

Prime Behavioral Health, LLC

CHILD/ADOLESCENT INTAKE PACKET

Counselor: _____

CLIENT INFORMATION

Client Name _____
Street Address _____ PO Box _____
City/State/Zip _____
Home Phone # _____ May we call or leave a message at this number? Yes No
Daytime Phone # _____ Can we contact you here and leave a message? Yes No
Cell Phone # _____ May we call or leave a message on this phone? Yes No
Client Date of Birth _____ Age: _____ Social Security # _____
Parent/Responsible Party Name (if client is minor) _____
Parent/Responsible Party Social Security # _____ Date of Birth _____
Primary Care Physician & Phone#: _____
Emergency Contact Name (required): _____ Phone #: _____
Address (required): _____

Insurance Information (Copy of Insurance Card and ID is Required)

• This section is required to be filled out in full •

1) Primary Insurance Company _____ Ins Co Phone # _____
Employer of Subscriber _____
Name of Subscriber _____ Date of Birth _____
Subscribers Social Security # _____ Relationship to Client _____
Address of Subscriber (if different from Client) _____

2) Secondary Insurance Company _____ Ins. Co Phone # _____
Employer Name _____
Name of Subscriber _____ Date of Birth _____
Subscribers Social Security # _____ Relationship to Client _____
Address of Subscriber (if different from Client) _____

IF THERE IS A THIRD INS. PLEASE NOTIFY RECEPTIONIST TO GIVE YOU ATTACHMENT

CLIENT/ RESPONSIBLE PARTY AGREEMENT

The above information is current and correct to the best of my knowledge.

I understand my insurance coverage as noted above and that I am responsible for paying the co-pay, if required, and/or the amount not covered by my insurance policy. This agreement also grants authorization to PBH to release such information as may be necessary for completion of my insurance claim with payment of benefits to PBH for services rendered.

Responsible Party Name (please print) _____ Responsible Party Signature _____ Date _____

Witness _____ Date _____

Revised 10/15

Instructions: To assist us in helping your child, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to the child, leave them blank.

Information supplied by: _____ Relationship: _____ Today's Date: _____

Identifying Information

Child's Name: _____ Date of Birth: _____ Age: _____
 Gender: Male Female Race: _____ Height: _____ Weight: _____
 Hair Color: _____ Eye Color: _____

Behavioral Health

Why is the child coming to counseling?

What issues or circumstances do you believe contribute to the child's problems?

How long has this problem persisted? _____

Under what conditions do the problems usually get worse?

Under what conditions do the problems usually improve?

Has the child previously been involved in counseling? No Yes If yes, describe the reasons for counseling, who provided the counseling and what was the outcome.

Counselor _____

Reason:

Outcome:

List your child's greatest strengths:

List your child's greatest weaknesses:

List your child's main difficulties at home:

List your child's main difficulties at school:

Psychiatric Hospitalizations: None Past Recent

Dates of Service:	# of Days	Where & Reason (suicidal, depressed etc.)

Dates of Service:	# of Days	Where & Reason (suicidal, depressed etc.)

Behavioral Health Symptom Checklist

Please indicate the degree your child has experienced any of the following symptoms in the last 4 weeks.

