Viewpoint Psychology & Wellness, LLC
Child / Adolescent Intake Form

Name:	Age:	Date:

Presenting Problems and Concerns

Describe the problem(s) that brought you to us:

Please identify all of the behaviors and symptoms that you consider problematic:

☐ Distractibility
☐ Hyperactivity
☐ Impulsivity
☐ Boredom
☐ Poor memory / confusion
☐ Phobias
☐ Sadness
☐ Defiance
☐ Peer / Sibling Conflict
☐ Hopelessness
☐ Thoughts of death
☐ Self-harm behaviors
☐ Crying spells
☐ Loneliness
☐ Low self-worth
☐ Stealing
☐ Manipulative
☐ Fire Setting
☐ Other:

☐ Change in Appetite
☐ Lack of motivation
☐ Withdrawal from others
☐ Anxiety / worry
☐ Panic attacks
☐ Fear away from home
☐ Social Discomfort
☐ Obsessive thoughts
☐ Compulsive behaviors
☐ Aggression / fights
☐ Frequent arguments
☐ Irritability / anger
☐ Homicidal thoughts
☐Destroys Property
☐ Hearing voices
☐ Recurring disturbing memories
☐ No New Friends
☐ Legal Problems

☐ Suspicion / Paranoia
☐ racing thoughts
☐ Mood swings
☐ Excessive Energy
☐ Sleep problems
☐ Nightmares
☐ Eating Problems
☐ Curfew Violations
☐ Computer addiction
☐ Fatigue
☐ Swearing
☐ Sexual problems
☐ Running Away
☐ Work / school problems
☐ Alcohol / drug use
☐ Visual Hallucinations
☐ Bed Wetting
☐ Sexual Behaviors

Are your child's problems are affecting any of the following:

☐ Handling everyday tasks
☐ Hygiene
☐ Legal Matters
☐ Health

☐ Self-esteem
☐ Work / school
☐ Finances
☐Other:

☐ Relationships
☐ Housing
☐ Recreational Activities

Has your child ever had thoughts, made statements, or attempted to hurt him / herself? ☐ Yes ☐ No If yes, please describe.

Has your child ever had thoughts, made statements, or attempted to hurt someone else? ☐ Yes ☐ No If yes, please describe.

Has your child recently been physically hurt or threatened by someone else? ☐ Yes ☐ No If yes, please describe.

Family and Developmental History

Relationship	Name	Age	Quality of Relationship
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Other Relative			

Family Mental Health Problems	**Who**
Hyperactivity	
Sexually Abused	
Depression	
Manic Depression	
Suicide	
Anxiety	
Panic Attacks	
Obsessive Compulsive	
Anger Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Abuse	
Drug Abuse	

Other Family Medical Health Problems / Concerns:

Please check appropriate situation:

☐ Parents legally married or living together ☐ Mother remarried _____ # of times ☐Father remarried _____# of times
☐ Parents separated ☐Parents divorced

Please check if you have experienced any of the following types of trauma or loss

☐ Emotional Abuse
☐ Sexual Abuse
☐ Physical abuse
☐ Parent substance abuse
☐ Teen pregnancy
☐ Neglect
☐ Violence in the home
☐ Crime Victim
☐ Parent illness
☐ placed a child for adoption
☐ Lived in a foster home
☐ Multiple family moves
☐ Homelessness
☐ Loss of a loved one
☐ Financial problems

Were there any medical problems during the pregnancy or birth of your child? ☐ Yes ☐ No If yes, please describe.

Did the biological mother use any tobacco, medication, street drugs, or alcohol while pregnant with this child? ☐ Yes ☐ No
If yes, please describe.

Did your child have any developmental delays in early childhood (crawling, walking, talking, toileting, etc.)? ☐ Yes ☐ No
If yes, please describe.

