Coping Partners™

CLIENT INTAKE FORM

Referral Source: _____ May I thank referral person? Y N

Name of Client: _____

Date of Birth: _____ Gender: M ☐ F ☐ Age: _____

Address: _____
(street) (city) (state) (zip)

Home phone: _____May I leave a message? Y N

Cell/Work: _____May I leave a message? Y N

Email: _____May I e-mail you? Y N

(I understand that e-mail transmission is not encrypted and cannot be guaranteed to be secure as information can be intercepted, lost, arrive late or incomplete. Further, I understand that it is recommended that I provide a personal e-mail address and not a work or school e-mail address.)

Marital Status: _____ Occupation/School & Year _____

Guarantor Name: _____ Date of Birth: _____Gender: M F

Address: _____
(street) (city) (state) (zip)

Home Phone:_____ Cell/Work: _____

Email: _____

Marital Status: _____ Occupation/School & Year: _____

Additional Family Members	DOB	Gender M F	Phone/ Email	Occupation/School & Year	Relationship to Client

CLINICAL INFORMATION:

Have you ever had previous counseling or psychotherapy? Yes ☐ No☐

If "yes," by whom, when and for what?

_____

_____

_____

Have you ever been hospitalized for a psychiatric reason? Yes ☐ No☐

Have you ever made a suicide attempt/gesture? Yes ☐ No ☐

Do you (or child) have any current thoughts of hurting or killing self? Yes ☐ No ☐

Have you or your child had any substance abuse issues? Yes ☐ No ☐

Please list any current or chronic health problems:

_____

_____

_____

Please list any current medications (prescribed & OTC): _____

_____

_____

In the space below, please describe your reason(s) for seeking services: _____

_____

_____

_____

Coping Partners™

155 REVERE DRIVE UNIT 8
NORTHBROOK, IL 60062

INTAKE PHONE: 847.497.8378 **COPINGPARTNERS.COM**

CLIENT SERVICE AGREEMENT & INFORMED CONSENT FOR TREATMENT

CLIENT NAME: _____ DATE: _____

In consideration of the therapeutic services being rendered to the above-named Client by Coping Partners™ or Children Coping Clinic™, the above-named Client, or the undersigned representative acting on behalf of the above-named Client, acknowledges his/her understanding of the following terms of service, and agrees and consents as follows:

LEGAL RELATIONSHIP BETWEEN COPING PARTNERS/CHILDREN COPING CLINIC & THERAPIST

Please be advised, some Coping Partners™/Children Coping Clinic™ therapists are independent contractors and are not employees or agents (actual or apparent) of this practice. Coping Partners/Children Coping Clinic does not supervise or control independent contractors and, therefore, Coping Partners/Children Coping Clinic does not assume any liability for an independent contractor's actions or inactions. Independent contractors are responsible for their own actions and conduct treatment services under their own entity names, if any, and maintain their own liability insurance, tax identification numbers, and National Provider Identifiers (NPI), as necessary and applicable under the law.

FEES & PAYMENT

The fee for an initial evaluation is $200. The fee for an individual therapy session and for a family session is $170. Services lasting less than 10 minutes within a week period will not be charged. When services last longer than 10 minutes, you will be billed for services at the prorated hourly fee of $170. Billable services lasting longer than 10 minutes include, but are not limited to: report writing, telephone consultations, attendance at meetings with other professionals you have authorized, preparation of treatment records or treatment summaries, and the time spent performing other services you may request of me. Payment is expected at the beginning of each session, unless another arrangement is agreed upon in advance.

For psychological testing, a flat fee will be charged based on the hours required to administer and score tests, interpret the results, write a report, and provide feedback. In the instance, an observation of your child in his/her school setting is recommended or requested or attendance and participation in a school meeting with school professionals to review test results is recommended or requested, you will be charged the hourly rate for the time spent at the school. In the instance collaboration with your or your child's other providers (e.g., psychiatrists, psychotherapists, occupational therapists, tutors, teachers, or other school

professionals) is required or requested, you will be asked to provide your written consent for such collaborations and communications. You will be charged the hourly rate for these conversations/collaborations. For psychological testing, you are required to make payment of half of the estimated total amount owed up front after the initial consultation, the remainder of the balance for the psychological testing must be made prior to the release of the report.

