

New Patient Information Sheet  
(PLEASE PRINT)

**PATIENT INFORMATION:**

Patient's Name \_\_\_\_\_  
Last Name First Name Middle Initial

Responsible Party (if a minor) \_\_\_\_\_

Mailing Address (Street and/or PO Box) \_\_\_\_\_ Apt # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Email Address: \_\_\_\_\_  Yes, I would like to receive periodic informative emails from ABT, Inc.

Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security Number \_\_\_\_\_  
\_\_\_\_\_ Single \_\_\_\_\_ Married (How long? \_\_\_\_\_) \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Separated

Please list children and their ages: (if applicable)  
\_\_\_\_\_  
\_\_\_\_\_

Patient Employer \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Occupation \_\_\_\_\_

How or from whom did you hear of ABT? (Name: \_\_\_\_\_)

Doctor  Church/Pastor  Yellow Pages  Current/Former Patient  Internet  Other \_\_\_\_\_

In Case of Emergency, Please Contact: \_\_\_\_\_ Phone \_\_\_\_\_

**PARENT/SPOUSE INFORMATION:**

Spouse/Parent \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Social Security Number \_\_\_\_\_

**INSURANCE INFORMATION:**

Primary Insurance Company \_\_\_\_\_ Phone Number \_\_\_\_\_

Subscriber's Identification Number \_\_\_\_\_ Group Number \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Subscriber's Social Security Number \_\_\_\_\_

**RELEASE OF INFORMATION:** I authorize ABT, Inc. to obtain/release/exchange information with my Primary Care Physician (PCP), other healthcare practitioners, or as requested by my insurance company for the purpose of service coordination and continuity of care.

Primary Care Physician's/Other practitioner's name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Check here if you do not authorize this release of information.

\_\_\_\_\_  
(Signature of Patient or Responsible Party) (Date)

*For Office Use Only:*  
  
Chart# \_\_\_\_\_  
  
 ABT  Medisoft

## Communication Between You and ABT, Inc.

Occasionally it will be necessary for our office to contact you regarding appointments or other matters about counseling. This permission form will help us know when and how to contact you in ways which are comfortable for you.

**By giving permission for us to contact you in one or more of the ways listed below, you are agreeing for us to leave messages and information. We will always try to be discrete in any messages we leave, but we cannot guarantee confidentiality once the message is left.**

Which is your **preferred contact phone number**? (circle one) Home    Work    Cell

### **Home**

Yes   No    May we contact you at your home telephone number? # \_\_\_\_\_

### **Work**

Yes   No    May we contact you at your work telephone number? # \_\_\_\_\_

### **Cell Phone**

Yes   No    May we contact you at your cell telephone number? # \_\_\_\_\_

### **E-Mail**

Yes   No    **Would you like us to remind you of your appointment via e-mail?** *If you choose this option, you will not receive a phone call reminder. E-mail reminders are sent one business day before your scheduled appointment.*

E-Mail Address: \_\_\_\_\_

### Note:

- The Business Office does not communicate via e-mail with patients. If you need to make/change/cancel an appointment, have patient account or insurance questions, please call our office.
- It is unethical for therapists to give out personal telephone numbers, home addresses, or personal e-mail addresses. If you need to contact us, always call and leave your messages at our office number. All calls/messages are confidential.

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Client or Guardian Signature: \_\_\_\_\_

# Patient Health Questionnaire (PHQ)

ASSOCIATES IN BRIEF THERAPY, INC.