Previous Mental Health Treatment

Yes	No	Type of Treatment	When	Program / Provider	Reason
		Outpatient Counseling			
		Medication			
		Psychiatric Hospitalization			
		Drug / Alcohol Treatment			
		Self Help support groups			

School Information

Current Grade Placement:

This year's school grades:	☐ Excellent	☐ Good	☐ Fair	☐ Bad
Past school grades:	☐ Excellent	☐ Good	☐ Fair	☐ Bad
This year's school behavior:	☐ Excellent	☐ Good	☐ Fair	☐ Bad
Past school behavior:	☐ Excellent	☐ Good	☐ Fair	☐ Bad

Has your child had any of the following difficulties at school?

☐ Suspension	☐ Incomplete homework	☐ Learning problems	☐ Detentions
☐ Poor grades	☐ Teased or bullied	☐ Speech problems	☐ Attendance issues

Does your child have an after school provider? ☐ Yes ☐ No If yes, please describe.

Has your child ever repeated or skipped a grade? ☐ Yes ☐ No If yes, please describe.

Has your child ever received special education services? ☐ Yes ☐ No If yes, please describe.

What does your child's teacher(s) say about him / her?

Substance Abuse History

Substance Type	Current Use				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine / Crack								
Ecstasy								
Heroin								
Inhalants								
Meth								
Pain Killers								
PCP / LSD								
Steroids								
Tranquilizers								
Others								

Has your child ever had withdrawal symptoms when trying to stop using any substances? ☐ Yes ☐ No If yes, please describe.

Has your child ever had problems with work, relationships, health, the law, etc., due to your substance use? ☐ Yes ☐ No
If yes, please describe.

Medical Information:

Date of last physical exam:

Has your child experienced any of the following medical conditions during his / her lifetime?

☐ Allergies
☐ Chronic pain
☐ Dizziness / Fainting
☐ High Fevers
☐ STDS
☐ Ear Infections
☐ Asthma
☐ Surgery
☐ Meningitis
☐ Diabetes
☐ Abortion
☐ Other:
☐ Headaches
☐ Serious Accident
☐ Seizures
☐ Hearing Problems
☐ Sleep Disorder
☐ Stomachaches
☐ Head Injury
☐ Vision problems
☐ Miscarriage
☐ Infertility

Please identify any other CURRENT health concerns:

Current Prescription Medications

Medication	Dosage	Date Prescribed	Prescribed By

Current over the counter medications (vitamins, herbal remedies):

Allergies and / or adverse reactions to medications:

Interpersonal / Social / Cultural Information

Please describe your child's social support network:

☐ Family ☐ Neighbors ☐ Friends ☐ Students
☐ Co-workers ☐ Support group ☐ Community group ☐ Religious / spiritual center

If Adolescent (12 to 18 years), is patient sexually active? ☐ Yes ☐ No If yes, please describe.

To which cultural or ethnic group does your child belong:

If your child is experiencing any difficulties due to cultural or ethnic issues please describe:

How important are spiritual matters to your child? ☐ Not at all ☐ Little ☐ Somewhat ☐ Very Much

Please describe your child's strengths, skills, talents, hobbies and interests:

Legal

If the parents are separated or divorced, what is the current child custody / visitation arrangement?

Is your child currently the subject of a custody chase? ☐ Yes ☐ No

Has your child ever been a ward of the court with CPS guardianship? ☐ Yes ☐ No

Does your child have any legal offenses on record or pending in the courts ☐ Yes ☐ No If yes, please describe.

