- Mileage
- Time away from the office, including travel time, due to the subpoena and/or the inability to reschedule with clients once appointments are cleared in order to testify.

The following fees are not included in the retainer fee, and will be billed after the court appearance, and are due upon receipt.

- Actual time required to give testimony or deposition: $250 per hour.
- All attorney fees and costs incurred by the therapist as a result of the legal action.
- If records are requested, an additional cost, depending on who requests the records, will be charged in accordance with the Ohio Department of Health's then effective fee schedule, in accordance with ORC §3701.741.

I understand and agree to pay the fee structure as listed above.

_____ _____

Client or Guardian's Signature Date

_____ _____

Witness Date

Child/Adolescent Background Questionnaire

Because parents are often the first to notice a problem with their child's behavior, learning or emotions, please complete the following questionnaire in as much detail as you are comfortable. If necessary, you may attach additional sheets. The information will remain confidential and will save time in the early appointments.

Name of child_____ DOB: _____

Parent / Guardian completing this form: _____

Is the child: adopted fostered biological (Please circle which applies)

Please list name, relationship, and age of other household members:

1)_____

2)_____

3)_____

4)_____

Age of father _____ (If deceased, age when died and cause of death)
Father's occupation _____

Age of mother_____ (If deceased, age when died and cause of death)
Mother's occupation _____

Are/were the parents divorced? YES NO If yes, what age was the child when divorced? _____

Does the child have stepparents and/or a blended family? Please explain. _____
_____

List all siblings of the child and their ages, if not listed as a household member. _____

_____

Please list all current medications, including over the counter medications and supplements:

Medication Name: _____Dosage and frequency: _____
Reason for medication: _____How long used? _____

Medication Name: _____Dosage and frequency: _____
Reason for medication: _____How long used? _____

Medication Name: _____Dosage and frequency: _____
Reason for medication: _____How long used? _____

Medication Name: _____Dosage and frequency: _____
Reason for medication: _____How long used? _____

During conception, was the mother or father using any substances or taking any medications?
YES NO If yes, please list: _____

During pregnancy, did the mother smoke, drink alcohol or use substances? YES NO
Was a Caesarian section performed? YES NO

Was the child premature? YES NO If yes, by how many weeks? _____

Were there any birth defects or complications? _____

Were there feeding problems? YES NO (Explain)_____

Were there any sleeping problems? YES NO (Explain)_____

Were there any developmental problems or delays in the first five years? YES NO

If yes, please explain: _____

Who is your child's primary care physician? _____

How would you consider your child's present health? _____

What is the date of his/her last physical exam? _____List medical problems encountered: _____
_____
_____

List the date and type of in-patient and out-patient hospitalizations or surgeries your child has experienced:

Date: _____ Reason: _____

Date: _____ Reason: _____

Please list all substance abuse and mental health hospitalizations:

Date: _____ Facility: _____
Reason: _____Helpful? YES NO

Date: _____ Facility: _____
Reason: _____Helpful? YES NO

List any allergies, including medications: _____

What is your main concern today?
_____

How long have you had these concerns? _____
What have you tried to help with these difficulties? _____

Has the child received an evaluation or treatment for these or past concerns? YES NO

If yes, when and with whom? _____

Please circle any of the following that apply to your family:

Financial Stressors	Alcohol or drug use (parent)	Alcohol or drug use (child)
Family Violence	History of Abuse (parent)	History of abuse (child)
Death of a loved one	Major physical illness (parent)	Major physical illness (child)
Moved residences	Custody issues	Legal issues.

