520 S. Main Street, Suite 2518
Akron, Ohio 44311
330-687-4439
www.yourstorycounsel.com

Patient Information

Date: _____

Client Name _____ _____ _____
First Name Middle Last

Date of Birth _____ Preferred Name/nickname _____Preferred Pronoun _____

Address _____ City _____ State _____ Zip _____

Phone Number: _____ Email: _____

Preferred contact method for appointment reminders: **TEXT** **EMAIL** **CALL**

*If a minor client, Mother's Name*_____ *Phone:* _____

Address (if different) _____

If a minor client, Father's Name: _____ *Phone*_____

Address (if different) _____

Do you give permission for therapist to contact phone? ____ Yes ____ No

Explain (if needed) _____

Patient Marital Status: Married Divorced Single Separated Widowed

Patient Employment: full-time part-time student unemployed

Emergency Contact(s)

Name _____ Relationship to Client _____

Preferred Phone Number _____

Client Medical and Birth Information

Primary Care Physician _____ Phone _____

Doctor's Office Practice Name _____

Date of last Physical Exam _____ Allergies _____

Please list any current medications _____

Physical Disabilities _____ Developmental Disabilities _____

Does client have a history of head injury? Yes, what? _____No _____

Does client (or family) have a history of alcohol or drug use/abuse? Yes _____No _____

Is there a family history of suicide? Yes _____No _____ (To be further discussed in first session)

Your Story
COUNSELING SERVICES, LLC
ABOUT YOU • YOUR CHILD • YOUR FAMILY

Primary Insurance Information

Client Name _____ _____ _____
Last Name **First Name** **Middle Name**

Client Date of Birth _____ **Client Social Security Number** _____

Who is insurance through? ☐ *Self* ☐ *Spouse* ☐ *Child* *Other:*_____

Who is insurance through? ☐ *Self* ☐ *Spouse* ☐ *Child* *Other:*_____

Name of Insured if different than client: _____

Insured Date of Birth _____ *Primary Insured Social Security Number* _____

Cell Number _____ *Home Number* _____

Address of Insured _____
Street *City* *State* *Zip*

Employer this insurance is through: _____

Insurance Company_____

Subscriber#, ID#, MMIS_____Group# _____

Copay _____ Deductible Amount _____

Assignment of Benefits and Insurance Release: I assign to Your Story Counseling Services, LLC (YSCS) my rights to any and all insurance benefits (private insurance or EAP as well as medicaid/medicare) to which I may be entitled for all services rendered by YSCS. I authorize any holder of mental health/behavioral health benefits to release to YSCS and its agents any information needed to determine these benefits. I understand that my signature requests that payment be made to YSCS and authorizes release of medical information necessary to pay the claim. I understand that I am responsible to pay directly to YSCS any copay, coinsurance, deductible, and non-covered services payments, and that these amounts are due at the time of service. I recognize the amount of copay, coinsurance and deductible and which services are covered are based on the particular insurance plan I have and determined by that company.

I understand that YSCS may disclose information necessary to be paid for mental health/behavior health services as permitted by law. I understand that may revoke this authorization at any time in writing, except to the extent action has been taken in reliance on it.