Viewpoint Psychology & Wellness, LLC
Authorization For Treatment / Counseling
Notification of Patient / Client Rights
Privacy Policy & Breach
Fee Agreement & Insurance Information
Date Effective 04-15-20

Appendix A Required

Welcome to our clinic. This "Authorization" document contains important information about our professional services and business policies. Please read it carefully and ask any questions that you might have so that we can ensure they are answered. **Once you sign document, it will constitute a binding agreement between you and the Practice of Viewpoint Psychology and Wellness, LLC, which, from this point thereafter, shall include our contracted wellness providers and administrators.**

Our mission is to assist children, adolescents, adults, families, and couples create change for themselves and reach their highest potential. Whether you are looking for therapy, assessment and testing, or are interested in more of a wellness-based model, we are here to address your concerns and provide effective treatment. Our focus is on the needs of our clients and how we can help them achieve their goals. Our providers come from a variety of educational backgrounds and training experiences, which allows us to have expertise in a variety of treatment interventions that will optimally benefit the client. We understand as wellness providers, that our clients are often coming to us during a difficult time in their lives. Therefore, we strive to provide a therapeutic environment that will include the support and guidance needed to create the change that our clients are looking to accomplish.

Our mental health practice routinely includes, but is not limited to, Licensed Clinical Psychologists, Licensed Social Workers, and Limited License Psychologists, Licensed Professional Counselors, Nurse Practitioners, Psychiatrists and administrators. Our reputation allows us to be a primary referral destination for numerous pediatric, family, and specialty medical practices, agencies, hospital programs, schools and other mental health practices.

As practitioners, our education, training, and experience allow us to successfully treat people of all ages. We provide services in individual, couples, and family therapy, in addition to interpersonal, skill based, and support therapy groups. We additionally offer psychological assessment and testing. Each practitioner is skilled in various therapeutic styles that are supportive of change and reaching client goals. These styles include, but are not limited to, Acceptance and Commitment Therapy, Cognitive Behavioral Therapy, Psychodynamic Therapy, Person Centered Therapy, Interpersonal Therapy, Play Therapy, Family Systems Therapy, Dialectical Behavior Therapy and Mindfulness, and Couples / Marital treatment.

Treatment Process
Services offered at Viewpoint are tailored by the individual wellness provider. However, each start with an assessment where your wellness provider will talk with you about your current situation, ask you about your history, and make a recommendation for services. You will then develop a "treatment plan" together that outlines how services will go and what outcomes are expected.
Individual sessions usually last 40-60 minutes. They may be weekly or at a frequency agreed upon with your provider. The frequency will likely decrease over time. Your wellness provider will talk with you about what is recommended for you. Group therapy options are available as well.
If you and your wellness provider believe that psychiatric medications might be helpful, your wellness provider can make a recommendation. While Viewpoint does provide medication management, you are under no obligation to seek treatment via one of our providers. If you are only seeking medication management, your provider may recommend and / or require that active therapeutic treatment also take place. Similarly, you are under no obligation to seek such treatment by one of our providers.

Risks & Benefits
Mental health services are generally effective in treating most mental health conditions. We review outcomes and we find that most people benefit from therapy and/or medications. Few people get worse from treatment. Improvements do require attending appointments and following through with recommendations.
When we develop a treatment plan with you, we will discuss risks and benefits. Also, if you are provided medication management services, the provider will talk with you about risks and benefits of medications that are prescribed.
If you feel treatment is not working, you can either discuss with your provider and /or ask to be transferred to a different provider within Viewpoint. If you wish to transfer to a provider outside of Viewpoint, we will require signed consents.

Minors and Custody
Viewpoint's role is to help people with mental health issues make lasting life improvements. It is not our role to conduct a custody evaluation, determine whether a parent is "fit" or not, recommend one parent over another, nor focus on reunification of a child and parent. We will not testify in court about custody issues, unless we are compelled by a court.

For children with divorced parents, we expect the parents to communicate with each other about services, decide who will schedule appointments, who will bring the child to treatment, etc. The wellness provider and the child cannot be messengers between parents.
It is important to note that **both** parents have access to a child's record, regardless of custody, unless parental rights have been revoked.
Since children benefit from an expectation of some privacy, we try not to share details of what a child says or does in treatment. We will share progress in treatment, as well as notify parents of any risks of harm. We include parents in treatment for the benefit of the child.

