Sarah R. Sacks Inc.

Consent for Treatment

This is to acquaint you with the policies of this practice as well as to establish consent for treatment. Please read and sign this agreement. Feel free to ask for any clarification needed. Your signature means you were informed, understand, and agree to all items listed below as of the date indicated.

Session are 45 to 50 minutes and are billed at a rate of $165.00 or based on insurance contract rates. This will be discussed and agreed upon the initial consultation. There will be a $35.00 charge for any bank charges on returned checks. Any copies of documents request by the court or other authorities will be billed at $100.00 per report.

There will be a $75.00 charge for all urinalysis procedures.

If you are unable to keep an appointment or attend group, please notify the office as soon as possible If you are unable to reach a staff member, please leave a message at 561-575-2020. There will be a $50.00 charge for any cancellations, less than 24 hours in advance or no shows.

Court appearances, depositions and conferences with attorneys are billed at a rate of $300 per hour portal to portal. Ultimately this fee is your responsibility and is payable in advance.

In an emergency, please call 911. Crisis care may also be obtained by calling the Crisis hotline at (561) 383-1111 or at the following locations:

- Jupiter Medical Center
  1210 South Old Dixie Hwy, Jupiter
- St. Mary's Institute for Mental Health
  901 45th Street, West Palm Beach
- JFK Medical Center North
  2201 45th Street, West Palm Beach

I authorize treatment and acknowledge consent to be treated.

Client Signature: _____ Date: _____

Sarah R. Sacks, Inc

Notice of Privacy Practice

The Notice of Privacy Practice, HIPAA (Health Insurance Portability and Accounting Act, 4/2003) is posted. If you would like a copy, please request one. Any disclosure regarding your treatment will be in a manner to respect your confidentiality.

Confidentiality is an essential component of therapy. However, there are legal limits to confidentiality. Issues involving the abuse of children, the elderly, or the mentally or emotionally handicapped will be reported to the Department of Children and Families. Also, therapists have a duty to warn and a duty to protect should you become a danger to yourself or another. In these instances, confidentiality cannot be kept.

No information pertaining to your treatment will be released without either your informed consent or court order. Please be aware that once information is released, it is no longer confidential. Medical records or summary letter of your treatment experience will be released to you based upon clinical appropriateness. An appointment will need to be scheduled with your primary therapist to discuss any release of records.

Closest living relative (does not live with you): _____

Address: _____Phone#: _____

Are we able to speak with this person in case of an emergency? ☐ Yes ☐ No

If No, Emergency Contact: _____ Relation: _____

Phone#: _____ Alternate#: _____

What number can we use to confirm your appointment? : _____

I understand and agree to the terms of the privacy practice.

Client Signature: _____ Date: _____

Sarah R. Sacks Inc

Client Information

Name: _____

Address: _____

City: _____ State: _____ Zip code:_____

Phone #: Home: _____ Work: _____ Cell: _____

Date of Birth: _____/_____/_____ Social Security#: _____-_____-_____

Email Address: _____

Marital Status: ___ Married ___ Single ___ Divorced ___ Widowed

Employment Status: ___ Full time ___ Part time ___ Student ___ Unemployed ___ Retired

If Employed, Name: _____

Employer's Address: _____

Who Referred you to us?: _____

Insurance Information

Name of Subscriber: _____

Address: _____

City: _____ State: _____ Zip code:_____

Phone #: Home: _____ Work: _____ Cell: _____

Date of Birth: _____/_____/_____ Social Security#: _____-_____-_____

Employer: _____

Name of Insurance Company: _____

Telephone #: _____ Member ID#:_____

Policy/Group #: _____ Authorization#: _____

Authorization of Benefits

I authorize the release of any medical or psychiatric information necessary to process my insurance claims. I also authorize payments to Sarah R. Sacks, LCSW CAP and Oceana Counseling for professional service rendered.

Client Signature: _____ Date: _____

Sarah R. Sacks, Inc
Medical Health History

Client Name: _____

Date of Birth: _____ Height: _____ Weight: _____

Eye Color: _____ Hair Color: _____ Ethnicity: _____

Have you ever experienced:

_____ Heart disease or attack
_____ Hospitalization last five (5) years
_____ Asthma or hay fever
_____ Diabetes
_____ Epilepsy or seizure disorder
_____ Attention deficit or hyperactivity
_____ Chronic Cough
_____ Tuberculosis
_____ Kidney or urinary infection
_____ Stomach or bowel disorder
_____ Eye injury
_____ Backache or back trouble

_____ Chronic medical illnesses
_____ Rheumatic Fever
_____ High or low blood pressure
_____ Varicose Veins/ Leg Ulcers
_____ Jaundice or hepatitis
_____ Skin problems
_____ Ulcers
_____ Cancer
_____ Frequent headaches
_____ Head injury
_____ Dizziness/ Fainting
_____ Amputation, any body part

If any answers above are "yes", please list diagnosis, dates, physician's name, hospital, and location:
_____
_____
_____

_____ Have you attempted suicide?
_____ Are you presently taking medications?
_____ Do you or have you ever used tobacco?
_____ Do you consume alcohol and how often?

If "yes", please explain:_____

Allergies: Food: _____
Medicine/Drugs: _____
Other things: _____

Name of Primary Physician: _____

Address: _____ City: _____ State: _____ Zip: _____

Client Signature: _____ Date: _____

Acknowledge of Financial Responsibility

Payment for services is expected, at the time of visit, unless prior arrangements have been made.

We accept cash, check, Master Card, Visa, American Express or Discover for payment. If credit card is used there will be a 3% service charge. I am responsible for any amount my insurance doesn't cover.

I authorize Sarah R. Sacks, LCSW CAP to release any information requested from the insurance company regarding processing my claim for services.

I understand that I am responsible to pay for the services rendered, including reasonable attorney's fees and cost of collection in the event of default of payment from your insurance company. I further understand that if the payment becomes 30 days past due, delinquency charges will be calculated at the annual rate of 18% or the maximum allowable rate, will be due on delinquent amounts from the date the payment was due from your insurance contract.

Client Signature: _____ Date:_____

Date of Birth: _____/_____/_____ Social Security #:_____-_____-_____