Center for Solutions
In Brief Therapy, Inc.

Client Name: _____ Male_____ Female_____
(First) (Middle initial) (Last)
Date of Birth: ____/____/____ Social Security Number: ____-____-____
(Not needed if client is a minor)
Address: _____ City: _____ State: _____ ZIP: _____
Home Phone: (____) _____ Marital Status: _____ Spouse's Name: _____
Cell phone: (____) _____ Email: _____
(For appointment reminders)
☐ I give Center for Solutions staff permission to leave a voicemail on the given phone numbers' mailbox
Client Employer/School: _____ Work Phone: (____) _____
Who Referred You Here: _____

For Minors:
Child lives with: Both Parents_____ Mother_____ Father_____ Other: _____
Mother: _____ Address: _____
(if different)
Date of Birth: ____/____/____ Social Security Number: ____-____-____
Home Phone: (____) _____ Cell Phone: (____) _____
Place of Employment: _____

Father: _____ Address: _____
(if different)
Date of Birth: ____/____/____ Social Security Number: ____-____-____
Home Phone: (____) _____ Cell Phone: (____) _____
Place of Employment: _____

Insurance Information:
Primary Insurance Co.: _____ Member ID#: _____ Group #: _____
Policy Holder: _____ Date of Birth: ____/____/____
(First) (Middle Initial) (Last)
Social Security Number: ____-____-____ Employer: _____
Client's Relationship to Cardholder: Self_____ Spouse_____ Dependent_____

Secondary Insurance Co.: _____ Member ID#: _____ Group #: _____
Policy Holder: _____ Date of Birth: ____/____/____
(First) (Middle Initial) (Last)
Social Security Number: ____-____-____ Employer: _____
Client's Relationship to Cardholder: Self_____ Spouse_____ Dependent_____

Identification of other physicians/healthcare entities involved with my medical care whom I authorize ongoing release of information for continuity of care:
Primary Care/Referring Physician: _____ Phone: (____) _____
Address: _____ State: _____ ZIP: _____

I understand that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information provided on the office policies and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

_____ _____
Client Signature (Parent Signature if Client is a Minor) **Today's Date**

Center for Solutions
In Brief Therapy, Inc.

Office Policies for Services Rendered

Updated to take effect on January 1, 2014

In order to ensure that you have been informed about our office policies, we would appreciate that you review the following information and sign.

A. General

- Confidentiality – The therapeutic relationship is based on confidentiality. Neither the therapist/supervisor, nor any employee at Center for Solutions in Brief Therapy, Inc. will divulge information about any client without the client's written consent with the following expectations:
    - When required by the individual's insurance, the client having signed a waiver when signing the insurance.
    - Information will be provided to the referring physician, when applicable.
    - When it is felt that the client is in danger to himself or others.
- The professional client – therapist relationship will remain so throughout therapy: dual relationships, i.e. friend/therapist, business partner/therapist are not permitted.
- Center for Solutions in Brief Therapy will send email reminders of scheduled appointments if you keep an email on file, but no phone call reminders occur.

B. Fees

- **After the first missed appointment, you will be charged the full amount of $130.00 for all subsequent missed appointments, unless the office staff is notified at least 24 hours prior to your set appointment time. If you do not allow 24 hours in advance to cancel your appointment, you will be charged $65 as a late cancellation fee.** We have a voicemail available 24 hours a day and seven days a week to leave a message to cancel your appointment. This is necessary because there is usually someone waiting to be scheduled, someone who could have used the time slot that was reserved for you. Insurance companies will NOT allow us to bill them for any missed appointments. Therefore, when we do not have the benefit of a 24 hour notice, you will be billed directly for the entire amount of the missed appointment and you alone will be responsible for paying the fee.
- If your account were to become past due, the person listed as being financially responsible for your account may be sent to our collection agency. Any account that is over 90 days past due with no payment arrangements will be sent to collections. There is a $25 collection fee if an account is sent.