Fees are subject to increase at any time, and written notice will be provided to all affected parties 30 days in advance of the fee increase.

If your account balance has not been paid for more than 30 days and arrangements for payment has not been agreed upon, services may be terminated. In the event your account balance has not been paid for more than 60 days and arrangements for payment have not been agreed upon, legal means to secure payment may be utilized. This may involve hiring a collection agency or going through small claims court. If legal action is necessary for the collection of payment, you understand and agree to pay any and all costs of collection including, but not limited to, attorney's fees and court costs. In most collection situations, only information necessary to pursue the claim will be revealed, and as permitted by federal and state law, which may include a client's name, the nature of services provided, and the amount due.

Please be aware that therapy involving children and adolescents generally requires a number of services over and above the face-to-face session time spent with a client. These services include, but are not limited to: communication/collaboration via telephone or in-person with relevant people in the child's life (e.g., parent(s), teachers, school social worker, psychiatrist, occupational therapist, etc.); school observations and staffings; and progress reports and treatment summaries requested by schools or the court system. These services require a provider's professional time and will be billed in accordance with the fee structure discussed in the aforementioned paragraph (i.e., a charge for services that take longer than 10 minutes). When possible, you will be informed in advance about the need for these services and any questions you have should be asked and will be answered to the best of the provider's ability.

INSURANCE REIMBURSEMENT

While your therapist does not accept insurance, you may request a monthly statement indicating the dates of sessions, charges and payments, as well as all codes that are necessary for insurance reimbursement. You are solely responsible for submitting claims to your insurance provider. *Furthermore**, you—not your insurance company---** are ultimately responsible for full payment of services rendered at the time they are provided.* For that reason, it is highly recommended that you find out exactly what mental health services your insurance policy covers and that you keep track of pre-certifications, pre-authorizations, pre-notifications, deductibles, co-pays, co-insurance, and total sessions allowed.

CANCELLATION POLICY

Appointments must be cancelled **at least 24 hours in advance** of the scheduled session. If you do not call to cancel and/or fail to show, you will be

charged the full fee for that appointment. The therapist reserves the right to charge your credit card on file the full fee at the time of the missed appointment. Extenuating circumstances are considered when appropriate.

CONTACTING YOUR THERAPIST
You may leave a confidential voicemail at the number provided to you by your therapist. Regarding voicemail messages, you understand that messages are retrieved regularly Monday through Friday, and those messages lefts over the weekend are retrieved on Monday of the following week. Always be sure to leave contact numbers, times you will be available, and any special instructions with respect to leaving messages with family members or co-workers. Should it become clear to you, to your therapist, or both, that the nature of the presenting concerns exceeds the availability of this practice, referrals will be offered.

You understand that the services provided per this agreement are offered in the form of **regularly scheduled therapy visits of a non-emergency nature**. You further understand that should emergency services be required, you should call 911 or seek services at the nearest emergency room, or contact another mental health therapist/practitioner which provides emergency services, including through referrals made by your therapist, if any.

CONFIDENTIALITY/PRIVACY
All information concerning clients is held confidential and is released only through procedures consistent with applicable federal and state law and professional ethics. You should be aware of the following disclosures that may be required upon a therapist's information and belief:

MANDATED REPORTING

The Abused and Neglected Children's Reporting Act in Illinois requires that "mandated reporters" must disclose any suspected instances of abuse or neglect of minors to the Illinois Department of Children and Family Services (DCFS). Therapists are mandated reporters, as are all mental health service providers. The only requirement is that the "provider" has a good faith belief or conclusion that a neglect or abuse situation exists. If this is so in the mind of the therapist, the law **absolutely requires** that a phone call be made to DCFS, such that DCFS may investigate the situation. If such a report is made, it is the policy of this office to first advise the client that the report will be made. Subsequent to a "mandated" report, the client, and possibly others, will be contacted by a follow up investigator from DCFS. If these investigators confirm the presence of abuse or neglect, a letter so indicating will be issued, and possible court hearings could result. If the DCFS investigators conclude that no abuse or neglect has occurred, a letter will be issued indicating that the claim is "unfounded." The therapist has no choice but to make reports in these situations. The client should be aware that the statute provides for loss of license if a mandated reporter fails to make a mandated report. The statute also provides the therapist with absolute immunity from any criminal or civil liability in the event that such a report is made, even without the consent of the Client.

