CROSSWAY COUNSELING
CHILD CLIENT INTAKE

Name _____ Date _____
First Middle Last

DOB _____ Age_____ Grade _____ School attending_____

Lives with _____ Main Phone # _____

Address_____City:_____State:____Zip:_____

Child is: Biological Adopted Parents are: Married Separated Divorced

Legal Guardian_____

Father _____ DOB _____
Father's Address _____ City_____State____Zip_____
Father's Employer _____ Father's Occupation_____
Father's Main Phone# _____
StepParent's Name _____Employer & Occupation_____

Mother _____ DOB _____
Mother's Address _____City_____State____Zip_____
Mother's Main Phone # _____
Mother's Employer_____ Mother's Occupation_____
StepParent's Name_____ Employer & Occupation_____

Primary Insured's Full Name _____ DOB _____
Primary Insured's Address_____
Primary Ins.'s Phone #_____Relationship to client_____
Employer_____ Insurance Company _____
Group# _____Contract/Policy #_____

Secondary Insured's Full Name_____ DOB_____
Sec. Insured's Address_____
Sec. Insured's Phone#_____Relationship to client_____
Employer_____ Secondary Insurance Company_____
Secondary Ins. Contract/Policy#_____ Secondary Group#_____

Person to contact in case of emergency _____
Phone # _____ Relationship to client _____

List all members of your family and all others living in the home:

Name	Age	Relationship

Have major changes of any kind occurred in your family during the past **five** years (moves, changes in family composition, changes in schools, illness/disability, etc.):

_____

Has there been any counseling for the client and/or anyone else in the family in the past? Yes No If yes, who? _____
When? _____ Where? _____

List any significant health problems for which the client is currently receiving treatment:

_____

Is the child on medication? Yes No If yes, please name the medication, dosage and Prescriber_____

_____

Child's Primary Physician _____

Who referred you to Crossway Counseling today _____

Church attendance: Yes No Where?_____

Briefly describe your reason(s) for seeking help today and what you hope to gain or to change by coming:

_____

_____

Pease circle any of the following problems that pertain to the client. What **Date** did these problems start? : _____

Anxiety	Depression	Fear	Shyness
Health problems	Sexual issues	Self-Harm	Loneliness
Grades	Divorce	Anger/Temper	Friendships
Self-Control	Relaxation	Stress	Lack of Ambition
Making decisions	Insomnia	Attention/Focus	Behavioral Issues
Inferiority feelings	Eating Disorder	Traumatic Event	Social Skills
Alcohol Use	Homicidal thoughts	Appetite	Headaches/Migraines
Drug Use	Suicidal thoughts	Fatigue	Stomach Troubles
School	Nightmares	Separation	Intrusive Thoughts
Grief	Unhappiness		

Other_____

INFORMED CONSENT DOCUMENT

THERAPIST-CLIENT AGREEMENT

Welcome to CrossWay Counseling Center! This document contains important information about our professional services and business policies. Please read it carefully. **Sign, initial and date where specified**. If you have any questions, please bring them up during your initial session.

Psychotherapy is not easily described in general statements. It varies depending upon the personalities of the therapist and client, and the particular problems that you are experiencing. There are many different methods that may be used to deal with the problems that you hope to address. Psychotherapy 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 effective, you will have to work on things that are talked about both during the session and at home. Psychotherapy can have benefits, as well as risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, etc. These tend to lessen as individuals make progress toward their goals. Psychotherapy has been shown to have many long-term benefits. It often helps the person to have better relationships, find solutions to specific problems, and reduce feelings of distress. However, there are no guarantees of what you will experience.

Standard sessions are 53 minutes. However, the length of your session may be determined by your insurance company, so some sessions could be shorter than the standard session. It may be helpful for you to bring up important issues in the beginning of the session, so the issues can be adequately addressed within your scheduled session. It is also helpful for you to remain aware of the time passing, and for you to bring up important issues in the beginning of the session so that they can be adequately addressed. To ensure confidentiality and for professional courtesy, please do not continue to discuss issues at the front window checking out or scheduling your next appointment.

If you are seeking Individual or Marital/Couple treatment, the first few sessions will involve an evaluation of your needs. Depending on the therapist, this may include an in-depth clinical interview and possibly Psychological, Personality or Prepare-Enrich (for couples) testing. (Some of these assessments are not covered by insurances, so please speak to your therapist with any concerns).