Rights & Responsibilities
I understand that my (my child's) being seen by a contracted wellness provider at Viewpoint is on a voluntary basis, and I understand and accept the consequences of treatment as explained to me. I am free to decide to accept or reject any special type of treatment, including diagnostic procedures and / or hospitalization, except as required by law, that members of the clinic staff may recommend for me. I have also read and understand my rights as listed below:

- Be treated with dignity and respect
- Have the right to be served without discrimination as to age, sex, race, creed, color or national origin
- With your treatment plan
    - Choose from available services and supports that are consistent with the plan
    - Participate in & assist in the development of the plan
    - Receive services consistent with that plan
    - Participate in periodic review and reassessment of service and support needs
    - Receive a copy of plan if requested
- Have all services explained, including expected outcomes and possible risks;
- Give informed consent in writing prior to the start of services, except in a medical emergency or as otherwise permitted by law.
- Have the right to confidentiality. Except as required by law, no information, written or verbal, concerning my (my child) shall be released or requested without a dated, signed, and witnessed statement made by me authorizing the practice and / or the wellness provider to do so. The statement of authorization shall indicate by name to whom, what specific information, and for what purpose this information will be transmitted.
- Not participate in experimentation
- Have the right to be notified and discharged if services cannot be provided.
- Receive prior notice of service conclusion or transfer, unless it poses a threat to health and safety.
- Be free from abuse or neglect and to report any incident of abuse or neglect without being subject to retaliation;
- Be informed at the start of services, and periodically thereafter, of the rights guaranteed by this rule;
- Be informed of the policies and procedures, service agreements and fees applicable to the services provided, and to have a custodial parent, guardian, or representative, assist with understanding any information presented. A summary of policies is available upon request.
- Have family involvement in service planning and delivery;
- Have the right to ethical treatment by my wellness provider according to the ethical standards and ethical code of conduct.
- Expectations are that clients arrive for their scheduled appointments, talk about and actively attempt with the wellness provider to reduce their problems and pay any required fees for services rendered.
- No smoking, weapons or illegal drugs are permitted at Viewpoint.
- It is understood that treatment will be rendered by appropriate licensed or certified professional personnel.
- I may contact the clinic or the primary therapist as the need arises. If the primary therapist is unavailable, the clinic will arrange for contact as soon as possible by the primary therapist or another professional staff member
- Have the right so seek treatment by an alternate provider within or outside of Viewpoint.

Complaints & Grievances
If you are unhappy with the services of a contracted wellness provider at Viewpoint, you have a right to file a complaint. You may do it informally by talking directly with your wellness provider or by contacting the owner whose contact information can be found at www.viewpointpw.com. Defamation, or equivalent, of Viewpoint and / or the providers, without factual evidence is prohibited in accordance with the Consumer Review Fairness Act of 2016.

Responsibilities
There are also responsibilities that come with receiving treatment by a contracted provider at Viewpoint. These include the following:

Coverage
Please bring a copy of your insurance card to each appointment. If you are no longer eligible for benefits, we will discuss payment options.

Cancellations and No-Shows.
We require a 24-hour advance notice for cancellations or re-schedules. **Please call your wellness provider directly**. A late cancellation or no-show will result in a charge of **$75 dollars.** (***see Cancellation and No Show Policy***). This fee is not covered by insurance and is due prior to or at the next appointment. If we do not believe you will make progress on your mental health condition because of no-shows or late cancellations, we may end treatment with you. Overall, we will consider that you are not an active client with us if 60 days have passed since your last appointment.

Cr**isis & Emergencies.**
Call 911 if you are experiencing a medical emergency.

Financial Responsibilities

The private pay individual fee per session for your therapy, if applicable, is $ See Attached Appendix A.

Copays and deductibles are always billed per your coverage / EOB (explanation of Benefits) unless financial hardship dictates otherwise. These fees may change from time to time based on you need or coverage. To the extent possible, you may be notified in advance if this is going to occur. If you schedule Psychological Testing and / or Assessment or another specialty wellness service, the fee might differ from the fee for your regular therapy sessions.