C. Payment

- **We will bill your insurance company as a courtesy to you. If your insurance company fails to pay for your services, you will be held responsible. We will do our best to estimate the amount you owe at the time of the session. This amount, whether it be a deductible payment, copayment, or full pay, is due at the time of service. If you are unsure of your insurance coverage and we are unable to verify your benefits, we will require full payment at the time of your visit until the exact amount of your co-payment is determined. We reserve the right to reschedule your appointment if you do not have your payment.**
- In the case of divorce, the parent or guardian who is bringing the child in for services will be held responsible for payment, regardless of divorce decree.

Your signature below will indicate your understanding of our policies and your agreement to pay for services rendered. If you have any questions about the above information or have any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help you.

_____ _____

Client Signature (Parent Signature if Client is a Minor) **Today's Date**

Center for Solutions
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Consent to the Use and Disclosure of Health Information for Treatment, Payment, and Healthcare

I understand that as part of my healthcare or the healthcare of my minor child, Center for Solutions in Brief Therapy, Inc. originates and maintains health records for describing my health history, symptoms, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routing healthcare operations such as assessing the quality and reviewing the competence of healthcare professionals.

I understand that I have the option to be provided a HIPAA Privacy Notice that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent and will ask the receptionist if interested. I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

- I request the following restrictions to the use of disclosure of my health information

_____

_____

_____

_____ _____

Client Signature (Parent Signature if Client is a Minor) **Today's Date**

_____ _____

Witness Signature **Today's Date**

Informed Consent to Receive Mental Health Treatment

I, _____, hereby voluntarily consent to, and authorize, Center for
(Client Name or Parent/Guardian Name of Minor)
Solutions in Brief Therapy, Inc. to render mental health treatment to myself and/or minor child. The treatment plan and/or form of treatment to occur will be discussed with me. I understand that I can, at any time, withdraw my consent in writing.

_____ _____

Client Signature (Parent Signature if Client is a Minor) **Today's Date**

_____ _____

Witness Signature **Today's Date**

Center for Solutions
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Psychological Evaluations and Testing Clients

Dr. Barber, Dr. Johnston, and Dr. Fourman clients please note that your testing process is different

Thank you for choosing Center for Solutions in Brief Therapy, Inc. for the purpose of psychological evaluation of possible learning disabilities, attention-deficit/hyperactivity disorder, developmental delays, personality/emotional issues, and in some cases, memory problems and weight-loss management.

At Center for Solutions in Brief Therapy, Inc. we attempt to be comprehensive and thorough in the assessment of any given problem.

The psychological testing typically takes seven sessions each lasting one hour, as insurance rarely pays for more than one hour. The first appointment in an initial interview, the subsequent five appointments are all testing sessions, and the final appointment is to review testing results.

Once the testing is completed, the client (or parent of) will meet with one of our psychologists to discuss testing results and recommendations. A short written report is included in the cost of the appointment to assist client, parent, school, and/or physician. A full, more comprehensive report, takes approximately two-three hours to complete and has a one-time charge of $150. This fee is not paid by the insurance company and will need to be paid in full prior to receiving the report.

If you have any questions please discuss them with the office staff or any of the therapists.

Your signature below will indicate your understanding of our policies and your agreement to pay for services rendered.

_____ _____

Client Signature (Parent Signature if Client is a Minor) **Today's Date**

Thank you for choosing Center for Solutions in Brief Therapy, Inc. and welcome!

Our Mission

Develop a vision and goals for your life as you move forward into the future.

"Success is to be measured not so much by the position that one has reached in life as by the obstacles which he has overcome."

(Booker T. Washington)

Our Approach

Center for Solutions' approach is brief therapy which focuses on solutions not on problems, pathology, causes of problems or even how problems are maintained. Our approach facilitates realistic, achievable, specific, and behaviorally defined goals. Brief Therapy utilizes the importance of homework assignments, reframing, humor, and paradoxical tasks as facilitators for client-generated solutions.

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www.centerforsolutions.net