For Marital/Couple sessions, some will include individual sessions and some couple sessions (this is determined by the therapist). In both Individual and Marital/Couple sessions, we will identify specific treatment goals and discuss both the treatment approach and plan to be implemented in the initial sessions. You should carefully evaluate this information along with your own commitment of time, money, and energy, and we welcome you to initiate concerns in these areas whenever they arise.

You are strongly encouraged to put daily effort into the things discussed, rather than only working on your issues during sessions. You will typically be given homework assignments at the end of each session. The more effort you put into completing these, the more quickly you may reach your treatment goals. Please bring your homework back to the next session.

If you have doubts on your progress in therapy, please communicate that to your therapist. Your therapist will be glad to help you set up a meeting with another mental health professional for a second opinion.

If you are seeking Family therapy or therapy for a Child/Adolescent, the initial session should be with the parent(s) alone, with the child attending the second session.

If there is a legal documentation of custody, this must be given to the office before a session can be scheduled for the child. A copy of the custody order and right to consent for mental health treatment will be required to remain in the child's file. If a grandparent or other adult will be bringing the child to counseling, proper documentation from a custodial parent must be signed in person by the custodial parent prior to the child being seen.

After rapport has been established with the child, depending on the therapist,

psychological/personality testing may be performed to further assess needs and treatment options (Some assessments are not covered by insurance, so please speak to your therapist with any concerns).

Upon the start of each session with a child/adolescent, the therapist usually speaks with the parents/guardians for the initial 10 minutes of each session, then spend a significant portion of the remainder of the session with the child, and possibly the final portion with either the parents/guardians alone or with the client.

After assessing the presenting problem, it is our goal to help the family in choosing the right strategy to assist them in managing the issues which brought them here. By involving everyone in this process (including the child), everyone feels both a part of the solution and that they have some sense of control in their lives. Your presence and participation communicates to the child that you care and love them enough to be a meaningful part of their efforts. It also communicates to the child that counseling is important, which will make it more likely that they too will perceive it as important. It is you who will be implementing the strategies and techniques you will learn, and who will be supporting your child's efforts toward change once you go back home.

Therapy with children is viewed as a "systems approach," meaning that the family unit functions as a system comprised of everyone working together. It is important that the child understand the importance of owning their own behaviors and taking responsibility without being labeled the "problem to be fixed." Many times changing simply dynamics in the way a family system operates is very helpful to bring about rapid change in children.

Your feedback is extremely vital to the success of this process. It is helpful to have your thoughts organized and perhaps in a list so that we can make the most of our time together. Being aware of the time and expressing your thoughts in a concise manner is important so that we then have ample time to address your concerns and that I have adequate time to work with the child. It is not advised that you wait until the final moments of a session to bring up topics which require significant amounts of time. If the session is not enough time to get it all out or you feel you would like extended time, it is helpful and appropriate to schedule a separate session with just the parent(s) or a family session.

COUNSELOR AVAILABILITY:

Therapists are often not immediately available by telephone. We will not answer the telephone or return messages if we are in session. When we are unavailable, you may leave a message with the secretary/office manager, and we will make every effort to return your call within 24-48 hours, with the exception of Fridays, Weekends and Holidays. **If you are unable to reach your therapist and feel that you cannot wait for them to return your call, then contact your family physician, call 911, call 988 or go to the nearest hospital emergency room. If an emergency arises after-hours, go to your nearest emergency room, call 911 or 988.**

If your therapist will be unavailable for an extended period of time, then they will provide you with a name of a colleague to contact, if necessary.

DO NOT LEAVE URGENT MESSAGES OR REQUESTS WHICH NEED TO BE ADDRESSED IN A TIMELY MANNER ON YOUR THERAPIST'S VOICEMAIL (Therapists only check these messages during office hours on days that they are at Crossway). If you have an urgent need during office hours, leave this information with our secretary/office manager or on her voicemail.

Emails and faxes are checked by our office manager and then distributed to the therapist. Therefore, there may be a significant delay in getting any information you send via these methods. Be aware that if you use email, voicemail, or fax communications, these are not secure and can break confidentiality. DO NOT USE FAX OR EMAIL TO CANCEL AN APPOINTMENT, REPORT THAT YOU WILL BE LATE FOR AN APPOINTMENT, OR REQUEST TO RESCHEDULE AN APPOINTMENT. YOU MUST ONLY ADDRESS THESE CONCERNS VIA THE OFFICE MANAGER BY PHONE.

OFFICE HOURS:

Office hours for our Secretary/Office Manager are typically 8:00 a.m. until 5:00 p.m. Monday through Thursday, and 8:00 a.m. until 12 p.m. Friday, with the exception of Holidays.