DUTY TO WARN

Under the Illinois Mental Health and Developmental Disabilities Confidentiality Act, a therapist may "warn" any intended victim, as well as the responsible authorities, and disclose confidential information, where a client discloses in session that he or she intends to cause **serious mental or physical harm to a specifically identifiable victim** and presents a clear and imminent risk of harm**.** It is then the therapist's responsibility to take steps to notify the victim and/or local authorities and provide enough information with which the authorities and/or the victim might prevent the harm from occurring and/or in order to prevent a serious threat to public safety. Therefore, if a client discloses an intent to harm a specific person, the therapist must either contact that person and the authorities, or attempt to secure the hospitalization of the individual. These disclosures are also protected by an immunity clause in the statute.

FOID MANDATED REPORTING

Pursuant to Illinois mental health confidentiality laws and the Illinois Firearm Owner's Identification (FOID) Act, a therapist is a mandated reporter and is required to report to the Department of Human Services ("DHS") within 24 hours of determining that a client poses "a clear and present danger to himself, herself, or others," or is determined to be "developmentally disabled." Information provided to DHS by the therapist shall remain privileged and confidential, and shall not be redisclosed for any purpose except as required under the Department of State Police's dial-up system, utilized as part of the issuance of licenses under FOID. So long as the therapist has acted in good faith, the statute provides the therapist with absolute immunity from any criminal or civil liability in the event that such a report is made, with or without the consent of the client.

LEGAL PROCEEDINGS

By signing below, you agree that the therapist's involvement will be strictly limited to therapeutic services of the client. The client agrees that he or she will not attempt to gain advantage in any legal proceeding he or she may be involved in, such as a divorce or post-decree proceedings, from the therapist's involvement in treatment of the client, including adolescent clients whose parents are involved in such legal proceedings. Accordingly, the undersigned agrees that in any such legal proceedings, the Provider/Therapist will not be asked to testify in a court of law, whether in person or by affidavit. Further, the undersigned agrees to instruct his or her attorney(s) not to subpoena the therapist or to refer in any court filing to anything the therapist has said or done. This provision shall be applied to the extent necessary under the applicable laws of the state.

If for any reason the therapist is required by a court to appear as a witness, prepare records for release, give a deposition, and/or prepare an affidavit, the party responsible for the therapist's participation agrees to reimburse him/her at the applicable rate per hour for time spent traveling, preparing, testifying, being in attendance, and any other related costs incurred, including the therapist's attorney fees.

The therapist may be required to disclose mental health records pursuant to a valid subpoena and court or administrative order, to the extent that the request for disclosure pursuant to a mental health subpoena for records is in compliance with and authorized and permissible under the

CONSULTATION WITH QUALIFIED PROFESSIONALS
In order to provide clients with the best care and therapeutic services, the therapists of Coping Partners/Children Coping Clinic work as an interdisciplinary team and will often consult with each other for purposes of a client's treatment and care. When possible, therapists will make every effort to withhold identifying information regarding the client.

Additionally, Coping Partners'/Children Coping Clinic's therapists consult regularly with other highly qualified professionals regarding their clients; however, in these instances, clients' names or other identifying information are never mentioned and confidentiality is fully maintained. The consultant is legally bound to keep the information confidential.

PROFESSIONAL RECORDS
The laws and standards of this profession require that we keep a treatment record for each client. This record contains protected health information about you and/or your child. You may examine and/or receive a copy of your/your child's record (if your child is under 12 years old), by making a request in writing. Because these are professional records, they can be misinterpreted by untrained readers. For this reason, it is recommended that you review them in the presence of your therapist or have them forwarded to another mental health professional so you can discuss the contents.