0 = Never 1 = Occasionally 2 = Regularly 3 = Frequently

- _____ 1. Trembling, or feeling shaky
- _____ 2. Shortness of breath or smothering sensation
- _____ 3. Racing heart, heart palpitations or chest pain (circle which)
- _____ 4. Moist palms or excessive sweating
- _____ 5. Dizziness, lightheadedness, unsteady or faint (circle which)
- _____ 6. Nausea, diarrhea, or other abdominal distress (circle which)
- _____ 7. Frequent headaches or other muscle aches
- _____ 8. Startle easily
- _____ 9. Irritability (loses temper easily)
- _____ 10. Worrying a lot
- _____ 11. Trouble swallowing, "lump in throat", or choking sensation
- _____ 12. Fearful of or embarrassed by being watched or being the focus of attention
- _____ 13. Avoid talking to strangers
- _____ 14. Fear of embarrassment
- _____ 15. Persistent fear of an object (snakes) or situation (high places) considered excessive or unreasonable
- _____ 16. High levels of anxiety in the presence of an object or situation
- _____ 17. Regular and disturbing thoughts about a past traumatic experience
- _____ 18. Regular and disturbing dreams about a past traumatic experience
- _____ 19. Avoidance of thoughts feelings, or conversations associated with a traumatic experience
- _____ 20. Excessive hand washing or fear of germs
- _____ 21. Excessive checking (i.e., doors, locks, stove)
- _____ 22. Excessive need for order or neatness or counting ritual(s)
- _____ 23. Unusual and persistent sad feelings
- _____ 24. Diminished interest or participation in enjoyable or important activities
- _____ 25. Difficulty concentrating or poor memory (circle which)
- _____ 26. Tire easily or low energy level
- _____ 27. Thoughts of suicide
- _____ 28. Increased or decreased sleep (circle which): avg. hrs per night _____
- _____ 29. Feelings of hopelessness
- _____ 30. Persistent and abnormally elevated mood
- _____ 31. Over inflated feelings of self-worth
- _____ 32. Decreased need for sleep
- _____ 33. Rapid or racing thoughts
- _____ 34. Excessive involvement in pleasurable activities
- _____ 35. Excessive and/or reckless spending
- _____ 36. See or hear things that others around you are unable to perceive
- _____ 37. Hold ideas or beliefs that are not shared by others
- _____ 38. Self induced vomiting
- _____ 39. Excessive exercise
- _____ 40. Use of laxatives or diuretics to lose weight
- _____ 41. DiETING (very strict, women consuming less than 1400 daily calories or men less than 2000 calories)
- _____ 42. Careless mistakes in school work, work, or other activities
- _____ 43. Can only pay attention for short periods at school/work/home
- _____ 44. Failure to complete schoolwork, chores, duties
- _____ 45. Hyperactive: fidgets, squirms, talks excessively
- _____ 46. Acts without thinking of consequences

Drug and Alcohol History

Indicate the level of use for each substance by checking the appropriate box.

	No Use	Past use	Current Use		No Use	Past use	Current Use
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inhalants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hashish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stimulants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If current or past use is indicated to any of the above items complete the following questions?

Drug/Alcohol Type	Age of 1 st use	Date of last use	Frequency	Amount Used	Method <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> Injection
Drug/Alcohol Type	Age of 1 st use	Date of last use	Frequency	Amount Used	Method <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> Injection
Drug/Alcohol Type	Age of 1 st use	Date of last use	Frequency	Amount Used	Method <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> Injection

Has the child ever received inpatient drug and/or alcohol treatment? No Yes

If yes, When? _____ Where? _____

Has the child ever received outpatient drug and/or alcohol treatment? No Yes

If yes, When? _____ Where? _____

Is the child currently pregnant? No Yes Is the child an IV drug user? No Yes

Family History

Parent's marital status: Married Divorced Separated Never Married Widowed
 If the parents are not married, the child's age when divorce, separation or parents death occurred? _____

What is the relationship between the child and his/her custodial parent(s) Check all that apply:
 Parents married, together Single Parent, Mother Single Parent Father Parents Unmarried
 Mother & Stepfather Father & Stepmother Adoptive Family
 Other _____

Living Situation: Parent's Home Foster Home Relative's Home Homeless Group Home
 Residential Other _____

Household member's names (if client lives in more than one household list household 1 - 2)	Relation to the Client	Age	Race	Occupation or School	Level of Education

Significant Family Members/Others not listed above:	Relation to the Client	Age	Race	Occupation or School	Level of Education

Mother's age: _____ If deceased, how old was the child when she passed away? _____
 Father's age: _____ If deceased, how old was the child when he passed away? _____

Number of Brothers _____ Their ages: _____
 Number of Sisters _____ Their ages: _____

Where is the child in birth order (i.e. 1st born, 2nd born etc.) of his/her siblings? _____

Briefly describe the child's relationship with his/her siblings.