Lunch hours are usually between 12:00 p.m.-1:00 p.m. at which time our phones will not be answered. (However, these are not therapist office hours. Each therapist at Crossway have different schedules.)

FINANCIAL POLICY/BILLING & PAYMENTS:

Standard sessions (usually 53 minutes) are $140.00. Payment must be made at the time of service. You will need to check with your insurance company to determine if pre-authorization for services is required and if said services are covered under your contract by a Licensed Professional Counselor or Licensed Marriage &/Family Therapist. Our office is happy to file insurance claims to receive payment for our time, but only if your therapist has a contract with your insurance company. Your copayment is due at the time of your visit.

If there is a problem collecting payment from your insurance or managed care company for the balance, you remain responsible for payment of the full fee for each visit. If we have not received payment from your insurance or other third party payer within eight weeks of any counseling session, **we will charge the credit card on file or bill you directly for past and for ongoing visits at the customary fee of $140 per standard session.**

The charge for Psychological testing with the Personality Assessment Inventory is $140.00. ADD/ADHD testing using the TOVA is $155.00.

In circumstances of unusual financial hardship, we may be willing to negotiate a fee adjustment or payment plan. You are encouraged to speak with your therapist as soon as finances become an issue so that an alternate agreement can be worked out and your sessions will not be interrupted. If an agreement cannot be reached, then we will be happy to assist you in finding help elsewhere so that your needs are best met. If you have worked out an alternate payment plan with our office, the full negotiated fee is owed at the time of service. If you have an outstanding balance, a payment will need to be made on the balance at each visit beyond the amount of your co-payment.

A 24 hour notice is required for canceling or rescheduling appointments. If not given a 24 hour notice, $85.00 for missed appointments will be charged on your credit/debit card on file (exceptions would be sudden sickness or death in family, or other event which is sudden and could not have been foreseen.). The missed appointment charge must be paid BEFORE another appointment can be scheduled with your therapist or any other therapist. Unfortunately, your insurance company does not pay claims for missed visits.

If you will be late for your scheduled appointment, please call and let us know. If you are more than 15 minutes late, we will assume that you are not coming, and will take the liberty to fill your slot or may leave the facility for personal reasons. You will be charged $85 for not showing for your visit in this instance.

If you have missed a scheduled visit and you do not call our office to reschedule within 14 days, we will accept that as your notice that you have terminated this agreement and that you wish to discontinue counseling with our office. You may call at any time, however, to schedule another session for evaluating your needs and goals. If you have a financial balance on your account, this needs to be paid before setting up another appointment.

If your account balance is delinquent past 30 days and no effort has been made on your part to make arrangements for a payment plan with our office, your credit/debit card on file will be charged for the balance. If the card does not work, your account may be turned over to a collections agency. So, keeping your contact information up to date with our office is extremely important.

All credit/debit cards will be charged a 3% processing fee with each transaction. This fee is collected by our credit card processor by our credit card company.

OTHER FEES:

In addition to psychotherapy, we charge a standard session fee ($140.00) for other professional services that you may need. These services may include but are not limited to writing reports, preparing treatment summaries, and consulting with other professionals involved

in your care (where written consent has been provided). We will break down the cost if we work for periods of less than one hour. Please understand that requests for reports, letters, or paperwork of any kind should be submitted at least 2 weeks in advance.

If you, or someone else (another counselor, your lawyer, etc.), needs a copy of your records that may be legally necessary, our office charges $.25 per page for copying, plus postage. If our office is required to provide a verbal report, for example by telephone to your physician, a 10 minute consultation will not be charged. If the consultation exceeds 10 minutes, our office charges $40 per 15 minute increment. If our office must produce a written report or letter, the same fee will be billed for the time spent reviewing your file and drafting and publishing the report.

Our office also charges a $30 fee for checks that are returned unpaid for any reason.

Telephone calls from clients that are in dire need outside of scheduled appointments may be accepted depending on therapist availability. There is no charge for a phone call that lasts 10 minutes or less. For telephone consultations that require more than 10 minutes, our office charges $40.00 for each 15 minute increment. These fees are due and payable when they are incurred, but must be paid by the time of your next scheduled visit; insurance does not pay for telephone consultations. There may also be times when you want your counselor to read documents that will help with understanding you. If reading such documents requires extensive time, your counselor may bill you for that time. Telephone consultations on your behalf with other professionals or approved individuals that last more than 10 minutes will be billed to you at the same rate as stated above.

