



Kathleen Alexander, LMFT, CMPE
Individual, couples and family therapy

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Client Information

Name: _____

Date of Birth: _____ Age: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone: _____ Preferred Email Address: _____

I authorize Kathleen Alexander, or her representative, to leave appointment reminders or changes on the telephone number and/or email address listed above. I understand that I have the right to revoke this consent at any time in writing, and that revocation will only apply to future uses of this information.

Telephone messages yes _____ no _____ Comment: _____

Text messages yes _____ no _____ Comment: _____

Email messages yes _____ no _____ Comment: _____

(Initial _____)

Physician Information:

Physician: _____ Address: _____ Phone: _____

Medications: _____

Allergies and Other Health Concerns: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

I authorize Kathleen Alexander to release details of my diagnosis and treatment plan to the physician listed above.

(Initial _____)

Please initial the blank next to each paragraph, indicating that you have read and understand the following policies:

Initial _____ Authorization for Services and Payment at Time of Service:

I give permission to Kathleen Alexander to perform diagnostic and/or treatment services. I authorize payment directly to Kathleen Alexander from my insurance company. I accept responsibility for payment of services I request or which are required for my treatment, which may not be covered by my insurance. I am responsible for contacting my insurance company for initial authorization and verifying my mental health benefits. I am responsible for all fees applied to my account for treatment and services, and will make all deductible, co-payments or non-covered service payments at time of service.

Initial _____ Authorization for Credit Card on File (optional):

I authorize Kathleen Alexander to charge my credit card for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account. I understand that I may cancel this authorization at any time by contacting Kathleen in writing, and that any revocation by me of this authorization will only apply to future transactions.

Initial _____ Fees for Cancelled or Missed Appointments:

I understand that my appointment time is reserved exclusively for me, and I agree to provide a minimum of 24-hour notice if I am unable to keep that appointment. ***I understand that I will be charged \$50 for no-show/missed appointment, and I acknowledge that a pattern of missed appointments constitutes grounds for termination of services.***

Initial _____ After Hours Care:

I understand that Kathleen Alexander will respond to phone calls and emails during normal business hours, but will not be available to me outside of those hours. However, I am aware that if there is an emergency situation, I am to call 911 or report to the nearest hospital emergency room. I understand that the provided email address is available only for scheduling appointments, and is not intended for clinical services and is not continually monitored or encrypted for security.

Initial _____ Court-Related Work:

If Kathleen Alexander is called upon to appear in court, testify in court, or prepare reports for the court related to service I received, I agree to pay for all such services. A list of fees associated with court services is available upon request.

Initial _____ Consent to the Use and Disclosure of Health Information for the Purposes of Treatment, Payment or Healthcare Operations:

I understand that as a part of my care, Kathleen Alexander will originate and maintain paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment, including consulting with my referring physician, and staff of any health care facility that I am transferred to for continuance of care in an emergency
- A source of information for applying my diagnosis and procedure information to my bill
- A means by which a third-party-payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as quality assurance

Initial _____ Notice of Privacy Practices and Right to Restrict Disclosure:

I have reviewed the Notice of Privacy Practices prior to signing this consent. The Notice of Privacy Practices summarizes the way my medical record may be used or disclosed and states my rights with respect to my medical information. I understand that Kathleen Alexander has the right to revise information practices and to amend the Notice. I understand that in the event Kathleen revises the Notice of Privacy Practices, a revised Notice will be posted in the office, and I may obtain a current Notice at any time. I understand that I have the right to restrict how Kathleen uses and discloses all or any part of my medical record for treatment, payment, or health care operations. I further understand that Kathleen does not have to agree to such restrictions.

Initial _____ Right to Revoke Consent at Any Time:

I understand that I have the right to revoke this consent at any time in writing. I understand that any revocation by me of this consent will only apply to future uses and disclosures and such revocation must be in writing.

Signature of Client/ Legal Representative

Date

Witness

Date: