As We Grow Counseling
2240 Twelve Oaks Way - Suite 101
Wesley Chapel, FL 33544
Tel # 813-838-4807 Fax # 813-333-1236
Melissa@AsWeGrowCounseling.com

Consent for Treatment

I, the undersigned, do hereby consent to participate in *As We Grow Counseling* Assessment Process and if I so choose, subsequent treatment if recommended. I understand that the Assessment is a collaborative effort between my family (if indicated), other professionals or healthcare providers, *As We Grow Counseling*, staff and myself to determine a diagnosis and treatment recommendations.

_____ _____
Printed Name *Date*

_____ _____
Signature *Date*

Financial Responsibility Consent

I acknowledge full financial responsibility for services rendered by *As We Grow Counseling*, whether covered by an insurance company or not. I further authorize *As We Grow Counseling* to release all necessary medical information to my insurance company to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured / Guardian *Date*

Address (if different than patient's): _____

_____

_____

_____

Credit Card Information

Credit Card: Visa_____MasterCard_____Discover_____

Name on the Card: _____

Card Number: _____

Expiration Date: _____ Security Code: _____

ELECTRONIC PAYMENT AUTHORIZATION – Therapy Partner

Please indicate the form of payment you wish to use for any services rendered through this practice.

The following forms of payment are accepted: **Visa, MasterCard and Discover.**

Service fees will be deducted from the designated account at the time services are rendered and upon insurance explanation of benefits indicates a patient responsibility.

Client Information

Name: _____ Date of Birth: _____

Address: _____

City: _____State: _____ ZIP: _____

Home Telephone Number: _____

Mobile Number: _____

Email: _____

Cardholder Information

Please indicate the name and address associated with the credit or debit card you wish to

use. Name: _____

Address: _____

City: _____State: _____ ZIP: _____

I authorize any service fees to be deducted from the credit or debit card ending in _____ (provide the last four digits of the card).

_____ _____

Cardholder Signature *Date*

Credit / Debit Card Information

Please provide your payment information below. The debit or credit card information you provide will remain on the file for future patient responsibility of payments.

Credit Card: Visa_____MasterCard_____Discover_____

Name on the Card: _____

Card Number: _____

Expiration Date: _____ Security Code: _____

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Cancellation Policy

Please review our office policy regarding missed and/or cancelled appointments.

A missed appointment is when you fail to show up for an appointment without a phone call or cancelation without prior notification.

Late arrivals greater than 15 minutes are considered cancelled at that time and will not be seen, unless therapist is notified otherwise.

We strive to be on time for your appointment and ask that you give us the courtesy of a call when you are going to be late for an appointment.

- We **require** a **24 hour notice** for all cancelled appointments, otherwise a **$120.00** full session **fee will be charged**.

This allows us to use the appointment time for another patient.

- We will call and offer to re-schedule your appointment. However, you will be charged a missed appointment fee of $120. The credit card on record will be charged or a bill will be mailed to the address on record.

Signature _____ Date _____

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I understand that, under The Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain right to privacy in regards to my protected health information (PHI). I have received, read and understood The Notice of Privacy Practices.
The practice reserves the right to change the terms of its Notice of Privacy Practice. I understand the Practice will provide current Notice of Privacy Practice on request.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____

Patient's Parent / Guardian Signature: _____

Printed Name: _____

Relationship to the Patient: _____

---------- *For Therapist Use Only* ----------

I was unable to obtain the patient's signature

Date: _____

Reason: _____

_____