Amy L. Luzar, MSSA, LISW-S

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Instructions: This is a fillable PDF. You may download and open it using Adobe Acrobat or a browser, complete all fields, and save your changes. Once finished, please email the completed form to amy@amyluzar.com. You may also print, scan and send or bring to your first appointment.

CLIENT NAME		AGE		DOB	

ADDRESS		CITY		STATE		ZIP	

CLIENT PHONE #		CLIENT EMAIL	

EMERGENCY CONTACT		PHONE NUMBER	

Please provide information for the Responsible Party if it is different from the Client:

RESPONSIBLE PARTY NAME	

ADDRESS		CITY		STATE		ZIP	

PHONE #		CLIENT EMAIL	

How did you hear about my practice? _____

PAYMENT AND HEALTH INSURANCE

Please Read Carefully! My office handles health insurance differently than many health care providers. By choice, **I have not contracted with any insurance companies, and consequently am an "out of network" provider.** If you are relying upon your health insurance to cover or defray the cost of our services, I recommend that you check your policy's provision for out of network providers. Also, I am an "opted out" provider and do not accept Medicare.

I ask my clients to pay for services directly, and to submit health insurance claims for reimbursement. It will be your responsibility to manage the mechanics of your insurance claim. I do not accept direct assignment of payment from insurance carriers. Any reimbursement will go directly to you. Since I do not have access to anyone's insurance policy benefits, the best way to find out information about out-of-network benefits is to call your insurance company and ask the following questions:

1. Does my policy include reimbursement for out of network mental health treatment?
2. Is there a separate deductible for services that are out of network?
3. Once a deductible is met, how much of the session fee is covered?

PAYMENT METHODS

I use Ivy Pay to accept payment; it works with credit, debit, HSA and FSA cards. It is HIPAA-secure, keeps therapy information confidential, and facilitates the payment process. Your mobile number is entered, after which you will then receive a text message with a prompt to enter your payment information.

Please check one:

☐ Please send me a text invitation to add my payment information to Ivy Pay.

Credit card payments will include a 2.75% processing fee.

Or,

☐ Please send me a monthly invoice and I will pay by check or Zelle.

Though I am not affiliated with insurance companies, I can provide you with periodic billing summaries if you need them for insurance or health care spending accounts.

If another party is responsible for paying all or part of your charges, it is necessary for that individual to also complete a copy of our Office Billing forms. Please have that individual contact my office by phone at 216-973-9976, or by email at amy@amyluzar.com

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PROFESSIONAL SERVICES AGREEMENT

The Ohio Counselor and Social Work Board regulations require that all clients are fully informed regarding the costs for professional services. Following is a list of fees and a summary of our billing practices. We ask that you read this material carefully, and sign below to signify your acceptance of these terms. Please note that my rate is subject to change, and I will provide notice of any changes.

SERVICE	**FEE**
Office visit 45-50 min	200.00
Office visit 55-60 min	240.00
Family and Couples Therapy 55-60 min	240.00
Group Therapy 75 min	135.00
Extended Office Visit	Office visit rate pro rata
Other professional time	Office visit rate pro rata - Telephone consultation (over 10 minutes) and other services you request of me including participation in meetings or phone conferences with your permission, report, or letter writing.

Forty-eight hours (two full business day) cancellation notice is required for appointment times reserved. Should you cancel with less than 48-hour notice, I will do my best to fill the appointment hour. If I am unable to, your account will be billed the fee for the time reserved.

I have received and read the Notice of Privacy Practices (NPP), Tele-Mental Health Informed Consent, Authorization for Electronic Communication found on the forms page https://amyluzar.com/office-forms.

I have read and understand the information provided. I authorize Amy Luzar, LISW-S to provide me treatment and psychotherapy services accept full financial responsibility for fees incurred within the framework of this agreement.

_____Your name (Please print) _____ Your Signature

PERMISSION TO TREAT MINOR - Parent/Guardian signature is required for client under 18

I authorize Amy Luzar, LISW-S to treat my dependent child. I attest that I do have legal custody of this minor. I have read and understand the information provided and accept full financial responsibility for fees incurred within the framework of this agreement.

_____ Parent/Guardian Signature Date: _____

_____ Parent/Guardian Signature Date: _____