MINORS
Clients under 12 years of age and their parents should be aware that the law allows parents to examine their child's treatment records. Adolescents between the ages of 12 and 18 are entitled by law to limit access by their parents and others to their mental health records. Parents of children between 12 and 18 years old can examine their child's treatment records so long as the child is informed and does not object and the therapist does not find there to be compelling reasons for denying the access. The therapist may provide parents with general information about their child's therapy, including current physical and mental condition, treatment needs, services provided and needed, and his/her attendance at scheduled sessions. All other communication will require the child's authorization, unless the therapist feels that the child is in danger or is a danger to someone else, in which case the therapist will notify the parent of his or her concern. Before giving parents any information, the therapist will discuss the matter with the child, if possible, and use the therapist's best professional judgment to handle any objections he/she may have.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
I, the undersigned, acknowledge that I have received Coping Partners'/Children Coping Clinic's Notice of Privacy Practices (NPP) with an effective date of June 15, 2015 and that I have read and understand the rights I have under the *Health Insurance Portability and Accountability Act* (HIPAA). Further, I understand

that if I have any questions regarding this Notice, I may contact the Privacy Officer as designated on the NPP.

CLIENT CONSENTS TO TERMS OF AGREEMENT:

The undersigned Client, and/or his/her parents/guardians, understand the terms of this Agreement and consent to the rendering of services by the attending therapist, or other therapist acting in his/her place, in accordance with this agreement.

I, the undersigned, wish to become a Client of **Coping Partners™/Children Coping Clinic™** and primarily of the therapist: _____
(Write therapist's name)

The therapist has shared the above policies with me, and has explained their implementation and significance. I have been given a copy of this document, and fully understand it. I have also been advised that the therapist has offered no guarantees as to the success, or as to a specific outcome, of the treatment. Fully understanding the above information, it is my intention to proceed with and/or continue my treatment with _____ of Coping Partners/Children Coping Clinic at this time. (Write therapist's name)

A signature is required from the parent(s) or guardian(s) who have legal responsibility for medical decisions for children in treatment.

_____

Client Printed Name | Signature (if above the age of 12 years old) | Date

_____

Witness Name | Signature | Date

_____

Parent/Guardian Printed Name | Signature | Date

_____

Witness Name | Signature | Date

Coping Partners™

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW

Your Information.
Your Rights.
Our Responsibilities.

This Notice of Privacy Practices is effective as of June 15, 2015

YOUR RIGHTS: You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➢ *See **Page 2 & 3** for more information on these rights and how to exercise them*

YOUR CHOICES: You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➢ *See **Page 5 & 6** for more information on these choices and how to exercise them*

OUR USES & DISCLOSURES: We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a coroner/medical examiner
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➢ *See **Page 3-5** for more information on these uses and disclosures*

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. We will not use or disclose your health information other than as described here unless you provide written authorization. You may revoke your authorization at anytime, in writing, but only as to future uses or disclosures and only where we have not already acted in reliance on your authorization.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.
Please feel free to contact our Privacy Officer with any questions.

- **When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

Right to Inspect & Request an Electronic or Paper Copy of Your Medical Record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Right to Request a Correction to Your Medical Record

- You can ask us to correct health information about your protected health information that you think is incorrect or incomplete, as long as the information is kept by or for us.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Right to Request Confidential Communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will meet all reasonable requests.

Right to Request a Restriction on Certain Uses and Disclosures

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information relating solely to that item or service for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Right to Obtain an Accounting of Disclosures of Your Health Information

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make).
- We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Right to Obtain a Copy of this Notice of Privacy Practices

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Right to Receive Notice of a Breach

You have the right to be notified in writing following a breach of your health information that was not secured in accordance with security standards as required by law.

