

# Associate Counseling Center, Inc.

## PATIENT INFORMATION

Name: \_\_\_\_\_ SS#: \_\_\_\_\_  
                    First                      Middle                      Last

Address: \_\_\_\_\_  
                    Street                      City                      State                      ZIP

Phone: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

**Gender M F** (circle one)

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## **Primary Card Holder (if other than client)**

Name: \_\_\_\_\_ SS#: \_\_\_\_\_  
                    First                      Middle                      Last

Address: \_\_\_\_\_  
                    Street                      City                      State                      ZIP

Relationship to Client: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Birth Date \_\_\_\_\_ **Gender M F** (circle one)

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## **INSURANCE INFORMATION** – please show all insurance cards to receptionist.

Primary Insurance Carrier: \_\_\_\_\_

we do not file secondary insurances

I hereby authorize Associate Counseling Center, Inc. to release to my insurance company or its representative, any information regarding my treatment, including diagnosis, necessary to process my insurance claim.

I hereby assign all my rights to benefits payable by my insurance company to Associate Counseling Center, Inc. and thereby authorize and request my insurance company to pay my benefits directly to Associate Counseling Center, Inc..

All insurance information has been listed correctly. I understand that if I have any other health insurance coverage, including an HMO that is not listed above, any charges not covered by the listed insurance will be my responsibility.

I understand that if I fail to cancel an appointment 24 hours before appointment that I will be responsible for a cancellation fee of \$50. I also understand that I am responsible for payment regardless of insurance arrangements in the event insurance payment is not obtainable. I give ACC permission to bill and or contact me for payment issues by mail or voicemail.

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

**Primary Care Physician:** \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Current Health Problems: \_\_\_\_\_  
Medications Prescribed: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

**Emergency Contact:** Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Relationship to Client: \_\_\_\_\_ Phone: \_\_\_\_\_

**Counseling History:** Previous Psychiatric or Psychological Services: \_\_\_ Yes \_\_\_ No  
Treatment Provider: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Reason for seeking care: \_\_\_\_\_  
Treatment outcome: \_\_\_\_\_

Treatment Provider: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Reason for seeking care: \_\_\_\_\_  
Treatment outcome: \_\_\_\_\_

Please circle any of the following problems that pertain to you:

- |                |                      |                   |
|----------------|----------------------|-------------------|
| Nervousness    | Depression           | Fears             |
| Shyness        | Sexual Problems      | Suicidal Thoughts |
| Separation     | Divorce              | Finances          |
| Drug Use       | Alcohol Use          | Friends           |
| Anger          | Self-Control         | Unhappiness       |
| Sleep          | Stress               | Work              |
| Relaxation     | Headaches            | Tiredness         |
| Legal Matters  | Memory               | Ambition          |
| Energy         | Insomnia             | Making Decisions  |
| Loneliness     | Inferiority Feelings | Insomnia          |
| Education      | Career Choices       | Health Problems   |
| Temper         | Nightmares           | Marriage          |
| Children       | Appetite             | Stomach Trouble   |
| Bowel Troubles | Being a Parent       | My Thoughts       |

Additional reasons for seeking care: \_\_\_\_\_  
\_\_\_\_\_

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

| Name  | Age/Birth Date | Relationship |
|-------|----------------|--------------|
| _____ | _____          | _____        |
| _____ | _____          | _____        |
| _____ | _____          | _____        |
| _____ | _____          | _____        |
| _____ | _____          | _____        |

# Social History

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Birth Place: \_\_\_\_\_

Where did you grow up: \_\_\_\_\_

Current Marital Status: \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Separated \_\_\_\_\_ Single  
(Never married) \_\_\_\_\_ Divorced \_\_\_\_\_ Unmarried Couple

List your children in birth order and give their current ages:

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

## **PHYSICAL HEALTH:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Physician: \_\_\_\_\_

When was the last time you had a physical examination? \_\_\_\_\_

Are you presently taking any medications? \_\_\_\_\_ No Yes If yes, list medications and dosages.

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

Do you suffer with allergies? \_\_\_\_\_ No Yes If yes, please explain

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Sleep patterns (Past two weeks)     No problems     Nightmares     Insomnia  
 Early morning waking     Difficulty falling asleep     Restless  
Is this pattern    Typical    or    Unusual? (Circle one)

Daily eating habits (Past two weeks)  1-2 meals  2-3 meals  snacks  
Is this pattern    Typical    or    Unusual? (Circle one)

Do you have or have you ever had any eating disorders?    No    Yes

If yes, please explain. \_\_\_\_\_

Please describe any past or current sexual problems.

