**Family Information**

Name of person completing form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Client Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M/F DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_ Soc. Sec#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_Zip Code \_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents are currently: Married\_\_\_\_\_\_\_ Separated\_\_\_\_\_\_\_ Divorced \_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_

**Who is the legal Guardian of Minor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you have a copy of custody decree: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Would you like to receive text reminders for scheduled appointments: \_\_\_\_\_, if yes please verify cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Father’s Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status \_\_\_\_\_\_ Soc. Sec. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mother’s Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status \_\_\_\_\_\_\_ Soc. Sec. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Step Parent** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status \_\_\_\_\_\_ Soc. Sec. # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Foster Parent/Placement** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1) Sibling Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_ M/F Age \_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade \_\_\_\_\_\_\_\_\_

1) Sibling Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_ M/F Age \_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*School*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_ Grade \_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Primary Care Physician** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Informed Consent for Treatment**

I give consent for evaluation and treatment to be provided for myself/my child by Cedar Ridge Child & Family Counseling.

 **(Client Name)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

* I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment.
* The risks, benefits, side effects and alternatives of treatment as well as the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions.
* I understand that I need to provide accurate information about myself to my clinician so that I will receive effective treatment. I also agree to play an active role in my treatment process.
* I understand that I may terminate treatment at any time.
* I understand that what is discussed in therapy is confidential unless and until I (the client or parent) give consent to its release, with two exceptions. The therapist will need, and is compelled by law, to report to an appropriate other person(s) if:
1. The therapist believes that I am in danger of hurting myself or someone else, and
2. If there is reasonable suspicion that a child has been abused or neglected

My signature below shows that I understand and agree with all of the above statements. I have had the opportunity to ask questions about the treatment process. If the client is a minor or has a legal guardian appointed by the court, the client’s parent or legal guardian must sign this consent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Parent/Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Relationship to Patient (if applicable)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date

This counseling may include individuals or group psychotherapy, counseling, and testing. This counseling may include consultations with other associates of this institution. This counseling may include referrals to other State, County or professional agencies for further counseling.

**Privacy Notice**

I have received the Cedar Ridge Child & Family Counseling Health System Notice of Privacy Practices. My signature acknowledges I have received the Notice.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page 1

**Informed Consent for Treatment page 2**

* I authorize personnel of Cedar Ridge Child & Family Counseling to transport my minor child (Minor’s Name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in the community.

**TRANSPORTATION WAIVER AND RELEASE**

**I, the undersigned,** give my consent for the person identified above to be transported by Cedar Ridge Child & Family Counseling and will assume all liability for my/their participations in the activity and any injury that may result during the transport or at the activity.

**Further, by signing below**:

1. I will not hold Cedar Ridge Child & Family Counseling, its officers, agents, employees, assigns or anyone acting on its behalf, responsible or liable for injury occurring to the named person in the course of such activity or such travel.
2. I hereby accept financial responsibility for personal items lost by person identified above.
3. I authorize Cedar Ridge Child & Family Counseling to transport and to obtain, though a physician of its own choice, any emergency medical care that may become reasonably necessary for the person in the course of such activity/event or such travel, and agree to accept the cost of the transportation and/or treatment by medical personnel or facility.
4. I accept full responsibility and hereby grant permission for me or my minor child to travel with Cedar Ridge Child & Family Counseling.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Parent/Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Relationship to Patient (if applicable)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Professional Disclosure Statement

` **Name Title Degrees Universities Licensure**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Tricia Miller | Licensed Clinical Social Worker | B.S.W.M.S.W. | University of WyomingWalla Walla College | LCSW-603 |
| Karen Olsen | Provisional Clinical Social Worker | B.S.W.M.S.W. | Walla Walla College University of WyomingOn site supervisor Tricia Miller | PCSW-827 |
| Jennifer Bays | Provisional Professional Counselor | MS, LPC | University of Wyoming | LPC-1922 |
| Shelly Sands | Certified Social Worker | B.S.W. | University of WyomingOn site supervisor Tricia Miller | CSW-265 |
| Frank Shablo | Licensed Professional Counselor | MPA, MRC, LPC | Utah State University | LPC-1824 |
| Tori Shepard | Certified Social Worker | B.S.W. | University of WyomingOn site Supervisor Tricia Miller | CSW-323 |
| Rachel Yauney | Licensed Clinical Social Worker | M.S.W. | University of Nebraska at Omaha, NE | LCSW-1274 |

Professional Disclosure Statement

As a professional counselor licensed by Wyoming Mental Health Professions Licensing Board, it is my commitment

to adhere to the American Association Code of Ethics, it is required that this professional disclosure statement be given to prospective clients. The code specifically states that therapeutic relationships are professional in nature, and sexual intimacies are never appropriate. Likewise, in adherence to the code and in keeping with your right to professional treatment, confidentiality is respected and no information about you will released without you and/or your guardian explicit, signed release or authorization with the following expectations.