All information is kept confidential in adherence with current HIPAA regulations.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

People commonly have some problems in the following categories. Please indicate how you are affected by each by circling the appropriate number beside the item. Please circle only ONE number for EVERY item.					
Not a Problem 0	A Slight Problem 1	A Moderate Problem 2	A Serious Problem 3	A Severe Problem 4	
1. Feeling sad, depressed or unhappy 2. Feeling discouraged or hopeless 3. Feeling bad about yourself – or that you are a failure or have let yourself or your family down 4. Little interest or pleasure from things I usually enjoy 5. Feeling guilty, worthless, helpless 6. Crying spells 7. Restless, irritable or agitated 8. Feeling tired or having little energy 9. Trouble falling or staying asleep, or sleeping too much 10. Poor appetite or overeating 11. Trouble making decisions 12. Difficulty with concentration 13. Less interest in sex 14. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3	4
1. Anxious/nervous/worried 2. Stressed/overwhelmed 3. Intense fear, panic/discomfort 4. Panic or fear with physical symptoms (such as pounding heart, sweating, shaking, nausea, dizzy, fear of losing control, etc.) 5. Anxiety about being in certain situations (such as being in a crowd, traveling, standing in line, etc.) 6. Anxiety or fear related to being in social situations or having to perform (such as public speaking, test taking, etc.) 7. Fear, anxiety, or avoiding specific situations (such as flying, heights, animals, etc.) 8. Worrying about health problems	0	1	2	3	4
1. Having unwanted thoughts over and over again 2. Repeating specific acts over and over (such as hand washing, checking, etc.) or mental acts (such as counting, repeating words)	0	1	2	3	4
1. Euphoria (feeling high) 2. Sudden changes in mood for no apparent reason 3. Decreased need for sleep (such as feeling rested after only 3 hours of sleep) 4. More talkative than usual 5. Racing thoughts 6. Acting impulsive (such as buying sprees, drinking more, sexual activity, etc.) 7. Excessive irritability or agitation 8. Angry outbursts 9. Property destruction	0	1	2	3	4
1. Making careless mistakes at school, work or other activities 2. Difficulty sustaining attention during tasks 3. Difficulty following through or finishing things 4. Difficulty in organizing tasks or activities 5. Easily distracted 6. Losing things or forgetful 7. Hyperactivity (can't sit still) 8. Poor impulse control	0	1	2	3	4
1. Hearing things 2. Seeing things 3. Experiencing confusion 4. Memory lapses/forgetting 5. Feeling of unreality or being outside of self 6. "Missing time" 7. Suspiciousness (questioning other people's motives)	0	1	2	3	4
I have been experiencing these problems for: <input type="checkbox"/> < 1 Mo <input type="checkbox"/> 1-6 Mos <input type="checkbox"/> 7-12 Mos <input type="checkbox"/> > 1 Yr					

### Check any of the following that have caused concern or difficulties during the last 6 months:

- |                                                                 |                                                          |                                                                 |
|-----------------------------------------------------------------|----------------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> Taking care of personal grooming needs | <input type="checkbox"/> Preparing meals for family/self | <input type="checkbox"/> Getting along with spouse/partner      |
| <input type="checkbox"/> Taking care of children or others      | <input type="checkbox"/> Meeting financial obligations   | <input type="checkbox"/> Getting along with children            |
| <input type="checkbox"/> Enjoyment of hobbies                   | <input type="checkbox"/> Meeting "home" responsibilities | <input type="checkbox"/> Getting along with co-workers & others |
| <input type="checkbox"/> Enjoyment of work                      | <input type="checkbox"/> Meeting "work" responsibilities |                                                                 |

### Current Life Stressors

- |                                                                                   |                                                                      |
|-----------------------------------------------------------------------------------|----------------------------------------------------------------------|
| <input type="checkbox"/> Relationship issues (arguments, separation, divorce)     | <input type="checkbox"/> Health issues (illness or injury)           |
| <input type="checkbox"/> Financial (owe money, loss of job, unemployment)         | <input type="checkbox"/> Abuse (physical, mental, emotional, sexual) |
| <input type="checkbox"/> Legal difficulties (law suit, traffic, criminal charges) | <input type="checkbox"/> Substance abuse (alcohol/drugs/food)        |