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Do you presently experience emotions and/or moods severe enough to affect your day to day functioning? (Circle one)    Never    Seldom    Often (6 times a year)

Circle all that apply:    Anxiety    Frustration    Manic states    Depression    Anger  
Confusion

### **COUNSELING HISTORY:**

Have you had any prior counseling?    No    Yes    If yes, please describe.

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List any support groups you attend. \_\_\_\_\_

Is there a family history of (Circle all that apply)

Alcoholism                      Substance Abuse                      Mental Illness

Has anyone in your family been treated for a psychiatric disorder? No Yes If yes, please explain:

\_\_\_\_\_

**DRUG/ALCOHOL HISTORY:**

Have you ever used alcohol and/or drugs to change or alter your behavior or mood?

No Yes

If yes, please explain \_\_\_\_\_

Have you ever been charged with DWI/DUI? No Yes. If yes, please explain.

\_\_\_\_\_

Complete the following for family members who use or have a history of alcohol/drug abuse

| Family Member | Chemical Used | Current Use (Y/N) | Received Treatment |
|---------------|---------------|-------------------|--------------------|
|---------------|---------------|-------------------|--------------------|

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY & SOCIAL HISTORY**

**FATHER:** Nationality \_\_\_\_\_ Highest Level of Education \_\_\_\_\_

General Status of Health: Emotional \_\_\_\_\_ Physical \_\_\_\_\_

Occupation: \_\_\_\_\_

Describe your relationship: \_\_\_\_\_

**MOTHER:** Nationality \_\_\_\_\_ Highest Level of Education \_\_\_\_\_



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**VOCATIONAL STATUS**

Describe your employment history for the past five years beginning with your current position:

| Employer | Position | Time in Job | Reason for leaving |
|----------|----------|-------------|--------------------|
|          |          |             |                    |
|          |          |             |                    |
|          |          |             |                    |
|          |          |             |                    |
|          |          |             |                    |
|          |          |             |                    |

Describe any physical/emotional problems that prevent your being employed:

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**JOB PERFORMANCE**

Has your employer or supervisor ever expressed any of the following concerns to you? (Circle all that apply)

- |                          |   |                  |
|--------------------------|---|------------------|
| Missing too much work    | Assigned tasks not completed              | Irresponsibility |
| Poor/bad attitude        | Difficulty getting along with others      | Late too often   |
| Attitude/behavior change | Difficulty getting along with supervisors |                  |
| Increased errors         |   |                  |

**MILITARY HISTORY**

Have you ever served in the military service? No Yes Which branch \_\_\_\_\_

Age at enlistment: \_\_\_\_\_ Rank at discharge: \_\_\_\_\_

Did you ever serve in combat? No Yes

If yes, please describe:

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**LEGAL HISTORY**

Do you have any legal action now pending? No Yes If yes, please explain.

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Are you currently on probation and/or parole? No Yes If yes, please describe.

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**LEISURE, RECREATIONAL INTERESTS & HOBBIES**

Would you consider your life as (Circle Yes/No for each option)

|                  |     |    |                     |     |    |
|------------------|-----|----|---------------------|-----|----|
| Work oriented    | Yes | No | Family oriented     | Yes | No |
| Self oriented    | Yes | No | People oriented     | Yes | No |
| Leisure oriented | Yes | No | Recreation oriented | Yes | No |

Activities you enjoy by yourself: \_\_\_\_\_

Activities you enjoy with your family: \_\_\_\_\_

Activities you enjoy with your friends: \_\_\_\_\_

Do you exercise on a weekly basis? No Yes

How often weekly? (Circle one) 1-2 times 3-4 times 5+ times

Do you have physical limitations that prevent exercise or physical activity? No Yes

If yes, what are they? \_\_\_\_\_

Are you able to separate drug and/or alcohol use from your activities? No Yes Sometimes

### **SPIRITUAL HISTORY**

Although not required, the following questions would contribute to your therapist's understanding of you as a spiritual person., It is not our intent to impose our doctrinal perspective but to acknowledge that counseling is not value-free and to be sensitive to your beliefs. Feel free to discuss any questions with your therapist.