Please explain: _____

Does the child have cultural, ethnic, or religious needs that may impact treatment? YES NO

What are the child's major sources of emotional support? _____
_____

Please list the caregiver(s) for your child, besides parents (ex: grandparents, daycare, babysitter) _____

Is your child enrolled in school? Yes No

Name of school: _____ Grade: _____

List any school concerns, including special services, repeated grades, or behavior issues_____
_____

What subjects in school are most enjoyable? _____

What subjects are the most challenging? _____

Is your child active on social media? _____ How often and for how long? _____

Does your child participate in on-line gaming? _____ How often and for how long? _____

Describe difficulties with friends, past or present _____
_____

What disciplinary techniques are most effective? _____

What do you consider the child's assets and strengths? _____
_____

What would you like to have happened as a result of participating in counseling?
_____
_____

Please ra-te the following as never true, sometimes true, or often true for your child:

	Never	Sometimes	Often
Distractible, has trouble staying on task			
Fails to finish things			
Impulsive, acts without thinking			
Makes careless mistakes regularly			
Fidgets			
Feels restless, edgy			
Feels shaky, twitchy			
Suffers with confusion/indecisiveness			
Cranky/loses temper easily			
Defiant, talks back and argues with adults			
Blames others for his/her mistakes			
Easily annoyed by others			
Separation anxiety from loved ones			
Excessive worry			
Fear of criticism or fear of being embarrassed			
Afraid of making mistakes			
Lost interest in usual activities			
Feeling hopeless			
Feeling sad, unhappy or depressed			
More interested in things than people			
Headaches/Body aches			
Shortness of breath/holds breath			
Racing heart/palpitations			
Nausea, diarrhea, stomach pain			
Excessive need for order or counting things			
Excessive checking (doors, locks, etc)			
Inability to throw things away			
Excessive hand washing/fear of germs			
Difficulty sleeping			
Frequent nightmares			
Picky eater or excessive dieting			
Binge eating			
Excessive exercise			
Using laxatives or diuretics			
Self induced vomiting			
Wets Bed			
Difficulty with bowel control			
Sensitive to noise, lights, textures			
Self mutilation			

In response to a very stressful experience.

___repeated/unwanted memories.
___disturbing dreams
___feeling upset when reminded of event
___physical reactions to reminders
___avoidance internal/external reminders
___blame self.

___feeling distant/cut off
___super alert or on guard
___risky behavior
___negative beliefs about self, others, world
___strong negative feelings/lack of positive feelings.

Thank you. We look forward to working with you.

INFORMED CONSENT ADDENDUM FOR TELEMENTAL HEALTH

This is to be used in conjunction with, but does not replace, the Consent to Treat document that is required of all clients prior to starting therapy services.

What is Tele mental Healthcare?

Tele mental healthcare includes the practice of diagnosis, treatment, education, goal setting, accountability, referral to resources, problem solving, skills training, and help with decision making, through the use of internet-based videoconferencing or phone calls. Telehealth psychotherapy may include psychological health care delivery, consultation, coaching, and/or counseling. Telehealth psychotherapy will occur primarily through interactive audio, video, and telephone communications.

Risks of Tele mental Health

1. Technological failure, such as unclear video, loss of sound, poor connection, or loss of connection.

2. Nonverbal cues are less readily available to both the therapist and the client.

Benefits of Tele mental Health

1. Less limitations by geographical location.

2. Reduction of travel to a physical office, which includes decrease in travel time.

3. Participation in therapy from your own home or the environment of your choosing.

Tele mental health delivery by *Newark Granville Counseling, LTD* may occur only with current residents of Ohio. The current laws that protect privacy and confidentiality also apply to tele mental health. Any exceptions to confidentiality are described in the Informed Consent document.

All existing laws regarding client access to mental health information and copies of mental health records apply.

No permanent video or voice recordings are kept from tele mental health sessions. Clients may not record or store video conference sessions or face-to-face sessions.

Expectations of client during each session

1 Minimum bandwidth connection of 384 kb or higher. (generally, your phone will be sufficient)

2. Minimum resolution of 640x360 at 30 frames per second. (generally, your phone will be sufficient)

3.Operational web camera (HD 1080p is recommended). (generally, your phone will be sufficient)

4. Proper lighting and seating to ensure a clear image of each party's face.

5. Dress and environment appropriate to an in-office visit.

6. Only agreed upon participants will be present. The presence of any individuals unapproved by both parties and not part of the treatment plan will be cause for termination of the session.

7. The client must disclose the physical address of their location at the start of the session. Unknown locations will be cause for termination of the session. This is to ensure we are "meeting" at a place that will protect your confidentiality (no coffee shops, grocery stores, etc.). We may not meet while you are driving.