If you checked off any of the above problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all \_\_\_\_\_ Somewhat difficult \_\_\_\_\_ Very difficult \_\_\_\_\_ Extremely difficult \_\_\_\_\_

Briefly describe why you are seeking help at this time: \_\_\_\_\_

**Please check below if you have had any of the following medical conditions:**

- |                                          |                                                 |                                                     |                                         |
|------------------------------------------|-------------------------------------------------|-----------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> PMS                        | <input type="checkbox"/> Surgery: _____ |
| <input type="checkbox"/> Stomach ulcers  | <input type="checkbox"/> Head injury/concussion | <input type="checkbox"/> Asthma                     | _____                                   |
| <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Seizures               | <input type="checkbox"/> Other Respiratory Problems | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Hypothyroidism  | <input type="checkbox"/> Heart attack           | <input type="checkbox"/> Cancer                     | _____                                   |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Angina                 | <input type="checkbox"/> Menstrual Problems: _____  |                                         |
| <input type="checkbox"/> Colitis/Crohn's | <input type="checkbox"/> High blood pressure    |                                                     |                                         |
| <input type="checkbox"/> Chronic pain    | <input type="checkbox"/> Urinary retention      | <input type="checkbox"/> Pregnancy: _____ times     |                                         |
| <input type="checkbox"/> Lupus           | <input type="checkbox"/> Migraines              | <input type="checkbox"/> Miscarriage: _____ times   |                                         |
| <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Chronic headaches      | <input type="checkbox"/> Hysterectomy               |                                         |

**Please list all current medications:** (Use the back of this form if necessary)

Medication	Strength	Frequency	Date started	Prescribed by

**Please list all PREVIOUS psychotropic medications you have EVER taken.**

Medication	Strength	Frequency	Date started	Prescribed by

**Medication Allergies:**  No  Yes (Describe: \_\_\_\_\_)

**Please list all previous counseling/psychiatric treatment including any psychiatric hospitalizations.**

Dates	Reason	Counselor's/Doctor's Name

Yes  No Has any family member ever had a problem with drugs and/or alcohol? If so, who and what? \_\_\_\_\_

Yes  No Has any member of your family ever had any history of depression, anxiety, or other mental problems? Any history of suicide?  
\_\_\_\_\_

Yes  No  Never 1. Do you have thoughts about suicide now?

Yes  No  Never 2. Have you ever thought about suicide?

Yes  No  Never 3. Have you ever attempted suicide?

Yes  No  Never 4. Do you have access to guns/weapons?

Yes  No  Never 1. Are you thinking about hurting someone now?

Yes  No  Never 2. Have you ever thought about hurting someone else?

Yes  No  Never 3. Have you ever hurt someone else?

**Please answer the following questions:**

Do you drink alcoholic beverages?  Yes  No  Never (Skip to next section)

If yes, how many alcoholic drinks do you have in the average: day \_\_\_\_\_, week \_\_\_\_\_, month \_\_\_\_\_, year \_\_\_\_\_

**If yes to the above, please answer the following:**

- Yes  No Have you ever sought help for alcohol or drug use (including AA or NA meetings)?
- Yes  No In the past year, have you ever drunk alcohol or used drugs more than you meant to? Or have you spent more time drinking or using than you intended to?
- Yes  No Have you ever neglected some of your usual responsibilities because of using alcohol or drugs?
- Yes  No Have you felt you wanted or needed to **cut down** on your drinking or drug use in the last year?
- Yes  No Has anyone ever objected to your drinking or drug use?
- Yes  No Have you ever found yourself preoccupied with wanting to use alcohol or drugs?
- Yes  No Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?
- Yes  No Has your drinking or drug use ever caused legal problems (DUI's, traffic accidents, violence, etc.)?