1. While growing up, did you have a religious affiliation? If so, what and how important a part of family life was it?
2. Do you have any current religious affiliation? If so, briefly describe your present involvement.
3. Are spiritual issues or resources important to you in therapy? If so, briefly describe.
4. I would describe God as . . .
5. I think God see me as . . .
6. Where are you with God right now?
7. The most positive religious experience I have had is . . .
8. The most negative religious experience I have had is . . .
9. Has there been a significant change in your spiritual life or perceptions within the past year? If so, please describe briefly.
10. Please add additional information or comments that you feel might have significance in this area.

**Associate Counseling Center, Inc.**  
**380 Maple Ave. West**  
**Suite 304**  
**Vienna, Va. 22130**

Appointment Confirmation Agreement

In accordance with the HIPPA Privacy Rule, we may not leave a message at your home without your consent. This will mean that we may no longer confirm your appointments or contact you for a cancellation by leaving a message for you with someone else or on an answering machine.

Please initial the following statement that will pertain to you.

- \_\_\_\_\_ 1. You may contact me to confirm my appointments or notify me of cancellations by leaving a message.
- \_\_\_\_\_ 2. You may not leave me a message to confirm my appointments or notify me of a cancellation by leaving a message. I will be responsible for remembering my scheduled appointments.

\*\*\*Please keep in mind the missed appointment fee of \$50 for appointments cancelled less than 24 hours in advance or for not showing up at all.\*\*\*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name Printed

Associate Counseling Center, Inc.  
380 Maple Ave. West  
Suite 304  
Vienna, Va. 22180

Receipt of Patient Handbook

I, \_\_\_\_\_ acknowledge receipt of the Associate Counseling Center (ACC) Patient Handbook on the occasion of my first appointment with ACC staff for services on this date, \_\_\_\_\_. I further acknowledge that I have read and understand the contents of the Patient Handbook, including the Notice Form, and hereby give Informed Consent to treatment. I understand that Protected Health Information (PHI) held by ACC for the purpose of providing requested services to me will be handled in accordance with the HIPAA Privacy Rule, which affords me specific rights and responsibilities regarding my PHI. This agreement indicates my commitment to enter into treatment, and my understanding of the basic ideas, goals, and methods of this therapy. I consent to keep my therapist up to date about any changes in my symptoms or situation that may impact the success of treatment. I understand that as we evaluate progress periodically, these goals may change and new goals may be agreed upon to serve my long-term best interest. I realize that psychotherapy may arouse unpleasant feelings and emotional experiences, particularly in the initial phase of treatment. My relationships with significant others may also undergo substantial change during the course of treatment. I understand that if I elect to terminate treatment, I agree to schedule a closing session with my therapist to discuss my progress, outcomes of treatment, and any further clinical recommendations. I also understand that the staff at ACC can use my information for supervision.

\_\_\_\_\_  
Signature of Client or Guardian

\_\_\_\_\_  
Date

# VIRGINIA NOTICE FORM CLIENTS COPY – Please Keep

## Notice of Counselors' 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

Associate Counseling Center, Inc. (hereafter known as ACC) its clinicians, staff and authorized personnel 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 ACC provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when ACC personnel consult with another health care provider, such as your family physician or another psychologist.
  - Health Care Operations are activities that relate to the performance and operation of the ACC 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 ACC, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “Disclosure” applies to activities outside of ACC, such as releasing, transferring, or providing access to information about you to other parties.

### II. Uses and Disclosures Requiring Authorization

ACC may use or disclose PHI for purposes outside of treatment, supervision, payment, and 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 ACC is asked for information for purposes outside of treatment, supervision, payment and health care operations, ACC will obtain an authorization from you before releasing this information. ACC will also need to obtain an authorization before releasing your psychotherapy notes. “Psychotherapy notes” are notes ACC clinicians have made about our conversation during a private, group, joint, or family counseling session. These notes are given a greater degree of protection than PHI. If you request in writing at the first session that your PHI and psychotherapy notes be kept in separate files, ACC will maintain them in a separate file.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing.