Right to Choose Someone to Act for You

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

Right to File a Complaint

- You can complain if you feel we have violated your rights by contacting our Privacy Officer at **(847) 497-8378** or by mail to **155 Revere Drive, Unit 8, Northbrook, IL 60062.**
- You also have to right to file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Room 509F, Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

- **How do we typically use or share your health information?** We may use and share your health information for the following purposes:

Treatment: We may use and disclose your health information to provide treatment, and to coordinate care, or manage your healthcare and any related services by sharing it with other professionals, an integrated health system, or a member of an interdisciplinary team who are treating you. *Example: A doctor treating you for an injury asks another doctor about your overall health condition.*

Run Our Organization/Healthcare Operations: We can use and share your health information to run our practice, improve your care, and contact you when necessary. *Example: We may use your health information to conduct quality assessment and improvement activities.*

Payment: We can use and share your health information, as needed, to bill and obtain payment for our health care services from health plans or other entities. *Example: We give information about you to your health insurance plan so it will pay for your services.*

Business Associates: We may disclose your health information to our third-party business associates (for example, a billing company or accounting firm) that performs activities or services on our behalf. Business associates must agree in writing to protect the confidentiality of your information. *Example: We may use or disclose your health information to a business associate that we use to provide reminders to you of an upcoming appointment.*

Fundraising: We may contact you for fundraising efforts, but you will be provided an opportunity to opt-out of receiving such communications in the future.

- **How else can we use or share your health information?** We may be allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. The following are other uses and disclosures we make of your health information without your authorization, consent or opportunity to object: (For more information: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html)

Required by Law: We may share information about you to the extent that is required by state, federal or local laws under the circumstances provided by such law; this includes with the Department of Health and Human Services if it wants to see that we are complying with the federal privacy law.

Health Oversight Activities: We may use and disclose your health information to state agencies and federal government authorities, or to a health oversight agency, for activities authorized by law such as audits, administration or criminal investigations, inspections, licensure, accreditation or disciplinary action and monitoring compliance with the law, including in order to determine your eligibility for public benefit programs and to coordinate delivery of those programs. The Illinois Mental Health and Developmental Disabilities Confidentiality Act allows for the unconsented disclosure of your health information to a health information exchange (HIE), which oversees the electronic exchange of health information, for HIE purposes. *See* 740 ILCS 110/9.5.

Public Health & Safety: We may use or disclose your health information in certain situations, such as in order to prevent/report communicable diseases, helping with product recalls, reporting adverse reactions to medications, to prevent or reduce a serious threat to anyone's health or safety, and for work place surveillance or work related illness and injury.

Organ Donation: We may disclose your health information to organization that handle organ procurement and/or eye or tissue transplantation.

Research: We may disclose your health information for research.

Worker's Compensation, Law Enforcement, & Other Governmental Requests: We may disclose your health information as authorized to comply with worker's compensation claims, for law enforcement purposes or with a law enforcement official, and for special government functions, such as military, national security and presidential protective services.

Abuse, Neglect or Domestic Violence: We may disclose your health information to the designated public agency that is authorized by law to receive reports of child or elder abuse, neglect, or domestic violence. This disclosure will be made consistent with the requirements of applicable federal and state laws.

Coroner/Medical Examiner: We may disclose your health information to a coroner/medical examiner for an investigation of a death and/or homicide, identification purposes, determining cause of death or for the coroner to perform other duties authorized by law.

Lawsuits & Legal Proceedings: We can share health information about you in response to a valid court or administrative order, or in response to a subpoena, to the extent that such disclosure is authorized and permissible under the *Illinois Mental Health and Developmental Disabilities Confidentiality Act*, 740 ILCS 110/1 *et seq.*

- **Your Choice.** For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, please let us know. If you are not able to tell us your preference, we may share your information if we believe it is in your best interest. In the following cases, you have the right and choice to tell us to:

  - Share information with your family, close friends, or others involved in your care
  - Share information in a disaster relief situation
  - Include your information in a hospital directory
  - If your health information is accessible through the HIE, you may provide a written request to opt-out of further disclosure by the HIE to third parties, except to the extent permitted by law (See www.hie.illinois.gov for information on opting-out)

- **Written Authorization.** Any other uses and disclosures of your health information not described in this Notice will be made only with your authorization. Disclosures requiring your written authorization include:

  - Subject to exceptions, uses and disclosures of your health information for marketing purposes
  - Disclosures that constitute a sale of your health information

- Most uses and disclosures of psychotherapy notes.