If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for all of their professional time, including preparation and transportation costs, even if they are called to testify by another party. (Please ask before setting up an appointment if a therapist will go to court because some of our therapists do not and will not go to court or participate in legal proceedings.) Because of the difficulty of legal involvement, we charge $200.00 PER HOUR for preparation, travel and attendance at any legal proceeding. There is a $500 non-refundable charge upfront that must be paid in full before the court date or legal proceedings.

LIMITS OF CONFIDENTIALITY:

The law protects the privacy of all communications between a client and therapist. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets the legal requirements imposed by HIPPA. There are other situations that require only that you provide written, advance consent. Your signature on this form provides consent for those activities as follows:

You will need to be aware that we employ administrative staff. In most cases, we need to share protected health information with these individuals for purposes of scheduling, billing, and quality assurance. All staff members have received training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff person and the client. Disclosures required to collect overdue fees.

If a client threatens harm to him/herself, we may be obligated to seek hospitalization for him/her, or to contact family members or others who can provide protection.

If you choose to contact our emergency line after hours, you will be contacted by the therapist on call, which may or may not be your therapist. While the therapist on call will protect your privacy as a professional, your call will acknowledge to them your being a client of your therapist and currently receiving services.

There are some situations where we are permitted or required to disclose information without your consent or authorization: If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is usually protected by the psychologist-client privilege law. We cannot provide any information without your (or your legal representative's) written authorization or a court order. If you are involved or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order the therapist to disclose information.

If a client files a complaint or lawsuit against your therapist, we may be required to disclose relevant information regarding that client in order to defend them self.

If a client files for worker's compensation claim, we may be required to disclose information relevant to that claim to the client's employer or the insurer.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm, and we may have to reveal some information about a client's treatment. These situations include the following:

If we know or suspect that a child under the age of 18 has been abused or neglected, the law requires that we file a report with the appropriate governmental agency, usually the Alabama Department of Human Resources. Once such a report is filed, we may be required to provide additional information.

If we believe that disclosing information about you is necessary to prevent or lessen a serious and imminent threat to the health and safety of an identifiable person(s). We may disclose information, but only to those reasonably able to prevent or lessen the threat.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

Your signature below indicates that you have read all of the information in this document, understand it, and agree to the terms described.

_____ _____

Client Signature **Date Signed**

_____ _____

Therapist Signature **Date Signed**

CROSSWAY

COUNSELING CENTER, P.C.

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. *"Psychotherapy Notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* – If I am treating a child and I know or suspect that child to be a victim of child abuse or neglect, I am required to report the abuse or neglect to a duly constituted authority.
- *Adult and Domestic Abuse* – If I have reasonable cause to believe an adult, who is unable to take care of himself or herself, has been subjected to physical abuse, neglect, exploitation, sexual abuse, or emotional abuse, I must report this belief to the appropriate authorities.

27625 U S Highway 98
Building A
Daphne, AL 36526

- *Health Oversight Activities* – If the Alabama Board of Examiners in Psychology is conducting an investigation into my practice, then I am required to disclose PHI upon receipt of a subpoena from the Board.

- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety* – I may disclose PHI to the appropriate individuals if I believe in good faith that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of you or another identifiable person(s).

- *Worker's Compensation* – I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of PHI. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You may inspect and copy Psychotherapy Notes unless I make a clinical determination that access would be detrimental to your health. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's, Social Worker's, Counselor's Duties:

- I am required by law to maintain the privacy of protected health information regarding you and to provide you with notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with a revised notice at the beginning of our next session or by mail, whichever you will receive sooner.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice in person at our next session or by mail, whichever will occur sooner.

CrossWay

Counseling Center, Inc.

Acknowledgement of Receipt of Notices of Policies and Practices to Protect the Privacy of Your Health Information

I, _____ acknowledge that I have received a copy of the
(client's name)

"Acknowledgement of Receipt of Notices of Policies and Practices to Protect the Privacy of Your Health Information" from _____, an independent
(Therapist name)

practitioner at Crossway Counseling Center, Inc. I also acknowledge that I have read and understand the "Acknowledgement of Receipt of Notices of Policies and Practices to Protect the Privacy of Your Health Information" form.

Signature _____ Date _____
(Client/Parent or Guardian)

Witnessed by _____ Date _____

CROSSWAY COUNSELING
NOTICE OF POLICY REGARDING CANCELLATIONS OF APPOINTMENTS/NO SHOWS:

The purpose of this document is to clarify Crossway Counseling Center's policy regarding Missed Appointments (No Shows) and appointments which are cancelled without giving at least 24 hour notice. In the event that either of these situations occur, you will be charged **$85.00 (on the credit card that you have filed with us)** for each session booked on the day missed. This also includes missing your first initial appointment.