**Check if you have taken any of the following drugs:**  Yes  No  Never (Skip to next section)

- |                                             |                                                         |                                                              |
|---------------------------------------------|---------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Marijuana/Pot      | <input type="checkbox"/> Cocaine/crack                  | <input type="checkbox"/> Inhalants                           |
| <input type="checkbox"/> Amphetamines/speed | <input type="checkbox"/> Barbiturates/sedatives/downers | <input type="checkbox"/> Designer drugs, Ecstasy             |
| <input type="checkbox"/> Heroin/opiates     | <input type="checkbox"/> Intravenous drug use           | <input type="checkbox"/> Tranquilizers (Xanax, Valium, etc.) |
| <input type="checkbox"/> PCP/Angel Dust     | <input type="checkbox"/> Pain medicine                  | <input type="checkbox"/> LSD/hallucinogens                   |

Yes  No Have you ever taken prescribed medication inappropriately?

**Sleep Difficulties (Check all that apply):**

- |                                                  |                                                       |
|--------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> None                    | <input type="checkbox"/> Nightmares                   |
| <input type="checkbox"/> Falling asleep          | <input type="checkbox"/> Wets bed                     |
| <input type="checkbox"/> Falling back to sleep   | <input type="checkbox"/> Walks in sleep               |
| <input type="checkbox"/> Tired upon waking       | <input type="checkbox"/> Snores                       |
| <input type="checkbox"/> Early morning awakening | <input type="checkbox"/> Stops breathing during sleep |
| <input type="checkbox"/> Bad dreams              | <input type="checkbox"/> Falls asleep when emotional  |

**Usually, the time that I ...**

Go to bed: \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.  
Wake up: \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.

**Smoking:**

None  
Packs per day: 1  2  3  Other   
Age began: \_\_\_\_\_

**Caffeine (cups per day):**

Coffee: 1  2  3  4  More   
Tea: 1  2  3  4  More   
Soda/other: 1  2  3  4  More

Are you sensitive to caffeine?  Yes  No

**Please answer the following questions:**

- Yes  No Is there any history of violence, verbal or sexual abuse in your family?
- Yes  No Have you ever been physically abused?
- Yes  No Have you ever been sexually abused?
- Yes  No Have you ever experienced or witnessed a traumatic event (accidents, crime, major medical illness)?

If yes to any of the questions above, please elaborate with your counselor.

**I certify that all information above is true and accurate.**

\_\_\_\_\_  
**Signature of Client, Parent or Guardian**

\_\_\_\_\_  
**Date**

## **Associates in Brief Therapy, Inc.**

Main Business Office:  
4346 Starkey Rd., Suite 1  
Roanoke, VA 24018  
Phone: (540) 772-8043  
Fax: (540) 772-8242  
www.abtcounseling.com

Main Office: Roanoke, VA  
Satellite Offices: Salem, VA  
Blacksburg, VA  
Daleville, VA  
Floyd, VA

### **INFORMED CONSENT**

**Welcome to our practice.** We are pleased to have the opportunity to serve you and hope that this handout will provide helpful information in making an informed decision concerning our services. **Please ask questions at any time.**

**Organization Information:** Associates in Brief Therapy, Inc. (ABT, Inc.) consists of counselors who are employees and counselors who are independent contractors. The President and Clinical Director of ABT, Inc. is David L. Mortellaro, LPC, LMFT.

**Hours of Operation:** Our office staff, located in our Roanoke office, answers telephone calls from 8:30 a.m. until 5:30 p.m. Monday through Thursday and from 8:30 a.m. until 2:00 p.m. on Friday. At all other times calls are forwarded to a voice mail system. Therapists do not answer phone calls while they are in session. Therapists are available for appointments Monday through Friday. Evening appointments are available Monday through Thursday. Satellite office hours vary; please call our main office in Roanoke for specific appointment times.