* There is substantial or imminent danger or physical harm to self or others.
* There is suspicion of abuse or harmful neglect of children, the elderly or disabled or incompetent individuals.
* The validity of the will of a former client is being contested.
* Information related to counseling is necessary to defend against a malpractice action brought by client.
* In the context of civil commitment proceedings, where an immediate threat of self-inflicted harm is disclosed.
* The client alleges mental or emotional damages in civil litigation on his/her mental or emotional state becomes an issue in any court proceedings concerning child custody or visitation.
* The client is examined pursuant to a court case.
* In the context of investigations and hearings brought by the client and conducted by the board, where violations of this act are at issue.
* For nonpayment of owed fees, the client’s information will be given to a collection agency, or other necessary identities for collections of fees.

**Mental Health Professionals Licensing Board**

2001 Capitol Avenue, Room 104

Cheyenne, Wyoming 82002

Phone (307)-777-3628

 **THERE WILL BE TIMES WHEN I MAY NOT BE AVAILABLE, IF CRISIS/EMERGENCY OCCURS**

 **PLEASE GO TO YOUR LOCAL ER OR CALL THE FOLLOWING NUMBERS FOR HELP.**

* **911**
* **WYOMING BEHAVIORAL INSTITUTE: (307)-235-3026 OR (307)-237-7444**
* **WYOMING MEDICAL CENTER: (307)-577-7201**
* **SUICIDE PREVENTION-TOLL FREE: 1-800-273-8255**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client/Parent/Guardian Signature Date

  **Financial Information**

**REGULAR THERAPY SERVICES:**  Our intake session is $175.00. Each succeeding session is $150.00 for 60-minute session, $135.00 for 45-minute session, and $90.00 for 30-minute session. Case Management is billed in 15-minute increments at $37.50. Court appearances and testimony is charged at a rate of $150.00 per hour locally. Appearances outside of Casper, WY and travel time to and from court will be billed at a rate of $40.00 per 15 minutes. Payment will be required prior to court appearance. Any other payment or fee arrangement must be worked out before the end of the first session.

**INSURANCE INFORMATION/ THIRD PARTY PAYMENT:** We are licensed mental health providers so many insurance plans will help pay for therapy. You may obtain benefit information from the customer service number on your insurance card or from your agent. **Your insurance co-pay must be made at each visit.** There is a possibility that your health insurance plan will not cover outpatient mental health services. In either case**, the financial responsibility for services is yours as a client/parent**. Please note: Occasionally contact with collateral professionals, e.g., school counselors or teachers, may be needed and most insurance companies do not cover these expenses. This will require us to bill you directly with the above charges.

**CEDAR RIDGE CHILD & FAMILY COUNSELING CANCELLATION POLICY** requires that 24-hour notice be given if it necessary to cancel or change an appointment. At the discretion of the therapist, the following charges may be applies: First late cancellation or failure to show-$.0 charge: 2nd late cancellation or failure to show-$70.00: 3rd or more late cancellation or failure to show- $135.00 will be charged each time. I also understand that my insurance will not cover cancellation charges. All missed appointments fees must be paid in full before subsequent appointments can be scheduled. By signing this agreement, I am acknowledging that I understand, and I am agreeing to the requirements of the charges for missing appointment.

**PATIENT/PARENT/GUARDIAN AGREEMENT:**

Cedar Ridge Child & Family Counseling has notified me that there is the possibility that outpatient mental health services may not be a covered benefit by my health insurance. **If my insurance is not in effect today or a service is not a covered benefit, I agree to be financially responsible for the charges that occur today any other subsequent charges that may occur.**

I give this office permission to release any information to my insurance company during treatment of me or my family, which is necessary to obtain authorization or support any insurance claims on this account and secure timely payments due to the assignee or myself. I further expressly agree and acknowledge that my signature of this document authorizes my Mental Health Practitioner to submit claims for benefits for services rendered for services to be rendered without obtaining my signature on each claim to be submitted for myself and/or dependents and that I will be bound by the signature as though the undersigned has personally signed the claim.

I agree that in an event of non-payment of any amounts due under this agreement, and the issue results in assignment to an agency for collections, I promise to pay an additional fee of 35% of unpaid balance due.

**ASSIGNMENT OF BENEFITS:**

I hereby assign medical benefits, including those from government-sponsored and other health plans to Cedar Ridge Child & Family Counseling. A photocopy of this agreement is to be considered as good as the original. I agree to the above statement and attach my signature below.