Client name (print) _____

Client or Guardian/Parent Signature _____ Date _____

Witness (office) _____

Your Story
COUNSELING SERVICES, LLC
ABOUT YOU • YOUR CHILD • YOUR FAMILY

IF NO SECONDARY INSURANCE PLEASE LEAVE THIS PAGE BLANK

Secondary Insurance Information

Client Name _____ _____ _____
Last Name **First Name** **Middle Name**

Client Date of Birth _____ **Client Social Security Number** _____

Who is insurance through? ☐ *Self* ☐ *Spouse* ☐ *Child* *Other:*_____

Name of Insured if different than client: _____

Insured Date of Birth _____ *Primary Insured Social Security Number* _____

Cell Number _____ *Home Number* _____

Address of Insured _____
Street *City* *State* *Zip*

Employer this insurance is through: _____

Insurance Company_____

Subscriber#, ID#, MMIS_____Group# _____

Copay _____ Deductible Amount _____

Assignment of Benefits and Insurance Release: I assign to Your Story Counseling Services, LLC (YSCS) my rights to any and all insurance benefits (private insurance or EAP as well as medicaid/medicare) to which I may be entitled for all services rendered by YSCS. I authorize any holder of mental health/behavioral health benefits to release to YSCS and its agents any information needed to determine these benefits. I understand that my signature requests that payment be made to YSCS and authorizes release of medical information necessary to pay the claim. I understand that I am responsible to pay directly to YSCS any copay, coinsurance, deductible, and non-covered services payments, and that these amounts are due at the time of service. I recognize the amount of copay, coinsurance and deductible and which services are covered are based on the particular insurance plan I have and determined by that company.

I understand that YSCS may disclose information necessary to be paid for mental health/behavior health services as permitted by law. I understand that may revoke this authorization at any time in writing, except to the extent action has been taken in reliance on it.

Client name (print) _____

Client or Guardian/Parent Signature _____ Date _____

Witness (office) _____

Your Story
COUNSELING SERVICES, LLC
ABOUT YOU • YOUR CHILD • YOUR FAMILY

CLINICIAN-CLIENT SERVICES AGREEMENT

Welcome to Your Story Counseling Services, LLC. This agreement contains important information about our professional services and business policies. The signed document will represent an agreement between you and the clinician and/or practice. You may revoke this agreement in writing at any time.

COUNSELING SERVICES: Psychotherapy/counseling is not easily described in general treatments. It varies depending on the personalities of the clinician and client, and the particular problems that you hope to address. Psychotherapy/counseling is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will need to work on those things discussed both during the sessions and at home.

Psychotherapy/counseling can have benefits and risks. It can often lead to better relationships, increased self-confidence, solutions to specific problems, and significant reductions in feelings of distress. Since therapy often involves discussing and gaining insight into unpleasant aspect of your life, one may experience uncomfortable feelings before more pleasant feelings and personal resolutions occur.

APPOINTMENTS/EMERGENCIES: Appointments are made through contact with your clinician or calling the office number at 330-687-4439. We are not always immediately available to answer the telephone but will return your call as soon as possible. Please call to cancel or reschedule at least 24 hours in advance. We reserve the right to apply our cancellation fee for a missed appointment (no-show) or late cancellation. Insurance will not reimburse for missed appointments. Appointments are 50-60 minutes long but may vary for clinical reasons. If you are more than 20 minutes late for a scheduled appointment, we cannot guarantee that we will be able to provide services. This will result in the appropriate cancellation fee being applied.

EMERGENCIES: If you or your child is experiencing suicidal thoughts, homicidal thoughts, or any other crisis situation, please call 911 for medical help or the National Suicide Prevention Lifeline at 988. If you are over age 18, you may contact your family physician or go to the emergency room at the nearest hospital. Your Story Counseling Services, LLC does not provide 24/7 phone or email monitoring.

CONFIDENTIALITY: The law protects the privacy of all communication between clients and their therapist. In most situations, your therapist can only release information about your treatment to another party if the client signs a written authorization form (Release of Information). There are some situations where we are permitted or required to disclose information with or without client authorization:

- If you are involved in court proceedings, the court may order information be released.
- A government agency may require information to be released.
- If a child or vulnerable adult is being neglected/abused, information may be released as required by law.
- If your clinician believes you are in danger of harming yourself or others, protective action may be taken, and may include contacting family members, seeking hospitalization, notifying the potential victims, and/or contacting the police.
- If a client files a complaint or lawsuit against us, we may disclose relevant information regarding that client in order to defend ourselves.

It may occasionally be helpful to consult with another health and/or mental health professional about cases. During consultation, every effort is made to avoid revealing identifiable information about the client. The other professional is also legally bound to keep information confidential. Administrative staff may also come in contact with protected information during scheduling, billing, or quality assurance. All the mental health professionals are bound by the same rules of confidentiality, and all staff members have been trained about protecting your privacy.