Briefly describe the style of parenting (including types of discipline) used in the household.

Describe the reasons your child is disciplined.

Parent's Employment

Mother's Current Employment Status Employed Unemployed Job/Occupation: _____

Name of employer: _____ Date Last Worked _____ Satisfied with Job Yes No

Father's Current Employment Status Employed Unemployed Job/Occupation: _____

Name of employer: _____ Date Last Worked _____ Satisfied with Job Yes No

Family Financial History:

Amount of Monthly Income _____ Source(s) of income: _____

Loss of Income due to: _____

Financial Problems No Yes If yes, explain: _____

Developmental History

List any drugs/medications used by the mother or family at the time of conception or by the mother during pregnancy

Indicate important physical development issues including developmental milestones including sensory/motor, motor, cognitive, mental retardation or autism

List the ages when the following developmental milestones occurred:

	<u>Age</u>	<u>Comments</u>
Walking	_____	_____
Talking	_____	_____
Toilet Trained	_____	_____

Rate your child's development, compared to others the same age in the following areas

- Social Development Below Average Average Above Average
- Physical Development Below Average Average Above Average
- Language Below Average Average Above Average
- Intellectual Ability Below Average Average Above Average
- Emotional Expression Below Average Average Above Average

For each type of development that you rated as *Below Average*, describe your current *Specific* areas of concern.

Medical History

Physician Name: _____

Address: _____
Street & Number City State Zip

Date of most recent physical exam: _____ By Whom: _____ Phone: _____

Results: _____

Immunizations Check the immunizations for the following diseases:

- Chicken Pox Diphtheria German Measles Measles Mumps
- Polio Small Pox Tetanus

Drug Allergies: _____ *

List any major illness and/or operations _____

Has the child had any medical hospitalizations in the last three years No Yes, if yes, complete below:

Hospital	City	Date	Reason

List any *current* physical concerns (e.g. high blood pressure, headaches, dizziness, etc.): _____

List any *past* physical concerns: _____

Has the child ever had head trauma that resulted in loss of consciousness and/or required medical treatment? No Yes

What *medications* is client now taking? List all *medications* including over the counter and herbal therapy, dose (if known), how long taken, and the doctor who prescribed the medication.

Prescription/Over the Counter Medication: No Yes

Out of Medication: No Yes

Current Medication: _____
Total Daily Dosage: _____
Reason: _____
Compliance No Yes Partial Unknown

Current Medication: _____
Total Daily Dosage: _____
Reason: _____
Compliance No Yes Partial Unknown

Current Medication: _____
Total Daily Dosage: _____
Reason: _____
Compliance No Yes Partial Unknown

Current Medication: _____
Total Daily Dosage: _____
Reason: _____
Compliance No Yes Partial Unknown

Current Medication: _____
Total Daily Dosage: _____
Reason: _____
Compliance No Yes Partial Unknown

Current Medication: _____
Total Daily Dosage: _____
Reason: _____
Compliance No Yes Partial Unknown

Does the client/family think medications help the client get better? N/A No Yes Unknown

Does your child use caffeine? No Yes from (coffee, tea, soda) _____ Daily Use _____
Does your child use tobacco? No Yes from (cigarettes, snuff, snus) _____ Daily Use _____

On the average, how many hours of sleep does your child receive nightly? _____

After going to bed, how long does it take your child to fall asleep? _____

If falling asleep is a problem, how long has it been a problem? _____

Does your child regularly awaken in the night? No Yes

Does your child regularly have bad dreams or nightmares? No Yes

Does your child experience bad dreams and is unable to awaken during them? No Yes