Client (or parent/guardian signature) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_

Printed name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Financial Information page 2**

 **PLEASE MAKE SURE WE HAVE A COPY OF YOUR INSURANCE CARD**

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer/Group Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Date of Coverage \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family Coverage­­ Yes\_\_ No \_\_ Co-Pay Per Visit $\_\_\_\_\_\_\_\_\_\_\_\_\_

Deductible $\_\_\_\_\_\_\_\_\_\_ per person \_\_\_\_\_\_\_\_\_\_ per family \_\_\_\_\_\_\_\_\_\_ IS physician referral required? \_\_\_\_\_\_\_\_

Is authorization required? Yes \_\_\_\_ No \_\_\_\_ If yes, authorization #? \_\_\_\_\_\_\_\_\_\_\_ #of visits? \_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page 3 Financial Information

IVY Pay Guideline

We utilize IVY PAY, which is a credit card payment system designed specifically for

Counselors and their Clients. While checks and cash are my preferred payment method, this payment vehicle can be used for, phone or video sessions, missed sessions with less than the required 24 hours’ notice. Additionally, if you choose, Ivy Pay can be used in place of or in addition to, your usual payment method at any time after being set up. IVY Pay works with your debit card, credit card, HSA or FSA account. It is HIPAA secure.

Following completing this form, I will go ahead and send you an invitation text with a charge for either $1 or your full session fee depending. I ask that you use the link to set yourself up in the system at least 24 hours prior to our first or

next upcoming appointment time. It is quick, easy and very secure.

Just to be clear, I will not keep your credit card on file, (it will be on file and securely maintained through IVY PAY), so that you can easily pay for any sessions attended, remote, or missed without any hassle!

As always, payment is expected at the beginning of your session. If you have forgotten your checkbook and have not brought cash, or we are having a phone or video session, or you have missed or cancelled without 24 hours cancellation

notice, I will charge your credit card through IVY Pay. You will then receive a text from IVY Pay, notifying you of this charge. You can also let me know ahead of time or at the beginning of your session, that you would like to charge your

session via IVY Pay and I can then easily take care of it on my end, (after it has been set up).

I am happy to answer any questions via email or/and we can discuss this more in our next session. After signing this agreement, please watch for a text invitation and link to set up your Ivy Pay account. 2.75% Credit Card Fee

Here’s how it works:

1. You will be sent an invite text via IVY Pay’s secure system:

2. Tap on the link in your invite text to be taken to the secure ‘Add Card’ form.

3. Scroll down on the ‘Add Card’ form, add your card details, and tap ‘Save & Pay’. Your card will be encrypted and stored.

4. Moving forward, you will receive a text confirmation that your card on-file has been charged.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

We utilize Ivy Pay and it is our preferred billing method but if you prefer, we can run your credit card thru the Square system with 3.75% service charge fee added. Please complete the next page for the Square billing system

**Credit Card Payment Policy**

In an attempt to keep our client’s accounts up to date, we have implemented a very successful system of payment. By having your credit card information on file, we can efficiently update your account after each session.

In addition, Cedar Ridge Child & Family Counseling’s cancellation policy requires that 24-hour notice be given if it is necessary to cancel or change an appointment. At the discretion of the therapist, the following charges may be applied:

 First late cancellation of failure to show for an appointment -$0 charge

 2nd late cancellation or failure to show - $70 will be charged

 3rd or more cancellations or failure to show - $135.00 will be charged each time

I have been made aware of this policy and understand that my credit card may be charged for these fees. I also understand that my insurance will not cover cancellation charges.

I authorize Cedar Ridge Child & Family Counseling to charge this account for co-pays and cancellation fees as explained above.

 **Credit Card Information**

Card Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 V/MC Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3-digit CID \_\_\_\_\_\_\_\_

 Name of Card Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address of Card Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Cardholder Date

**Privacy Notice**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED

AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Our Counseling and Therapy Services are Designed With The Family In Mind….Working closely with parents and child, our professional staff helps families find new and productive ways of listening, learning and growing together. A primary goal is to identify short-term solutions and long-term strategies for dealing with family problems. Cedar Ridge Child & Family Counseling offers positive responses to the problems and pressures of daily life, enabling parents, children, and extended family members to build healthy and strong families.

Cedar Ridge Child & Family Counseling is also committed to serving as a knowledgeable partner with professionals by presenting individual and group consultation sessions focusing on the latest research, techniques and strategies in the fast-changing field of child development.

Office hours are generally Monday through Friday 8:00AM to 5:00PM; closed holidays. Alternative may be made on occasion.