Your Story
COUNSELING SERVICES, LLC
ABOUT YOU • YOUR CHILD • YOUR FAMILY

PROFESSIONAL RECORDS: The laws and standards of our profession require that protected health information about you be kept in your clinical record. Your clinical record includes information about your reasons for seeking therapy, a description of the way in which your problems affect your life, your diagnosis, the goals of treatment, your progress toward these goals, your medical and social history, your treatment history, results of any clinical tests, past records from other providers, professional consultations, payment records, and a copy of any reports to other professionals. You may examine your clinical records and request a copy in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, it is recommended that you initially review them in the presence of the clinician or have them forwarded to another mental health provider so you can discuss the contents. In most circumstances, the law allows clinicians to charge $25 for copies (either digital or hard copy). Records are released except for rare occasions where, we believe, such a release could bring harm to yourself or someone else, in which case we will provide them to a psychologist or licensed mental health professional designated by you.

MINORS/CLIENTS UNDER 18: Clients who are under 18 years of age, along with their parents, should be aware that the law provides for parents to examine therapy records, absent a court order blocking a parent's access. However, our experience suggests that in order for many child/adolescent clients to feel comfortable in therapy, it is beneficial to offer them the opportunity to talk with the therapist and to know that what they tell the therapist will not be relayed back to their parents except in cases of imminent danger to the client or others, or where the therapist considers the information to be so serious that the parents' ultimate responsibility for the client's welfare dictates that the parents be kept informed.

By signing this agreement, you are agreeing to this informal waiver of your right to full disclosure of the minor's records. If you choose not to informally waive this right, please talk with the therapist about your concerns prior to signing this form.

Both parents must recognize that if a minor child was born to parents who were married at the time of birth, both parents typically hold privilege on all communication involving the child while in therapy, unless otherwise stated within a court order or other legal custody documentation. In Ohio, if the parents were not married at the time of child's birth, and the child is not in the custody/guardianship of the biological mother, court documentation of custody will be required per Ohio Administrative Code, Chapter 4757-5. All legal documents regarding custody, visitation, shared parenting, and any other such matters, MUST be on file before any sessions can occur. This ensures that those consent forms for minors are signed by legal custodians and information regarding a minor's treatment and sessions is only given to those who have legal access to such information.

LEGAL SITUATIONS: If you become involved in legal proceedings that will require clinician participation, you will be expected to pay for all professional time, even if we are called to testify by another party. The fees are:

- $250 for record preparations and communications
- $175 per hour (minimum of 2 hours) for testimony

Half of the expected fees are due one week (no less than 7 days) prior to providing these services, and the second half plus any additional fees that may have accrued is due 24 hours before services are delivered.

BILLING AND PAYMENTS: You are expected to pay for each session (full charge or copay, coinsurance, or deductible as dictated by your insurance policy) at the time the session is held. Please see the Your Story Counseling Services, LLC Service Fees form given to you at intake, or ask for a copy at the time of your appointment for a list of potential fees.

If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, Your Story Counseling Services, LLC has the option to enlist an attorney or collections company to secure the payment. If your account falls behind more than two (2) sessions, we reserve the right to cancel/reschedule all appointments until payment is made in full. If you are having trouble meeting your financial obligations with our office, please contact the Office Manager to make payment arrangements. It may be possible to continue appointments while catching up on a balance, at the discretion of administration.

Your Story
COUNSELING SERVICES, LLC
ABOUT YOU • YOUR CHILD • YOUR FAMILY

INSURANCE AND REIMBURSEMENT: Most major medical insurance plans provide some coverage for mental health treatment. Ultimately, however, you, as our client, and not your insurance company, are responsible for clinician fees, as allowable by law and by each individual health insurance contract. We will assist, as we are able, to understand the benefits to which you are entitled, including copays, coinsurance, and deductible amounts.

You should be aware that in the process of billing the insurance company, a clinician is required to provide it with relevant clinical information. This is usually limited to appointment time, date, and duration, but also may include diagnosis or treatment plans or summaries. We will only release the required amount necessary to bill and secure the payment on your behalf.

Under changes to HIPAA 2009, you have the right to elect to NOT use insurance when seeing a therapist. In this case, we will not disclose information to your insurance company. If you elect to forego using insurance, the full fee for each appointment is due at the time of service.

CANCELLATION AND NO-SHOW POLICY: A cancellation or request to reschedule that is made less than 24 hours in advance will incur a cancellation fee. On July 1, 2023, this fee increased to $65 per occurrence. This fee includes those who are no-show for their appointment.