**Background & Training:** All of our clinicians have earned a graduate degree (Masters or Doctorate) from an accredited university. All ABT, Inc. counselors are licensed to practice in the state of Virginia. ABT, Inc. also employs resident counselors who have completed a graduate degree and are pursuing licensure under direct supervision of a licensed clinician. The clinical supervisor's name and credentials may be obtained upon request. Our clinicians only practice within their scope of training and experience. In the course of our training and previous employment, we have had experience in treating a wide variety of individuals including children, adolescents and adults in individual, couples, family, and group counseling. **Your counselor will have his/her own primary specialty areas of expertise.**

**Philosophy:** We accept in our practice only clients whom we believe have the capacity to resolve their own problems with our assistance. The foundation of the healing process is the therapeutic relationship which is based on trust, respect, honesty, confidentiality and effort. As people learn more about their strengths and weaknesses, they usually become more accepting of themselves and others and feel more empowered to accomplish their goals. As the client, you are responsible for setting the goals you want to accomplish and can terminate counseling at any time. Our responsibility is to help you accomplish these goals in the shortest time possible. If counseling is successful, you should feel better about yourself and be able to face life's challenges in the future without our support or intervention. We cannot guarantee results.

**We ask that you be as honest and as open as possible in discussing your concerns. If you are unclear about anything regarding your therapy, please ask questions.** Psychotherapy can be very helpful for some individuals but it is not without some risks. These risks may include the experience of intense and unwanted feelings, such as sadness, anger, fear, guilt or anxiety. It is important to remember that these feelings may be natural and normal and are an important part of the therapy process. Other risks might include: recalling unpleasant life events, facing unpleasant thoughts and beliefs or possible alteration of an individual's relationships. We will make every effort to minimize potential risks and hazards which are not helpful to the therapeutic process. Often in therapy, major life decisions are made, including: decisions involving families or friends, changes in relationships, or changes in your jobs or careers. These decisions are a legitimate outcome of therapy as a result of an individual's calling into question some of their beliefs and values, recognizing their strengths, increasing their self-acceptance, alleviating symptoms and problems or learning more helpful coping skills.

We use research-based "best practices therapy methods" including, but not limited to, Cognitive-Behavioral Therapy (CBT), Solution-Focused Brief Therapy, faith-based counseling, Person Centered Therapy, Strategic or System based approaches, assessments, and bibliotherapy. These methods sometimes utilize psycho-education methods with homework assignments.

#### **Confidentiality**

I understand the confidentiality of the work I do together with my therapist is upheld at all times. However, there are certain exceptions to this rule: (1) if my counselor suspects child or elder abuse has occurred, the law requires it be reported to the authorities; (2) if my counselor believes I am a clear and imminent danger to myself or another person, the counselor must notify appropriate authorities to prevent that occurrence; (3) if it becomes necessary to contact an attorney or collection agency, then my name, identifying information about how to reach me, and amount owed becomes available to these agents; and (4) in a legal proceeding, a court may order a release of information.

**Fees, Payments and Insurance:** We make every effort to keep down the cost of your medical care. Therefore we require that you pay for your treatment at the time of your visit. The cost of therapy is \$100.00 for the initial session and \$90.00 for each following session. Payment may be made by cash, check or credit/debit card. If you have insurance coverage we ask that you make your co-pay and unmet deductible fees at the time of your office visit. If at any time during your treatment you are having financial difficulties and cannot make the required payments on your account, you may contact the Office Manager to set up financial arrangements. Most plans include co-

payments/co-insurance, a deductible and other expenses which must be paid by the patient. If you have insurance, please bring your insurance card with you. We will automatically file your insurance for you if you have provided us with the necessary information. **However, we cannot fully guarantee your coverage or your benefits. In the event that your insurance company does not pay for services rendered, you will ultimately be responsible for payment.** If you have a change in insurance coverage or benefits, please notify the business office immediately.

**Returned Checks:** If you pay for any service provided with a check and that transaction is returned to us from your bank as non-payable, there will be a charge of \$35.00. After a non-payment incident, checks may no longer be accepted and you will be required to pay all outstanding balances on a **cash only basis**.

