Maple Counseling Center

A Marriage and Family Corporation

Today's Date:_____

Clients name:_____Referred by:_____

Age:_____Date of birth:_____ID#_____Marital status:_____

Spouse/partners name:_____Date of birth:_____

Address:_____

City: _____ State: _____ Zip: _____

Main phone:_____E-mail:_____

Primary M.D.:_____Phone:_____

Name of Employer:_____Phone:_____

Insured or responsible person's name:_____Date of birth:_____

Relationship to client:_____Occupation:_____

Emergency Contact: _____ Emergency Phone: _____

Insured's employer:_____Phone:_____
(if other than client)

Health Insurance Company:_____

Insured's ID#:_____Insured date of birth:_____
(if other than client) (if other than client)

PLEASE PRESENT INSURANCE CARD AND CREDIT CARD FOR PHOTOCOPYING

AUTHORIZATION TO PAY

I/We_____do hereby authorize_____
(name of insurance company)
to pay directly to the Maple Counseling Center medical benefits otherwise payable to me for mental health services.
I understand that I am financially responsible for charges not paid by my insurance company.

Date:_____Signature:_____
I/We, hereby authorize the Maple Counseling Center to release to my insurance company any information required in the course of my treatment, for billing and/or auditpurposes.

Date:_____Signature:_____

Clinician: _____

ICD: _____

2021 Sperry Ave. Suite 41
Ventura, CA 93003
805-669-8846 office | 805-272-9370 fax
www.maplecounseling.org
info@maplecounseling.org

OFFICE POLICIES

Payment: Co-payment or full payment for service is due at the end of each session unless other prior arrangements have been made. Please notify us if any problem arises during the course of therapy regarding your ability to pay for services and/or co-payments.

Insurance: We will bill your insurance company for services. Please notify us if you change insurance companies or no longer have insurance coverage. At intake, please have your insurance card ready for copying.

Cancellation: Please call at least **48 hours in advance** of any appointment you must miss. Failure to abide to this policy more than twice will result in all future appointments being canceled. You may ask to be put on our cancellation waiting list in this case, should an opening occur in our schedule. Cancellations may also be subject to a $60 late cancel charge.

Confidentiality: All information disclosed within sessions, including that of a minor, is confidential and may not be revealed to anyone without written permission except where disclosure is permitted or required by law.
Disclosure may be required in the following circumstances:

1. When there is reasonable suspicion of abuse of a child or a dependent or elder adult.
2. When the client communicates a threat of bodily injury to others.
3. When the client is suicidal.
4. When disclosure is required pursuant to a legal proceeding (e.g., court subpoena).

Our Notice of Privacy Practices (attached) provides specifics on safeguarding your information.

Emergency Procedures: If you need to contact me between sessions, please call the office phone number. If you cannot reach us, please leave a message. Reasonable effort will be exerted to return your call as quickly as possible.
If you cannot reach someone in our office **and/or** it is a true emergency, please **call 911**.

I acknowledge that I have carefully read and understand the above policies and procedures and agree to comply with them.

_____	_____	_____
PRINT NAME: Client or Parent/Guardian	DATE	SIGNATURE
_____	_____	_____
PRINT NAME: Client or Parent/Guardian	DATE	SIGNATURE

Clinician: _____

ICD: _____

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CONSENT FOR TREATMENT

I,_____
(PLEASE PRINT NAME: CLIENT **OR** PARENT/GUARDIAN)

authorize and request_____, a California Marriage & Family Therapist Intern to provide psychological examinations, treatment and/or diagnostic procedures which, now or during the course of my/my child's care as a client, are deemed advisable. The frequency and type of treatment will be decided between the therapist and me.

Please initial that you understand each of the statements below:

_____ I understand that the purpose of such procedures will be explained to me and be subject to my verbal agreement.

_____ I understand that, while there is an expectation that I/my child will benefit from psychotherapy, there is no guarantee that this will occur.

_____ I understand that maximum benefit will occur with consistent attendance and that I may feel conflicted about my/my child's therapy as the process, at times, can be uncomfortable.

I have read and fully understand this Consent for Treatment form.

Signature: _____ Date: _____
(Client or Parent/Guardian)

Signature: _____ Date: _____
(Client or Parent/Guardian)

Clinician: _____

ICD: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES, CONSENT FOR TREATMENT AND OFFICE POLICIES

By signing this form, you acknowledge receipt of my Notice of Privacy Practices, and executed copies of the Consent for Treatment and Office Policies forms that I have given to you.

We have reviewed the Consent for Treatment and Office Policies forms.
My Notice of Privacy Practices provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My Notice of Privacy Practices is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me as listed above.

If you have any questions about my Notice of Privacy Practices, please contact me.
I acknowledge receipt of the Notice of Privacy Practices and executed copies of the Consent for Treatment and Office Policies of the Maple Counseling Center.

Signature:_____ Date:_____
(Client/Parent/Conservator/Guardian)

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES, CONSENT FOR TREATMENT AND OFFICE POLICIES FORMS

I made good faith attempts to obtain my client's acknowledgement of receipt of my Notice of Privacy Practices, Consent for Treatment and Office Policies forms, including_____. However, because of _____, I was unable to obtain my client's acknowledgement.

Clinician Signature:_____ Date:_____

Clinician: _____

ICD: _____

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