By signing this document, you are indicating that you have read this agreement and agree to the terms. You consent for Your Story Counseling Services, LLC to conduct an assessment and provide mutually agreed upon, medically necessary services. You have received an explanation about the risks and benefits of any proposed services, alternative services, and the risk of having no services at all.

Client name (print) _____

Client or Guardian/Parent Signature _____ Date _____

Witness (office) _____

NOTICE OF PRIVACY PRACTICES - HIPAA
Effective Date: August 16, 2019

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. If you have any questions about this notice, please contact Your Story Counseling Services, LLC Directly.

OUR DUTIES
At Your Story Counseling Services, LLC, we understand that health information about you and your health is personal. We are committed to protecting health information about you and safeguarding that information against unauthorized use or disclosure. We are required by law to:

- maintain the privacy of your health information.
- provide you notice of our legal duties and privacy practices with respect to your health information.
- to abide by the terms of the notice that is currently in effect.
- to notify you if there is a breach of your unsecured health information.

HOW WE MAY USE AND DISCLOSE YOUR PERSONAL HEALTH INFORMATION
When you receive service from Your Story Counseling Services, LLC, health information is collected and created about you. We may receive, use, or share your health information for such activities as payment for services provided to you, conducting our internal health care operations, communicating with your healthcare providers about your treatment and for other purposes permitted or required by law. The following are examples of the types of uses and disclosures of your personal information that we are permitted to make:

- *Payment*· We may use or disclose information about the services provided to you and payment for those services for payment activities such as confirming your eligibility, obtaining payment for services, managing your claims, utilization review activities and processing of health care data.
- *Health Care Operations* - We may use your health information to train staff, manage costs, conduct quality review activities, perform required business duties, and improve our services and business operations.
- *Treatment* - We may share your personal health information with your health care providers to assist in coordinating your care.
- *Other Uses and Disclosures* - We may also use or disclose your personal health information for the following reasons as permitted or required by applicable law: To alert proper authorities if we reasonably believe that you, your child/ward, or any other person may be a victim of abuse, neglect, domestic violence or other crimes; to reduce or prevent threats to public health and safety; for health oversight activities such as evaluations, investigations, audits, and inspections; to governmental agencies that monitor your services; for lawsuits and similar proceedings; for public health purposes such as to prevent the spread of a communicable disease; for certain approved research purposes; for law enforcement reasons if required by law or in regards to a crime or suspect; to correctional institutions in regards to inmates; to coroners, medical examiners and funeral directors (for decedents); as required by law; for organ and tissue donation ; for specialized government functions such as military and veterans activities, national security and intelligence purposes, and protection of the President; for Workers' Compensation purposes; for the management and coordination of public benefits programs; to respond to requests from the U.S. Department of Health and Human Services; and for us to receive assistance from consultants that have signed an agreement requiring them to maintain the confidentiality of your personal information. Also, if you have a guardian or a power of attorney, we are permitted to provide information to your guardian or attorney in facto.
- *Uses and Disclosures That Require Your Permission* - We are prohibited from selling your personal information, such as to a company that wants your information to contact you about their services, without your written permission. We are prohibited from using or disclosing your personal information for marketing purposes such as to promote our services, without your written permission. All other uses and disclosures of your health information not described in this notice will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission. we will

no longer use or disclose your health information for the purposes stated in your written permission except for those that we have already made prior to your revoking that permission.

PROHIBITED USES AND DISCLOSURES

If we use or disclose your health information for underwriting purposes, we are prohibited from using and disclosing the genetic information in your health information for such purposes.

POTENTIAL IMPACT OF OTHER APPLICABLE LAWS

If any state or federal privacy laws require us to provide you with more privacy protections than those explained here, then we must also follow that law. For example, drug and alcohol treatment records generally receive greater protections under federal law.