- Changes to the Terms of this Notice: **We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site. *The effective date of this Notice of Privacy Practices is* June 15, 2015*.***

- **Other Instructions for Notice:** We further comply with the following state and federal laws and regulations related to the disclosure of your protected health information:

  - **Mental Health Records Disclosure:** We comply with the provisions of the *Illinois Mental Health and Developmental Disabilities Confidentiality Act*, 740 ILCS 110/1 *et seq.*
  - **Alcohol/Substance Abuse Records Disclosure:** We comply with the federal Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 *et seq.* If any requested records contain information regarding alcohol or drug abuse treatment, these records are protected by Federal confidentiality rules, and such information is prohibited from further disclosure without express permission by written consent of the person to whom it pertains or as otherwise permitted by Federal Rules. A general authorization for the use or release of medical or other information is insufficient for this purpose. Federal rules restrict use of the information for criminal investigation or prosecution of any alcohol or drug abuse patient. *See* 42 U.S.C. § 290dd-3 and § 290ee-3; 42 C.F.R. Part 2 *et seq.*; *and* 20 ILCS 301 *et seq.*

- **This Notice of Privacy Practices applies to the following entities:** This Notice of Privacy Practices applies to Coping Partners™ and Children Coping Clinic™, located in Northbrook, Illinois, and its employees, contractors, and providers.

OUR CONTACT INFORMATION:	**PRIVACY OFFICER:**
Dr. Leigh Weisz, Psy.D.	
Coping Partners™/Children Coping Clinic™	*Office*: (847) 497-8378
155 Revere Drive, Unit 8	*E-mail*: info@drleighweisz.com
Northbrook. Illinois 60062	

Coping Partners™

E-MAIL CONSENT FORM

I, _____, grant consent for my Coping Partners/Children Coping Clinic therapist, to correspond with me via e-mail for the purpose of scheduling appointments or conveying general information about my treatment or the treatment of my child. **I understand that due to the unencrypted nature of e-mail communications, e-mail is not a secure form of communication and that confidentiality of any e-mailed information cannot be ensured**.

Please be advised that e-mail is not to be used in order to communicate urgent matters or emergencies. This is not a consent to release information to any specific person other than the client (or the client's parent/guardian).

Please indicate your e-mail address:

_____

I understand that it is recommended that I provide a personal e-mail address and not a work or school e-mail address.

Name of Client:

_____

_____ _____

Signature of Client (12 years of age and older) Date

_____ _____

Witness Name & Signature Date

_____ _____

Parent Signature (For Clients under 18 years old) Date

_____ _____

Witness Name & Signature Date

Coping Partners™

CREDIT CARD ON FILE
AUTHORIZATION FORM

Dear Client/Parent/Guardian,

Please complete the following authorization to keep your credit card information on file. Even if you choose a different form of payment at the time of service, we require clients to have their credit card information on file with a signature authorizing a transaction if and when necessary or required per our policies, including when there is any outstanding amount owed. Accordingly, upon completing the form, please provide your signature under the "Office Policy" statement. Please note, you only need to sign the "Automatic Payment" line if you choose this form of payment and wish for us to automatically process payment upon services being rendered. All charges to your credit card will be reflected in the receipt you receive via e-mail, which you may submit directly to your insurance carrier for reimbursement. Of course, you are aware, that you are directly responsible for any outstanding balance on your account and that it is solely your responsibility to submit claims for reimbursement to your insurance carrier.

CREDIT CARD AUTHORIZATION INFORMATION

Name as it appears on card: _____

Account Number: _____

Expiration Date: _____ CVV 3-digit code: _____ Billing Zip Code: _____

Automatic Payment: I authorize Coping Partners/Children Coping Clinic to automatically debit my credit card number on file for current and future services rendered. I understand that I will receive a receipt via email for credit card charges in order to submit for insurance reimbursement if I so choose.

Signature _____Date _____

Office Policy: I authorize Coping Partners/Children Coping Clinic to automatically charge my credit card on file for the outstanding balance if payment is not made at the time of the session. Note this must be signed for services to commence or continue.

Signature _____Date _____