Describe your child's appetite? Poor Appetite Average Appetite Large Appetite

Has the child's weight changed in the last year? No Yes If yes, by how much? _____ weight gain loss

Has client had any of the following symptoms in the past 60 days? Please check.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Coughing | <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Memory Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Breathing Difficulty | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Tingling in Arms/Leg |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Falling | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Consciousness Loss | <input type="checkbox"/> Gait Unsteadiness | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Vision Changes |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Pulse Irregularity | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Other: _____ | | | |

Health History Questionnaire

Has the client or any relatives (related by blood) had any of the following health problems? If a blood relative has had the condition, please write down the relationship to the client (parent, brother, sister, aunt/uncle, cousin, children, etc.) in the comment section.

Problem	Client			Family History	Relationship to the Client
	Now	Past	Never		
AIDS					
Alcoholism					
Anemia					
Anxiety					
Arthritis					
Asthma					
Bipolar Disorder					
Bleeding Disorder					
Brain Tumor					
Cancer					
Cirrhosis					
Depression					
Diabetes					
Drug Abuse					
Epilepsy/Seizures					
Eye Disease					
GI Problems					
Glaucoma					
Headaches					
Head Injury					
Hearing Problems					
Heart Disease					
Hepatitis					
High Blood Pressure					
Hyperactivity					
Jaundice					
Kidney Disease					
Learning Problems					
Lung Disease					
Low Blood Pressure					
Menstrual Pain					
Oral Health/Dental					
Schizophrenia					
Sexually Transmitted Disease					
Speech Problems					
Stroke					
Suicide					
Thyroid					
Tuberculosis					

If the client has had any of the above, please write the problem, what treatment was received, and when

Problem & Treatment received:	When
Problem & Treatment received:	When

Educational History

School: _____
 Highest Academic Year completed: _____ Highest Vocational Year Completed: (if applicable) _____

Type of school placement: Regular Special Education Home-Schooled Unknown

Type of Special Education Placement: None Cognitive Disability Emotional Disability
 Learning Disability Multiple Disabilities
 Other: _____

Does your child experience any of the following problems (check all that apply):
 Poor Attendance Poor Grades Suspension/Expulsion

Has your child ever been retained in a grade? No Yes If yes, which grade(s): _____

Has your child passed the school's proficiency tests? Yes No Does not apply

Does your child have special communication needs? TTD Device Interpreter Services

Legal History and Children Services Involvement

Legal Guardian(s)/Custodians	Phones
Current Legal Status <input type="checkbox"/> None <input type="checkbox"/> On Probation <input type="checkbox"/> Detention <input type="checkbox"/> On Parole <input type="checkbox"/> Awaiting Charges <input type="checkbox"/> Other _____	
Convictions	
Incarcerations	
Probation/Parole Officer (if applicable):	Phone:
Juvenile Court Involvement (for Child Abuse, Neglect or Dependency) Current <input type="checkbox"/> No <input type="checkbox"/> Yes Past <input type="checkbox"/> No <input type="checkbox"/> Yes	
Family Court Ordered into Counseling <input type="checkbox"/> No <input type="checkbox"/> Yes	
Juvenile Court Case worker (if applicable):	Phone:
Civil Court Proceedings:	
Domestic Relations Court Involvement (i.e. Custody, Protective Services, Restraining Order):	
Child Support Enforcement Orders:	
Children's Protective Services Involvement with Family: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Name of GAL/CASA assigned to family (if applicable):	Phone:
Name of Children Services Caseworker assigned to the family (if applicable):	Phone:

Print Name (Person completing questionnaire): _____ Signature: _____ Date: _____

Staff only

Reviewer Name/Degree (if applicable) _____ Signature: _____ Date: _____

CANCELLATIONS & MISSED APPOINTMENTS

All appointment cancellations require a **24-hour notice** or in the case of illness, a message prior to 8:00 am on the appointment day. Our voicemail is available 24 hours/day to take messages after hours or on the weekends if you need to cancel an appointment. Adequate notification respects the doctor/therapist's time as well as allows availability to others requesting services. Failure to not show at all or to give a less than 24-hour notice on cancellations will result in a \$35.00 charge which must be paid prior to scheduling another appointment. In addition, arriving late to appointments could also result in charges that would be equal to the time you kept your therapist waiting. **Insurance will not be billed for this. ***