YOUR RIGHTS REGARDING YOUR PERSONAL HEALTH INFORMATION

You have the following rights regarding your health information (requests must be made in writing):

- *Right to Request Restrictions* - You have the right to request that we restrict the information we use or disclose about you for purposes of treatment, payment health care operations and informing individuals involved in your care about your care or payment for that care. We will consider all requests for restrictions carefully but are not required to agree to any requested restrictions.
- *Right to Request Confidential Communications* - You have the right to request that when we need to communicate with you. we do so in a certain way or at a certain location. For example, you can request that we only contact you by mail or at a certain phone number.
- *Right to Inspect and Copy* - You have the right to request access to certain health information we have about you. Fees may apply to copied information.
- *Right to Amend* - You have the right to request corrections or additions to certain health information we have about you. You must provide us with your reasons for requesting the change.
- *Right to An Accounting of Disclosures* - You have the right to request an accounting of the disclosures we make of your health information, except for those made with your permission and those related to treatment, payment, our health care operations, and certain other purposes. Your request must include a timeframe for the accounting, which must be within the six years prior to your request. The first accounting is no charge, but a fee will apply if more than one request is made in a 12-month period.
- *Right to a Paper Copy of Notice* - You have the right to receive a paper copy of this notice. You may obtain a paper copy by contacting the Your Story Counseling Services, LLC office or making an in-person request.

CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. We reserve the right to make the revised notice effective for health information we already have about you as well as any information we receive in the future. The effective date of each notice is listed above.

TO FILE A COMPLAINT

If you believe your privacy rights have been violated, you may file a complaint with the Your Story Counseling Services, LLC (see above) or with the Secretary of the Department of Health and Human Services. To file a complaint with Your Story Counseling Services, LLC, contact us directly. You will not be retaliated against for filing a complaint. If you wish to file a complaint with the Secretary you may send the complaint to: Office for Civil Rights, U.S. Department of Health and Human Services, Attn: Regional Manager 233 N Michigan Ave, Ste 240, Chicago, IL 60601.

Your Story
COUNSELING SERVICES, LLC
ABOUT YOU • YOUR CHILD • YOUR FAMILY

MY RIGHTS

- The right to be treated with consideration and respect for personal dignity, autonomy, and privacy
- The right to service in a humane setting which is the least restrictive feasible as defined in the treatment plan
- The right to be informed of one's own condition, of proposed or current services, treatment or therapies
- The right to consent to or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent to or refuse any service, treatment or therapy on behalf of a minor client
- The right to be informed and the right to refuse any unusual or hazardous treatment procedures
- The right to a current written treatment plan
- The right to active and informed participation in the establishment periodic review, and reassessment of the service plan
- The right to freedom from unnecessary or excessive medication
- The right to freedom from unnecessary restraint or seclusion
- The right to participate in any appropriate and available agency service, regardless of refusal of one or more other services, treatments or therapies, or regardless of relapse from earlier treatment in that or another service, unless there is a valid and specific necessity which precludes and/or requires the client's participation in other services
- The right to be advised of and refuse observation by techniques such as one-way vision mirrors, tape recorders, other video or audio recording, televisions, movies, or photographs
- The right to have the opportunity to consult with independent treatment specialists or legal counsel at one's own expense
- The right to confidentiality in accordance with state law
- The right to confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of client information under state and federal laws and regulations
- The right to have access to one's own psychiatric, medical, or other treatment records, unless access to particularly identified items of information is specifically restricted for that individual client for clear treatment reasons
- The right to be informed in advance of the reasons for discontinuance of service provision, and to be involved in planning for consequence of that event
- The right to receive an explanation of the reasons for denial of service
- The right to be not discriminated against in the provision of service based on religion, race, color, creed, sex, national origin, age, lifestyle, physical or mental handicap, developmental disability, or inability to pay
- The right to know the cost of services
- The right to be fully informed of all rights
- The right to exercise any and all rights without reprisal in any form including continued uncompromising access to service
- The right to file a grievance
- The right to have oral and written instructions for filing a grievance
- The right to have a second opinion and
- The right to request another therapist

Your Story
COUNSELING SERVICES, LLC
ABOUT YOU • YOUR CHILD • YOUR FAMILY

ACKNOWLEDGEMENT OF CLIENT RIGHTS AND HIPAA PRIVACY PRACTICES

I have received a copy of the HIPAA privacy practices and client rights and have had the ability to review them.