Insurance companies do not compensate therapists for missed appointments. Please understand that not only could someone else have used the time slot, but the therapists do not get compensated for that session. Because of the one-on-one nature of therapy, we cannot overbook in order to compensate for no shows and unexpected cancellations.

Many times being accountable for behavior, taking responsibility for choices, learning to think of how our behavior impacts others, or managing schedules in an organized manner are therapeutic issues for clients, and this situation provides accountability and consistency in the person's progress.

To assist you, we write your next scheduled appointment day and time at the bottom of your white receipt at checkout. We also provide notification reminders through our automatic system if you choose to use this option.

If you must cancel or reschedule your appointment, please do so with the secretary/office administrator. Do not leave your message regarding this on your therapist's personal voice mail or through email or fax.

Signing this document acknowledges that you understand these terms and agree to abide by them.

_____ _____

Signature Witness

_____ _____

Date Date

CROSSWAY COUNSELING

Appointment Reminder Notification

Please check only ONE way of contact that you would like for an appointment reminder. Usually a reminder is sent out 2 days prior to the appointment date.

_____ Text. Phone number to text to: _____

Is there an additional phone number you would like us to text it to? Yes No If Yes: _____

_____ Email. Email address to send to: _____

_____ Phone voicemail. Phone number to send to:_____

By signing below I give permission to Crossway Counseling Center to leave a message by means of indicated above to remind me of my appointments. I also understand that technology does not work all the time, so ultimately it is up to me to remember my appointments.

_____ _____

Client Signature Date

CROSSWAY COUNSELING

PRE-AUTHORIZED CREDIT CARD PAYMENT FORM
(Credit cards only)

This form must be filled out completely and this credit card will be charged for any missed appointments (including the initial first appointment) or cancelled appointments that are cancelled less than 24 hours before your appointment. This card will also be charged for any balances that are left on your account. Any transaction with your credit card will be charged a 3% processing fee by our credit card company.

I authorize my therapist or the staff at Crossway Counseling Center to keep my signature on file and to charge my designated credit card account.

This credit card is a: Visa Master Card Discover American Express

PATIENT NAME NAME ON CARD

CREDIT CARD ACCOUNT NUMBER EXPIRATION DATE CVV

CARDHOLDER ADDRESS CITY STATE ZIP CODE

CARDHOLDER SIGNATURE DATE

Cancellation of this agreement must be made in writing 30 days prior to cancellation. The outstanding balance shall be paid in full at that time.

CrossWay Counseling Center

27625 US HWY 98. Daphne, AL 36526

251-626-7959/Fax: 251-626-6122

Consent Form for Telehealth:

I understand that telehealth or teletherapy involves the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to receiving health care services to me via telehealth over a video conferencing platform or by use of telephone.

I understand that the laws that protect privacy and the confidentiality of my medical information also apply to telehealth or teletherapy. However, I understand that the use of any type of technology equipment is not 100% secure and there is still a risk using technology.

I understand that while telehealth or teletherapy treatment has been found to be effective in treating a wide range of disorders, there is no guarantee that all treatment of all clients will be effective.

I understand that there are potential risks involving technology, including but not limited to: Internet interruptions, and technical difficulties. I understand that technical difficulties with hardware, software, and internet connection may result in service interruption and that the health care provider is not responsible for any technical problems and does not guarantee that services will be available or work as expected.

I understand that I am responsible for information security on my computer and in my own physical location. I understand that I am responsible for creating and maintaining my user name and password and not share these with another person. I understand that I am responsible to ensure privacy at my own location by being in a private location so other individuals cannot hear my conversation.

I understand that my health care provider or I can discontinue the telehealth/teletherapy services if it is felt that this type of service delivery does not benefit my needs.

I have read and understand the information provided above regarding telehealth or teletherapy, have discussed it with my health care provider and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth or teletherapy in my care.

Agreement: Your signature indicates that you have read this document; that you understand all that it contains; that you agree to abide by its terms; and that you voluntarily consent to treatment. Clients understand digital/electronic signatures are considered valid, per:

- Federal Law (Public law: Pub.L. 106-229 & Statues at Large: 114 Stat. 464)

- 2006 Alabama Code – Section 8-1A-7

_____ _____

Client Signature Date