As a courtesy, Viewpoint will check with your insurance, as applicable, to verify your eligibility and benefits. However, this is not a guarantee of payment. It is your responsibility to understand your coverage, including co-pays, co-insurance, and deductibles. This also includes understanding what services are covered and what are not covered.

The person who signs the Acknowledgement page is agreeing to be the "financial guarantor", which means this person agrees to pay any of these fees. Co-pays are typically due at the time services are rendered. If we determine there is a balance on your account (i.e., you owe fees), we will send you a statement. We ask that you complete payment within 45 days. Payments beyond 45 days may incur a late fee of 10%. If the fees are not paid, we may send your account to a collection agency. You are responsible for paying any fees, including court, legal and collection. There is always a $25 service charge for returned checks (non-sufficient funds).

Notice of Privacy Practices
This Notice describes how protected health information (PHI) about you (or your child) may be used and disclosed by Viewpoint and / or its wellness providers. This Notice describes how you can access your information and your other privacy rights. By signing this agreement you authorize Viewpoint and / or its wellness providers to provide notice to you by telephone or verbally in the event of a breach of your (or your child's) PHI. This notice shall not be simply for administrative convenience.
We are required by law to:

1. make sure your medical information is kept private
2. give you this Notice about our legal duties and privacy practices about your health information and
3. do what we say in the Notice

If you have questions or concerns about privacy of information, you may contact the owner of Viewpoint or your wellness provider directly.

Use & Disclosure of Protected Health Information (PHI)

- **Written Authorization**. We have a form you can complete that allows us to share PHI with someone or an organization.

- **Treatment**. We use and disclose your PHI to you in order to provide treatment and other services. We may contact you to provide appointment reminders. We may talk to you about alternatives or other benefits and services that may be of interest to you. We may share information between Viewpoint providers and administrators in order to coordinate care. We may disclose information for supervision or case consultation within Viewpoint.

- **Payment**. We may use internally with administrators or externally by disclosing your PHI to obtain payment for services that we provide to you from your insurance plan or payer.

- **Health Care Operations**. We may use and disclose your PHI for our health care operations. This includes our internal administration and planning. This also includes various activities that improve the quality and cost effectiveness of the care that we deliver to you. For example, we may use PHI to evaluate the quality and competence of our providers. We may also disclose information within Viewpoint in order to resolve complaints.

- **Disclosure to Relatives Close Friends and Other Caregivers.** We will use or disclose your PHI to a relative, friend, or caregiver only if you are present and we can reasonably infer you do not object to the disclosure. For example, if you bring a friend or relative to a session, we may decide to use or disclose information for treatment purposes.

- **Public Health Activities**. We may disclose your PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (3) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (4) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

- **Abuse or Neglect**. If we reasonably believe you are a victim of abuse, neglect or domestic violence, we may disclose your PHI to the appropriate government authority. This include children, persons who have a mental health diagnosis, and the elderly. We may also disclose PHI if we come in contact with someone who has abused or neglected someone as defined by state laws.

- **Health Oversight Activities**. There are organizations who are responsible for overseeing compliance with government rules for delivering healthcare. We may disclose your PHI to such organizations to ensure compliance.

- **Judicial and Administrative Proceedings**. We may disclose your PHI in response to a court or administrative order.

- **Law Enforcement Officials**. We may disclose your PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena. This includes, but is not limited to, identifying or locating missing persons, fugitives, or suspects, or reporting crimes committed on our property.

- **Decedents**. We may disclose your PHI to a coroner or medical examiner as authorized by law. We may also disclose PHI as required for any investigation related to a death as allowed by law.

- **Health or Safety**. We may use or disclose your PHI to prevent a serious and imminent threat to someone's health or safety.

- **Special Government Functions**. We may use and disclose your PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State when the law requires it.