Client name (print) _____

Client or Guardian/Parent Signature _____ Date _____

Witness (office) _____

CONSENT FOR SERVICES

I consent for Your Story Counseling Service, LLC to conduct an assessment and to provide mutually agreed upon, medically necessary services. I have received an explanation about the risks and benefits of any proposed services, alternative services, and of having no services at all.

Client name (print) _____

Client or Guardian/Parent Signature _____ Date _____

Witness (office) _____

Your Story
COUNSELING SERVICES, LLC
ABOUT YOU • YOUR CHILD • YOUR FAMILY

Informed Consent for In-Person and Telehealth Services

Client Name _____ Date of Birth _____

Therapist Name _____ Location (circle) MAIN OFC. SCHOOL

MEETING IN PERSON

Sessions can be in person or via telehealth, which can be via video or phone call, as clients and clinicians together agree. You understand that by coming to the office, there is a risk of exposure to the COVID-19 or other communicable illnesses. Meeting in person, you and your clinician agree to the following to keep each other safer from exposure and sickness.

- You will keep your in-person appointment only if you are symptom free. If you have symptoms of illness, please contact your clinician as soon as you can, to switch your appointment to telehealth. Switching to telehealth will not incur late-cancellation fees. You have the right to cancel your appointment instead of telehealth, but doing so may incur late-cancellation fees.
- If you are bringing a child in, please be sure that they have not been exposed to any illnesses or viruses, and that they are following handwashing/sanitizing protocols to limit spread of any illness.
- If you, a minor client, or anyone in your family is positive for COVID-19 infection or other severe illness (examples: influenza, stomach viruses), you will let your clinician know so they can select telehealth until all household members are well.

Our practice is committed to the same above measures to ensure everyone stays as healthy as possible. Please let us know if you have questions about this effort.

TELEHEALTH

Telehealth appointments involve the use of electronic communications to enable clinicians and clients to conduct appointments when they are in different locations. Electronic systems used will contain integrated network and software security protocols to protect the confidentiality of client identification and safeguard data, ensuring integrity against intentional or unintentional corruption.

Please note that there are privacy and confidentiality risks involved with unencrypted electronic communications. Please do not share protected health information via email or text, and if you do so, your signature here shows you are aware of the risks and agree to hold Your Story Counseling Services, LLC harmless for any resulting damages.

Any computer files regarding our communications are maintained using secure and encrypted measures.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

I have read and understand the information provided above regarding meeting in person and telemedicine.

Client name (print) _____

Client or Guardian/Parent Signature _____ Date _____

Witness (office) _____

Your Story
COUNSELING SERVICES, LLC
ABOUT YOU • YOUR CHILD • YOUR FAMILY

Your Story Counseling Service, LLC Service Fees
Effective January 2022

The Federal No Surprise Act of 2022 requires medical providers such as Your Story Counseling Service, LLC (YSCS) to provide a good faith estimate for self-pay and out-of-network patients. Below you will find fees for the various services YSCS provides.

SERVICE	FEE
Diagnostic and Evaluation Session (first visit)	$156
Individual Therapy Session (one hour)	$152
Individual Therapy Session (45 minutes)	$120
Individual Therapy Session (30 minutes or less)	$96
Group Therapy	$50

- Additional fees could apply due to the length and/or complexity of the session. If you would like additional information regarding these fees, it will be provided to you.

Easy Ways to Make Your Payments

Pay online:
Look up our website: www.yourstorycounsel.com
At the top, click on MORE, and then FORMS OF PAYMENT. In the middle of that page, click on PAY NOW next to the feather logo. Enter the amount, client name and therapist, and method of payment. Click on PAY NOW.

You should receive notification that the payment has been processed. The office will also receive notice; this will be credited to your account within 24 business hours.

Pay via phone:
Call 330-687-4439 to reach Jennifer the Office Manager. She will verify the amount owed. You can pay over the phone. NOTE: at this time we do not keep credit card numbers on file for current or future charges.

Pay in the office:
You can pay directly with the receptionist or scan the QR code in the corner of the desk to be taken to the payment webpage.

Client name (print) _____

Client or Guardian/Parent Signature _____ Date _____

Witness (office) _____