Note to Parents – if you are financially responsible (the signer on this form) for your child, it is your responsibility to make sure you know when your child's appointments are, and it is your responsibility to pay this fee if the appointment is missed. Continued non-compliance in keeping your appointments can result in dismissal from the practice.

I HAVE READ THE OFFICE POLICY AND RECEIVED A COPY OR HAD ACCESS TO IT ON THE WEBSITE. I UNDERSTAND AND AGREE TO THE TERMS CONTAINED IN IT.

Responsible Party/Legal Custodian Signature

Date

Witness

Date

**PRIME BEHAVIORAL HEALTH, LLC
CONSENT FOR TREATMENT AND INFORMATION SHEET**

The decision to begin mental health treatment is one that may have important results for your life. Research has shown that individuals entering therapy achieve more favorable results when they have a good understanding of what to expect. We have developed this sheet to provide you with an overview, but no information sheet can answer all questions, so please feel free to ask us about any questions you have.

Individual sessions usually last 45-60 minutes providing us with time to think about what you have said, make notes, and plan your services. Your first session will usually be devoted to assessing the type and extent of the problems and concerns you have and to plan your services.

Your therapist has a responsibility to ask questions about your history, your life situation, and your current distress. Your therapist also has a responsibility to be open with you and to provide direct information about your treatment.

As being the responsible party for a client in our office, you will also have certain responsibilities for payment and for keeping your appointments. Your most important responsibility, however, is to yourself (and your child) – to work towards the goals we mutually set, and to work toward your goals both during sessions and during days between sessions. This is your time for you and your child.

There are charges which are not covered by insurance for missed appointments and late cancellations. Please refer to the Canceled and Missed Appointment Policy form for details on these charges.

Once any charge has remained on your account for 90 days, the entire outstanding balance will be forwarded to a collection agency. Any fees and/or interest added by the collection agency will be charged to you in addition to the outstanding balance which you owe Prime Behavioral Health.

We place a high value on the confidentiality of your records. Records will be held confidential except as required by law, or as released by your written authorization. In a small number of situations, therapists are legally required to reveal information; for example, if you reveal information that indicated a clear danger of injury to yourself, your child, or others. Records may, on occasion, be reviewed for quality and appropriateness of care by the clinic or by your insurance company.

Every effort is made to answer calls during our regular office hours. If we are unable to answer or the office is closed at the time of your call, please leave a message, and we will return your call as soon as we can.

Entering psychotherapy requires a commitment of time, energy and resources, and often also requires some courage to make the first appointment. Your commitment will be honored here and you will be treated with respect. Thank you for choosing our office.

**I HAVE READ THE ABOVE AND UNDERSTAND AND AGREE TO MY RESPONSIBILITIES, AND
CONSENT FOR TREATMENT.**

Responsible Party Signature

Printed Name of Client

Date

**IF CLIENT IS A MINOR, PERSON SIGNING THIS FORM ATTESTS TO HAVING LEGAL
CUSTODY AND CONSENTS TO FEES AND TREATMENT BY THIS SIGNATURE.**

Parent Signature

Date

Revised 10/15

COURT FEE SCHEDULE

- All fees charged for court activity are based on portal-to-portal travel.
- A retainer for the estimated full amount of the fee will be required one week before a court appearance.
- If actual fees exceed estimated fees, clients will be responsible for the remainder of the fee within one week of rendered services.
- Fees will be assessed in four-hour blocks.