**Psychological Testing:** Psychological testing is sometimes a critical component of evaluating problems and strengths and assisting clients in accomplishing their goals in the shortest time possible. After an initial interview your therapist may recommend such assessment. Costs for this service depend on the testing instruments used and the length of time required for administration and scoring. The exact charges will be discussed with you prior to any testing.

**Cancellations:** Since therapists see patients by appointment only, and each appointment constitutes a significant portion of the therapist's day, it is common practice to charge a fee for missed appointments. A charge of \$25.00 will be made when less than 24-hour advance notice is given for a cancelled appointment. A charge of \$45.00 will be made if you do not show up for an appointment or call in response to your absence. These charges are not reimbursable by insurance carriers. We would appreciate you notifying us at (540) 772-8043 if you will not be attending a session with as much notice as possible-preferably 48 hours or more. If you do not reach us personally, please leave a voice mail for the receptionist of your cancellation.

**Messages:** As you work together with your therapist, you will notice that he/she does not accept phone calls while with you. During those times and at other times during the day or evening, his/her calls are answered electronically. Messages are checked frequently during the day, and he/she will attempt to call you back as soon as possible. Usually, we can get back with you within 24 hours. If you need to speak with him/her directly during regular office hours, please leave your name and phone number on his/her voice mail. On evenings, weekends, and holidays, the messages will be received and acted upon during the next working day.

**Complaints:** If at any time you are dissatisfied with our services, please let your therapist know or contact our Office Manager or Clinical Director. If he/she is not able to resolve your concerns you may report your complaints to the Virginia Department of Health Professions at 1-800-533-1560. Your therapist is required to follow a Code of Ethics. If you would like to see a copy of the Code it can be found on-line at the website for the American Counseling Association at [www.counseling.org](http://www.counseling.org).

**Counseling and Financial Records:** Counseling and financial records are maintained on each client for a period of seven years. Records are stored in boxed paper files in a secure central location. The records are our property but may be reviewed by a client with 30 days notice.

**Noncompliance:** A therapist may cancel or terminate services for noncompliance with the plan of care, failure to keep or cancel appointments, violent behavior, a threat of violence or involvement in criminal behavior.

**Consultation:** In keeping with generally accepted standards of practice, we may confidentially consult with other mental health professionals regarding the management of treatment. The purpose of the consultation is to assure quality care. Every effort is made to protect the identity of the clients.

**Emergencies:** Our office is not set up to routinely provide crisis intervention services. In case of an emergency and/or our office is closed, you may go to your local Emergency Room, call Respond at (540) 776-1100 or call CONNECT at (540) 981-8181 to reach a crises counselor.

**Affiliation Relationships:** Employees and independent contractors of Associates in Brief Therapy, Inc. are each wholly responsible for his/her own acts and omissions.

**Copying Fees for Medical Records:** We attempt to honor your request of medical records as quickly as possible. We make every effort to respond within 30 days. The charge for copying and mailing medical records is as follows:

- Handling and processing fee \$10.00 per request
- Photocopying (pages 1 – 25) \$ .50 per page
- Photocopying (pages over 25) \$ .25 per page

This charge is billed to the organization/individual requesting the records as outlined in your authorization and **payment is due in advance of the records being released**. However, you will ultimately be responsible for any unpaid fees should that party not make payment.

**Permission to Treat a Minor Child:** Please note that we require written permission before we can treat any client under the age of 18:

- When parents are married, the signature of one parent is sufficient to provide treatment.
- If the parents are divorced, we require the signature of the parent having legal custody of the child.
- If the parents have joint legal custody, we may require the signature of both parents
- If the parents are separated, we may also require the signature of both parents to provide treatment.

Phone authorizations are not accepted. Parents must sign the “Informed Consent/Permission to Treat Form” in person or have it notarized with seal and signature if signed off premises. We will not provide treatment for any child who does not have the proper signed consent form(s) on file. The office staff is directed to reschedule your appointment if the form(s) is not completed.