- **Workers Compensation**. We may disclose your PHI as authorized by and to the extent necessary to comply with state law relating to workers' compensation or other similar programs.

- **As required by law**. We may use and disclose your PHI when required to do so by any other law not listed above.

Coordination with Primary Care

We believe in "holistic" care: the mind and body relate to one another. So, it is important for us to coordinate your care with your primary care provider (PCP). Both federal and state privacy laws encourage this coordination between health care

providers. We only share basic information such as diagnostic information, plans for care, and medications (if they are prescribed). If we need to share other information, it will be only the minimum necessary to coordinate care. You may "restrict" this disclosure if you do not want us to share information with your PCP.

Right to Inspect and Copy Your Health Information.
You may request access to your health information with your wellness provider and / or Viewpoint. To access your records, contact your provider or Viewpoints owner. If you request copies, we will charge you $50.00. Viewpoint's policy is to send your health information via fax and or certified mail. If you prefer records be sent via email, we will ask for prior written consent.

Teletherapy
You understand "teletherapy" as used herein includes the exchange of my health care information in a way that may not be confidential, via telephone or interactive audio, video or data communications, email or text. While Viewpoint, and its providers, utilize HIPAA compliant systems, when possible, devices external to Viewpoint may not provide such protections.

Health information you provide in this manner could be subject to unauthorized disclosure or redisclosure, or subject to unauthorized access. You further understand that external systems may collect or record data and maintain that data in a way that is not confidential, private, or secure. Viewpoint cannot guarantee the confidentiality or security of any information sent to or received from Viewpoint via teletherapy.

Teletherapy poses privacy risks, including, but not limited to, the possibility, despite reasonable efforts by Viewpoint, that the transmission of your confidential information could be disrupted or distorted by technical failures, the transmission of your confidential information could be intercepted or interrupted by unauthorized persons, and the electronic storage of your confidential information could be accessed by unauthorized persons.

It is your responsibility to provide written notice to Viewpoint if you wish to withdraw teletherapy authorization

Viewpoint shall not be liable for any breach of confidentiality or privacy arising from teletherapy with you. You agree that you shall fully defend and hold Viewpoint harmless for principal, interest, court costs and reasonable attorneys' fees, together with any judgment rendered against it as a result of or arising from this authorization

Provider Withdraw
In the event that your specific provider no longer provides services through Viewpoint, we will do our best to provide adequate notice and work to arrange treatment with another one of our providers. This is not a requirement for you to remain at Viewpoint as you are able to seek treatment, in part or in whole, elsewhere is desired.

By signing below, you agree to the terms, conditions and information as set forth in the "Authorization" document including private pay fees identified on Appendix A.

Print Name of Patient:	
Name of Parent, Guardian or Representative (if applicable)	
Signature of Patient, Parent, Guardian or Representative (as applicable)	Date:

Appendix A

If your sessions are private pay (not covered by insurance), the fee per session is $150 or as identified below:

If completing the "authorization" document online or prior to your appointment, be sure to review these fees with your provider at your first appointment

Copays and deductibles are always billed per your coverage / EOB (explanation of Benefits) unless financial hardship dictates otherwise.

Clinician Initials

$_____ For _____ _____

$_____ For _____ _____

$_____ For _____ _____

Notes on Fee as Applicable:

Viewpoint Psychology & Wellness, LLC

Behavioral Health Care and Primary Care Physician Coordination of Care Form

Patient Name:	Date of Birth:
Primary Care Physician:	Primary Care Physician Clinic or Group Name:
Primary Care Address:	
Primary Care Phone Number:	Primary Care Fax Number:

I, the above-named patient, authorize Viewpoint Psychology & Wellness, LLC and / or its wellness contractors, and my primary care physician to exchange information regarding my mental health treatment and medical healthcare for coordination of care purposes, including information relating to diagnosis, testing or treatment. I understand that this authorization shall remain in effect for one year from the date signed and that I may revoke this authorization at any time by written notice.