Fee Rates

- Fees for court related activities requested more than two weeks in advance = \$120 *per hour* (Minimum = \$480)
- Fees for court related activities requested less than two weeks in advance = \$240 *per hour* (Minimum - \$960)

Cancellation Policy

- If request for court related activities is cancelled 2 weeks prior to scheduled appearance the client will be entitled to a full refund minus an time the counselor used for preparation.
- If request for court related activities is cancelled 1 week prior to scheduled appearance, the client will be entitled to a 50% refund minus any time the counselor used for preparation.
- No refund will be given for cancellations that occur within the week of the scheduled activity.
- If a counselor is subpoenaed for court related activity and the subpoena is cancelled, regardless of retainer not being submitted, the client will be responsible for the initial requested fee.

Consideration for modification of this fee schedule will be made on a case-by-case basis.

Signature of Responsible Party/Legal Guardian _____ Date _____

Client name _____

Your signature states that you are aware of this policy. Please sign even if you feel that this will not apply to your situation.

Prime Behavioral Health
 647 Hill Rd. N Ste. B 711 N. Columbus St., Ste., 100
 Pickerington, OH 43147 Lancaster, OH 43130
 614-833-6900 740-653-6500

FEE SCHEDULE
 All Counselors

Initial Session	\$160
Office Visit ~60 Min	\$150
Office Visit ~45 Min	\$120
Office Visit ~30 Min	\$ 80
Family Counseling ~45 Min	\$130

I have read and understand the Financial Policy and office procedures at Prime Behavioral Health, LLC. I agree to the cancellation/reschedule policy. I further understand I will need to make my co-pay at each visit. I acknowledge that I have either received a copy of this policy or have it available to me from the website at www.carebyprime.com.

Client Name (please print)

If the client is a minor, the Guardian must sign below:

Responsible Party/Legal Guardian Name (please print)

Responsible Party/Legal Guardian Signature Date

Witness Date

Revised 10/15

Prime Behavioral Health, LLC

647 Hill Rd. N Ste. B
Pickerington, OH 43147
614-833-6900

711 N. Columbus St., Ste., 100
Lancaster, OH 43130
740-653-6500

Receipt of Notice of Privacy Practices Acknowledgement Form

I hereby acknowledge that on _____ I received the Notice of Privacy Practices of Prime Behavioral Health, LLC, or was notified of its availability on the website during my initial call, which sets forth the ways in which my personal health information may be used or disclosed by Prime Behavioral Health, LLC, and outlines my rights with respect to such information.

Please list anyone to whom we may speak or leave a message in regard to appointments or payments/billing along with their relationship to the client:

NAME	RELATIONSHIP
_____	_____
_____	_____
_____	_____
_____	_____

Would you like for us to leave information regarding scheduling and appointments on your voicemail?

_____ YES _____ NO

Signature _____

Date _____

October, 2015

Prime Behavioral Health

NOTICE FOR ACCOUNTS WITH BALANCES DUE

Please take note of our new policy regarding our scheduling policy due to outstanding balances.

Beginning immediately, if you have an account with balances from unpaid copays, fees for missed/late canceled appointments, and coinsurance and/or deductibles for claims that HAVE FINISHED PROCESSING through your insurance, the clerical staff have been advised to not schedule any new appointments until the balance is paid in full. Please keep 3 appointments booked at all times so that you will still have at least 2 appointments on the books. We will not cancel any appointments already on the schedule. Please pay the amount requested when you check in for your appointments to avoid this issue. We diligently try to ask for the proper amount we expect to be due after your insurance processes your claim to keep you from getting behind. We adjust the balance accordingly, when needed, after we receive the final decision from your insurance. However, policies with co-pays do require the payment at the time of service. Payment can be made in person, over the phone, or via our website or QR codes on our statements.

We would encourage you to keep a credit/debit card on file with our office and sign to give us permission to charge your card for balances due (as needed) to be sure that there is no disruption to your care. Ask the receptionist about this option.

If you have questions or concerns, please feel free to discuss this with us.

Name

Date

January 11, 2024