8. The client shall also provide a phone number where they can be reached in the event of service disruption.

Tele mental health may not be the most effective form of treatment for certain individuals or presenting problems. Arrangements to meet via telehealth must be made in advance. *Newark Granville Counseling Ltd* reserves the right to reject requests to meet via telehealth if the clinician does not think the situation is appropriate or is unable to organize the technology in time to meet client request.

Response to technical difficulties

Should technical difficulties cause session disruption, *Newark Granville Counseling* will contact the client via preferred telephone contact. If the technical difficulties can be resolved quickly, the session will resume, and the client will not experience a shortened session length. If the technical issues cannot be resolved in a timely manner, the session will be rescheduled for a time when functionality is restored. The client will be contacted by telephone to develop a plan for continuation of the session.

Payment

Session costs are outlined in the *Office and Financial Policy*. Please refer to that document for a more detailed discussion of session cost and payment.

Contact between sessions.

Video conference technology is reserved for therapy sessions only. Please refer to the Office and Financial Policy document for cost of contact outside of scheduled video conference sessions.

_____ _____

Client/Parent or Guardian's signature *Date*

Newark Granville Counseling, Ltd
945 River Rd., Granville, OH 43023-9169
Correspondence Address: PO Box 481, Granville OH 43023
Phone 740.587.5252 **Fax** 740.587.2571
www.ngcohio.com Email: office@ngcohio.com

CREDIT CARD PRE-AUTHORIZATION FORM

The current healthcare system requires the client to be financially responsible for a large portion of their healthcare needs. NGC is committed to making the billing and payment process as easy as possible. Our policy **requires all clients** to have a credit card on file. We will run the card for each co-pay, after the insurance processes the claim for those clients who do not have a copay or for self pay clients. We run our payments through a secure HIPAA compliant software where your information is stored in the processing companies' vault. For your protection, only the last four digits of your card will show in our system. You will receive an email receipt from each transaction which will come from *Practice Management Bridge*. (check spam/junk folder)

Cards on file will be used for, co-pay amount, co-insurance amount, unmet deductible amount, no show or late cancellation fee, and outstanding balances. If the outstanding balance is too large for one transaction, a payment plan may be worked out.

Please note if your card is declined there will be a $40 fee applied per declined transaction.

Client's Name: _____

Cardholder's Name: _____

Cardholder's Address: _____

City: _____ State: _____ Zip: _____

Credit Card Number: _____ Exp Date: _____

Cardholder's Signature: _____ Date: _____

If you would like a receipt emailed to you when your credit card is charged, please include your email address below.

Email address _____

Account #_____ (OFFICE USE)

Rev 12/23

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HSA CARD PRE-AUTHORIZATION FORM

The current healthcare system requires the client to be financially responsible for a large portion of their healthcare needs. NGC is committed to making the billing and payment process as easy as possible. Our policy **requires all clients** to have a credit card or HSA card on file. We will run the card for each co-pay, after the insurance processes the claim for those clients who do not have a copay or for self pay clients. We run our payments through a secure HIPAA compliant software where your information is stored in the processing companies' vault. For your protection, only the last four digits of your card will show in our system. You will receive an email receipt from each transaction which will come from *Practice Management Bridge*. (check your spam/junk folder)

Cards on file will be used for, co-pay amount, co-insurance amount, and any unmet deductible amount. **Please note for HSA cards**: no show/late cancellation fees cannot be charged to the HSA card on file. Those will need to be paid either by check, cash, or credit/debit card. If the outstanding balance is too large for one transaction, a payment plan may be worked out.

Please note if your card is declined there will be a $40 fee applied per declined transaction.

Client's Name: _____

Cardholder's Name: _____

Cardholder's Address: _____

City: _____ State: _____ Zip: _____

HSA Card Number: _____ Exp Date: _____

Cardholder's Signature: _____ Date: _____

If you would like a receipt emailed to you when your credit card is charged, please include your email address below.
Email address _____

Account #_____(OFFICE USE)

Rev 12/23