Please select one:

☐ I authorize communication with my primary care physician

☐I do not authorize communication with my primary care physician

_____ _____

Signature of Patient or Personal Representative Date

For Provider Use Only

Notes:

_____ _____

Clinician Name Clinician Credentials

_____ _____

Clinician Signature Date

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. 42CFR prohibits you from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general statement or disclosure authorization is not sufficient.

Viewpoint Psychology & Wellness, LLC
Patient Profile

Items Required

Copy of Front and Back of Insurance Card
Copy of License or ID (if applicable)

Patient Information

Patient Name:		Date:	
Address:		Referred By (if applicable):	
City:		State:	Zip:
Date of Birth:		Sex:	Email:
Home Phone:	Cell Phone:	Occupation / Grade:	Employer / School:

Additional Patient Information

Spouse / Partner Name:			
Mother (if Minor):			
Father (if Minor):			
Children / Siblings (names and DOB):			
Emergency Contact:			
Pharmacy Name:	City:	Phone:	Crossroads:

Insurance Information (Information for Primary Card Holder)

Card Holder's Name:	Phone:
Email:	Date of Birth:
Address (if different):	Address City, State and Zip
Email	Patient Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other

Communications ***Patient Initial***

Would you like to Receive Appointment Reminders Via Email	☐Yes ☐No	
May our staff contact you via email or text for matters OTHER than Appointment Reminders.	☐Email ☐Text ☐Both	

Viewpoint Psychology and Wellness, LLC

Cancellation and No-Show Policy

Viewpoints goal is to provide quality care and attention in a timely manner. Late cancellations and No Shows create inconvenience and prevent scheduling of other patients who need access to care and attention in a timely manner. We understand situations arise when you may need to cancel your appointment and we appreciate advance notice when that happens. This helps us be respectful of other patients needs and enables us to give the appointment time to another patient who needs to see us.

Please call our office or call / email your individual clinician prior to 24 hours of your scheduled office appointment to notify us if you need to reschedule or cancel. Office appointments which are rescheduled or cancelled without advanced notice will be subject to the following:

- A cancellation of less than 24 hours OR a no-show will be charged $75.00.
- A cancellation of more than 24 hours will result in no charge.

Cancellation and No Show Fees Are NOT Covered by Insurance and shall be due immediately upon occurrence. If we do not believe you will make progress on your mental health condition because of no-shows or late cancellations, we may end treatment with you. If you have no-showed and have not scheduled an appointment after 30 days, we will assume you are ending your treatment. We may close your file at that time.

Overall, we will consider that you are not an active client with us if 60 days have passed.

By signing below, you understand Viewpoint cancellation policy.

_____ _____

Name of Patient Date

_____

Signature of Patient

Patient Name _____

Viewpoint

Viewpoint Psychology and Wellness, LLC

Credit Card Payment Authorization Form

This form authorizes Viewpoint Psychology and Wellness, LLC to make a debit to your credit card listed below, at any time, for any co-pays, deductibles, private pay, insurance deemed patient responsibilities, no show or cancellations which are due.

This form is in conjunction with the Financial Responsibilities set forth in your Fee Agreement / Authorization for Treatments agreed upon during your orientation. This form shall be renewed annually or as applicable.

Should your credit card change or should you need to edit the information please contact your Clinician.

Please complete the information below:

I _____ authorize Viewpoint Psychology and Wellness, LLC to charge my credit card account indicated below for any co-pays, deductibles, private pay, insurance deemed patient responsibilities, no show or cancellations which are due as a result of Counseling services / products rendered at or through Viewpoint.

Payments will be charged at the time of visit or as applicable, as deemed by the billing department.

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Other

Cardholder Name _____

Account Number _____

Expiration Date _____ Code: _____

City, State, Zip _____

If the Client is Different that the Card Holder, identify name of Client: _____

SIGNATURE _____ DATE _____