**Requests for Letters:** Therapists take a great deal of time corresponding with requested individuals on the behalf of their patient. There is a charge for letters written by therapists at the request of the patient. If a legal letter is needed, a fee ranging from \$25.00 to \$100.00 will be charged. The charge will vary and is based on the clinical and clerical time required to complete the letter. Insurance benefits will not cover this charge; therefore, you will be fully responsible for this cost. Payment must be received before a letter can be delivered.

**Request for Forms:** In most instances your therapists will complete health or treatment forms on your behalf. However, please be aware that there is a charge of \$15.00 for forms to be completed by therapists at the request of the patient. In the event that the form is lengthy or complex, your therapist may request that you schedule an appointment and complete the form as part of your session. Insurance benefits will not cover this charge; therefore, you will be fully responsible for this cost. Payment must be received before a form can be delivered.

**Telephone Consultations:** There is usually no charge for a brief phone conversation with your provider. If you require a more lengthy discussion, a receptionist will schedule a time with your therapist by phone. Please ask your therapist to explain his/her rate for phone consultations. Insurance benefits will not cover this charge; therefore, you will be fully responsible for this cost. We ask that you pay by credit card prior to the consult.

**Court Appearances:** Therapists are occasionally needed to testify in court or provide a deposition as an expert witness for a patient regarding a legal matter. If you think you may be involved in a legal dispute or may require your therapist’s testimony, please inform him/her as quickly as possible. If a judge or another party subpoenas your therapist or your medical records, we are legally required to comply. If you or your attorney subpoenas any of our therapists at ABT, Inc. to appear in court on your or your dependent’s behalf, you will be charged a fee of \$300.00. Full payment is expected to be paid prior to the scheduled court date. Since our therapists have to rearrange their scheduled patients in order to appear in court for you, pre-payment is required. If the time required in court is in excess of three (3) hours (including travel time) you will be charged an additional \$100.00 per hour. You will be billed for the balance due. You will be charged for our therapist’s presence in court, regardless if they testify or not. If court is cancelled our office needs at least a 24 hour notice in order for you to receive reimbursement of your initial \$300.00 fee. Insurance will not reimburse for these fees.

**Payment of Outstanding Balances:** Each month we mail billing statements for each account with outstanding balances due. **You are responsible for paying the total amount due upon receipt of the statement.**

- If we do not receive payment in full for balances due within 30 days of billing, this may result in the suspension of services.
- Outstanding balances exceeding 90 days past due will result in collection procedure. In the event that your account is forwarded to an external collection agency, all collection fees will be added to your account. In addition, finance charges of 1.5% will be added each month to accounts which are 90 days past due.

**Damages to Facility:** Our office is structured in order to provide a comfortable and professional setting for you. It is our policy to hold our patients or their parents financially responsible for any damages imposed upon our building or its contents. Patients or parents will be billed in full for any cost of repairing or replacing anything which is damaged. Children/adolescents must be accompanied by an adult at all times while in our office.

**Emergencies at the Facility:** In case of a medical emergency at our facility, we will contact the nearest and most appropriate medical facility to provide care.

*We hope this brief introduction answers some of your questions. Please feel free to ask any additional questions you may have. Again, we welcome you to our work together and trust that it will be mutually beneficial.*

**(This page intentionally left blank.)**

**INFORMED CONSENT Signature Page**

Permission for treatment is hereby authorized to \_\_\_\_\_, to render treatment  
to \_\_\_\_\_ whose relationship to me is (circle one) self, child, spouse, guardian or  
other \_\_\_\_\_ .

\_\_\_\_\_  
Signature of Client, Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness or Counselor

\_\_\_\_\_  
Date

**I have received a copy of this Consent Form.**

\_\_\_\_\_  
Signature of Client, Parent or Guardian

\_\_\_\_\_  
Date