### III. Uses and Disclosures with Neither Consent nor Authorization

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

- Child Abuse: If ACC clinicians have reason to suspect that a child is abused or neglected, they are required by law to report the matter immediately to the Virginia Department of Social Services.
- Adult and Domestic Abuse: If ACC clinicians have reason to suspect that an adult is abused, neglected or exploited, they are required by law to immediately make a report and provide relevant information to the Virginia Department of Welfare or Social Services.
- Health Oversight: The Virginia Board of Psychology has the power, when necessary, to subpoena relevant records should ACC be the focus of an inquiry.
- Judicial or 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 ACC will not release information without the written authorization of you or your legal representative, or a subpoena (of which you have been served, along with the proper notice required by state law). However, if you move to quash (block) the subpoena, ACC is required to place said records in a sealed envelope and provide them to the clerk of court of the appropriate jurisdiction so that the court can determine whether the records should be released. 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:** If ACC is engaged in professional duties and you communicate to a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and the ACC clinician believes you have the intent and ability to carry out that threat immediately or imminently, they must take steps to protect third parties. These precautions may include (1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18; or (2) notifying a law enforcement officer. If you communicate that a family or friend has informed you that they are planning to do harm to themselves or others, and ACC believes they have the motive, intent and means to perform such an act that ACC will take appropriate action to protect those at harm.
- **Worker's Compensation:** If you file a worker's compensation claim, ACC is required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.
- **Supervision from ACC staff or other supervisor.** There will be an attempt to conceal all identifying information not necessary for supervision.

#### IV. Patient's Rights and Counselor's Duties

##### Patient's Rights:

- **Right to Request Restrictions** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, ACC is 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 a clinician at ACC. Upon your request, ACC 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 and psychotherapy notes in ACC mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. ACC may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, ACC staff 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. ACC may deny your request. On your request, ACC staff 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 for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, ACC staff 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 ACC upon request, even if you have agreed to receive the notice electronically.

##### Counselor's Duties:

- ACC is required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- ACC reserves the right to change the privacy policies and practices described in this notice. Unless ACC notifies you of such changes, however, ACC is required to abide by the terms currently in effect.
- If ACC revises its policies and procedures, ACC will provide all current patients with a written copy of the revision to its policies and procedures at the time of your next appointment after the revisions are made, or by U.S. mail in the event that you are not available for receipt of the revisions in office.

#### V. Complaints

If you are concerned that ACC has violated your privacy rights, or you disagree with a decision ACC has made about access to your records, you may contact John Raymond, ACC Privacy Officer, at 703-999-5567.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

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

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

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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 by the time of your next appointment after the revisions are made, or by U.S. mail in the event that you are not available for receipt of the revisions in office. REVISED 07/05/2006

**Associate Counseling Center, Inc.**  
**CASH PAYMENT AGREEMENT**

We are fully committed to helping you accomplish the goals you establish when you enter counseling, to help you maximize your investment of time and finances. We will deal with you fairly, equitably and with sensitivity in financial matters. We believe that a clear understanding of our financial policies is important for both client and therapist. The following information is presented with this in mind. A copy for your records will be provided upon request.

PATIENT NAME:

\_\_\_\_\_

RESPONSIBLE PARTY

\_\_\_\_\_

NORMAL FEES

| Usual Charges              |                     |
|----------------------------|---------------------|
| Licensed individual        | \$100 / 50 min.     |
| Licensed family            | \$115 / 50 min.     |
| Licensed family w/o client | \$105 / 50 min.     |
| All groups                 | \$25 / hr. / person |
| Intern MA.                 | \$75 / 50min.       |
| Intern                     | \$45 / 50 min.      |

We can adjust our fees for those whom do not have insurance as a courtesy to our patients.

**PAYMENT MUST BE PAID BEFORE BEING SEEN UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH THE OFFICE MANAGER.**

**I agree to make prompt arrangements to pay for my total outstanding balance. I agree to pay a monthly interest rate of 1.67% (APR of 20%) if my account balance is not paid in full within 30 days of the billing date. I understand that I am responsible for payment of these charges, as well as any collection costs including, but not limited to, attorney fees of 40% of the balance due and any related costs of collection should such action become necessary.**

To change an appointment, please phone the office at any time. If the office is closed, voicemail is available. Except in cases of true emergencies, I agree to give 24-hour notice if unable to keep an appointment. **I understand that I will be billed a \$50.00 missed appointment fee for appointments that I do not keep and for appointments canceled less than 24-hours before the scheduled time. An additional \$32.5 charge will apply if intern is also scheduled.**

I understand that I am responsible for all charges incurred during the course of my treatment, including any psychological testing or other services not previously stated. I understand that after hours call, written consultations and telephone consultations of ten minutes or more will be charged at the therapist's discretion. I understand that I am responsible for any and all court cost related to my sessions.

\_\_\_\_\_  
PATIENT/GUARANTOR SIGNATURE

\_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_  
SOCIAL SECURITY NUMBER

\_\_\_\_\_  
TODAY'S DATE

\_\_\_\_\_  
WITNESS  
\_\_\_\_\_  
DATE

**ASSOCIATE COUNSELING CENTER, Inc.**  
**INSURANCE PAYMENT AGREEMENT**

We are fully committed to helping you accomplish the goals you establish when you enter counseling, to help you maximize your investment of time and finances. We will deal with you fairly, equitably and with sensitivity in financial matters. We believe that a clear understanding of our financial policies is important for both client and therapist. The following information is presented with this in mind. A copy for your records will be provided upon request.

PATIENT NAME: \_\_\_\_\_

RESPONSIBLE PARTY: \_\_\_\_\_

INSURANCE #1 \_\_\_\_\_  
START DATE \_\_\_\_\_

ALLOWABLE \_\_\_\_\_

ESTIMATED INSURANCE  
COVERAGE AMOUNT \_\_\_\_\_

ESTIMATED INSURANCE  
DEDUCTIBLE \_\_\_\_\_

VISITS PER YEAR \_\_\_\_\_

| Usual Charges              |                     |
|----------------------------|---------------------|
| Licensed individual        | \$100 / 50 min.     |
| Licensed family            | \$115 / 50 min.     |
| Licensed family w/o client | \$105 / 50 min.     |
| All group                  | \$25 / hr. / person |
| Intern MA.                 | \$75 / 50min.       |
| Intern                     | \$45 / 50 min.      |
| In                         |                     |
| N                          |                     |

ESTIMATED AMOUNT DUE FROM PATIENT FOR EACH SERVICE IS \_\_\_\_\_, WHICH MUST BE PAID BEFORE THE BEGINNING OF EACH SESSION.

**\*\*THE ABOVE INFORMATION THAT IS GIVEN TO US BY YOUR INSURANCE COMPANY ARE ESTIMATES ONLY. WE ARE NOT RESPONSIBLE FOR COPAYS AND/OR DEDUCTIBLES THAT MAY DIFFER FROM WHAT WE ARE TOLD\*\***

I understand that my insurance co-payment and any outstanding insurance deductible is due at the time services are rendered. I acknowledge that I am responsible for the total outstanding balance in the event that my insurance carrier denies benefits or does not provide benefits in the estimated amounts, regardless of the reason the insurance denies coverage. If anything changes with your insurance, you must notify us 24 hours prior to your next appointment or you may be responsible for the full fee for that visit. **I agree to make prompt arrangements to pay for my total outstanding balance. I agree to pay a monthly interest rate of 1/67% (APR of 20%) if my account balance is not paid in full within 30 days of the billing date. I understand that I am responsible for payment of these charges, as well as any collection costs including, but not limited to, attorney fees of 40% of the balance due and any related costs of collection should such action become necessary.**

To change an appointment, please phone the office at any time. If the office is closed, voicemail is available. Except in cases of true emergencies, I agree to **give 24-hour notice** if unable to keep an appointment. **I understand that I will be billed a \$50.00 missed appointment fee for appointments that I do not keep and for appointments canceled less than 24-hours before the scheduled time. I realize that these charge are not covered by insurance and I accept full responsibility for payment.** An additional \$32.5 charge will apply if intern is also scheduled.

I understand that I am responsible for all charges incurred during the course of my treatment, including any psychological testing or other services not previously stated. I understand that after hours call, written consultations and telephone consultations of ten minutes or more will be charged at the therapist's discretion. I understand that ACC does not file secondary insurances. I understand that I am responsible for any and all court cost related to my sessions – that these are generally not covered by insurance companies.

\_\_\_\_\_  
PATIENT/GUARANTOR SIGNATURE

\_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_  
SOCIAL SECURITY NUMBER

\_\_\_\_\_  
TODAY'S DATE

WITNESS: \_\_\_\_\_

DATE: \_\_\_\_\_