Understanding Your Health Record Information

Every time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. This record may include your symptoms, examination and test results, diagnosis, treatment, and plans for future care or treatment. Your medial provider uses this information, often referred to as your health record, to plan your care and treatment. The many health care professionals who assist in your care communicate through your health record. Your health information is also used by insurance companies to verify that services we billed for were actually provided. Although your health record belongs to the healthcare provider or facility that compiled it, you do have certain rights with regard to your health information.

Your Rights:

* You have the right to humane treatment in an atmosphere of dignity and respect regardless of race, religion, sex, age, national origin, sexual orientation, or disabilities.
* You have the right to receive this and other information in a language you and your family or legal guardian can understand.
* You have the right to an individualized treatment plan developed by you and your counselor. You have the right to review the treatment plan with our treatment provider and consult with others regarding you treatment plans.
* You have the right to have your family involved in your treatment.
* You have the right to refuse treatment and/or interventions with possible consequences discussed.
* You have the right to an explanation of the total cost of the counseling,
* You have the right to understand and participate in your evaluation, care, and treatment planning.
* You have the right to receive consultation from other physicians, therapists, clergy, or attorneys.
* You have the right to information concerning the credentials of the clinical staff responsible for your care.
* You have a right to expect that your health information will be kept secure and used only for legitimate purposes.
* You have a right to understand how your health information may be used and disclosed by Cedar Ridge Child & Family Counseling.
* You have a right to receive this privacy notice that tells you how your health information may be used or disclosed.
* You have a right to ask questions about any health privacy issue and have those questions clearly and promptly answered.
* You have a (limited) right to know who has seen your health information, and for what purpose. If you make additional requests for such an accounting during any 12-month period, we may charge you a reasonable, cost-based fee.
* You have a right to see, and to keep a copy of, all of your health records (except psychotherapy notes). Your request for a copy of your record must be in writing. We may charge you a reasonable cost-based, coping fee.
* You have a right to ask for correction-or inclusion of a statement for anything in you records that you feel is in error. Your request must be in writing and include supporting documentation.
* You have a right to authorize or reuse additional uses of your health information, such as for fundraising, marketing, or research.
* You have a right to request extra protection for health information you consider especially sensitive, and to request that we communicate with you by alternative means.
* Any concerns or complaints over care, please direct to your primary mental health professional. If there are still problems, please direct them to Tricia Miller, Owner of Cedar Ridge Child & Family Counseling (307) 333-1301.

Our Responsibilities

We also have certain responsibilities. These include:

* Maintaining the privacy of your health information;
* Providing you a copy of this Notice:
* Abiding by the terms of this Notice;
* Notifying you if we are unable to agree to a requested amendment or restriction; and
* Accommodating reasonable requests you may have to communicate health information by alternative means or at alternative locations.

If our information practices change, we may change this Notice. If we do so, the change will be effective for information gathered both before and after the effective date of such change. However, before we change our practices, we will post a copy of our new Notice in our office. The effective date of our Notice will always appear at the end of the Notice. We will not use or disclose our health information without your authorization, except as described in this Notice.

Disclosures for Treatment, Payment and Healthcare Operations.

We may use or disclose your information for treatment, payment, and healthcare operations without your permission. However, if state law requires us to obtain your written permission to use or disclose your health information for treatment, payment, or healthcare operations, we will do so.

We will use or disclose your health information for treatment.

For example: Information obtained by a therapist or psychiatrist will be recorded in your record and used to determine the course of your treatment. Healthcare and Mental Healthcare team members will communicate with one another personally and through the health record to coordinate your care. We may provide your physician or other healthcare providers with copies of reports that may help determine your future treatment. We may also disclose your information to another healthcare provider for its payment purposes or its healthcare operations.

We will use or disclose your health information for payment.

For example: We may send your bill to you or your insurance company. Your bill may contain information that identifies you, as well as your diagnosis.

OTHER DISCLOSURES THAT MAY BE MADE WITHOUT YOUR AUTHORIZATION:

* Specialized governmental functions:

We may disclose your mental health information for military, veteran’s activities, national security and intelligence activities and similar government functions as required by law.

* Correctional institutions:

If you are an inmate of an institution, we may disclose to the institution’s agents health information necessary for your health and the health and safety of other individuals.

* Law enforcement judicial and administrative proceedings:

We may disclose your health information for the above purposes as required or permitted by law in response to a valid subpoena, court order or other binding authority.

 HIPAA

Treatment records are protected under federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. section160 & 164. HIPPA protection may not apply to re-disclosure of information by the recipients of the information disclosed, pursuant to this authorization.

If a child is in DFS custody that agency will have access to information as their legal guardian.