A.B.L.E.

**2100 E. Broadway, Suite 200A**
**Columbia, MO 65201-6082**
**Phone 573.214.2253 Fax 573.474.5683**
**www.ABLEWellnessCenter.com**

# CONFIDENTIAL CLIENT INFORMATION SHEET

(Please Print)

## CLIENT INFORMATION

| | | |
|---|---|---|
| **Client's Last Name:** | **First:** | **MI:** |
| SSN: | DOB: | Sex: ❑Male ❑Female |
| Street Address/PO Box: | | |
| City: | State: | Zip: |
| Email address(es): | | |
| Home Phone<br>( )<br>May we leave a message? | Work Phone<br>( )<br>May we leave a message? | Cell Phone<br>( )<br>May we leave a message? |
| How were you referred to A.B.L.E. or your provider? | | |

## FAMILY INFORMATION

RELATIONSHIP STATUS:
❑ Married/Living with Partner ❑Single ❑ Divorced ❑ Widowed ❑ Never Married ❑ Separated
❑ Other (specify):

### OTHER PEOPLE IN THE HOME:

| Name | DOB | Relationship to Client | Occupation |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## EDUCATION INFORMATION:

***If YOU are being seen today, please complete the following:***

Highest grade level completed: 1 2 3 4 5 6 7 8 9 10 11 ❑ Completed High School
❑ Some College ❑ Undergraduate Degree
❑ Graduate Degree ❑ Other: _____

***If YOUR CHILD is being seen today, please complete the following:***

School: _____ Grade: _____

Teacher: _____ Principal: _____ School Counselor: _____

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# FINANCIAL POLICY

Thank you for choosing us as your provider of psychological, educational, or wellness services. The following is a statement of our Financial Policy, which we ask you to read and sign prior to receiving any services. All clients must complete an intake form and provide any applicable insurance information prior to treatment. **PAYMENT IS DUE AT TIME OF SERVICE WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD.** Each provider is an independent contractor and sets his/her own fees and arranges any payment plans. You will be given advance notice of any fee increases. In certain circumstances, a payment plan can be arranged.

## MISSED APPOINTMENTS AND LATE CANCELLATIONS

If you cannot attend a scheduled appointment, you will be expected to call your provider 24 hours in advance to cancel. Any sessions missed or cancelled fewer than 24 hours in advance may be charged a **$25.00** Missed Appointment Fee. Please help us better serve you by keeping scheduled appointments.

## PAST DUE ACCOUNTS

Payment is expected at the time of service. If you are late on payments and have not made prior arrangements with your provider, a 3% late fee will be added to the amount and an invoice will be sent to you. You will be expected to pay the balance of your account or call to set up a payment plan when you receive that invoice. If necessary, your account may be turned over to a collection agency for collection. Reasonable fees for collection, including collection agency fees as well as court cost incurred for collection, will be your responsibility.

## FEE FOR SERVICES

Our hourly fee typically ranges from $80-120 per session, depending on the provider and the services provided. In addition to weekly appointments, we charge this amount for other professional services you may need, though we will break down the hourly cost if we work for periods of less than a typical 45-50 minute hour. *Other services include report writing, telephone conversations lasting longer than 05 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of us*. If you become involved in legal proceedings that require our participation, you will be expected to pay for all of our professional time, including preparation and transportation costs, even if we are called to testify by another party. Because of the difficulty of legal involvement, we typically charge $150 per hour for preparation and attendance at any legal proceeding.

## CLIENTS WHO ARE MINORS

The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment.

Thank you for reading and understanding our Financial Policy. Please let us know if you have any questions or concerns.

***I have read the Financial Policy for A.B.L.E. I understand and agree to this Financial Policy:***

X_____Date_____
Signature of client or responsible party

_____ Date: _____
Witness

Rev. 10/14

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# Informed Consent for Wellness Services

I, _____, hereby give my consent to have A.B.L.E. practitioners provide wellness services to me and any other identified participants with the following understandings.
If I am a minor, the following areas have been discussed with me in age appropriate terms with my parent/guardian present.

1. I have read and understand the procedures designed to protect my personal information.
2. My rights to confidentiality will be protected except under the ethical and legal limitations that I have discussed with my provider. These may include:
    a. Mandated reporting for suspected child or elder abuse and neglect;
    b. Duty to warn for threatened suicide or homicide;
    c. Court ordered release of records;
    d. Written consent for release of records.
3. Working with couples, families, groups, or businesses involve unique issues related to confidentiality and the treatment process. I understand confidentiality in these types of settings as I have discussed them with my provider and the other participants.
4. Change can be difficult and requires effort from the participant(s). I understand that entry into services may bring with it the risk of emotional discomfort or distress. Sometimes wellness services such as life coaching need to be postponed to deal with deeper issues using other services such as psychotherapy. Typically, such services are referred to another provider. I also understand the potential benefits of treatment, such as personal growth.
5. I recognize that the practice of wellness services is not an exact science, and therefore acknowledge that no guarantees have been made or can me made regarding the likelihood of success or a specific outcome of any services provided.
6. I understand that my provider and I will determine the length of services. I may end services at any time by my own decision, and I may seek the opinion of another provider at any time.
7. I understand that a typical session lasts 45-50 minutes, unless other arrangements are made. I will arrange a session schedule with my provider.
8. I have read and understand the A.B.L.E.'s Financial Policies form.
9. I agree to inform my provider by the preceding day when I cannot attend a scheduled appointment. I understand that I will be responsible for payment for any missed appointments that are not re-scheduled or cancelled 24 hours before my session time.
10. I have read and understand the Client Services Agreement which is available in the waiting area and which a copy to take home is available upon request.

_____ _____
Client signature Date

_____ _____
Parent/Legal Representative Date

_____ _____
Witness signature Date

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have been provided with A.B.L.E.'s Policies and Practices to Protect the Privacy of Client's Health Information and consent to the use or disclosure of my protected health information by A.B.L.E. for the purpose of diagnosing or providing treatment to me, obtaining payment for my mental health care bills, to conduct mental health care operations of A.B.L.E., and as required by law.

I acknowledge my rights as a client of this practice concerning my protected health information. I am aware that A.B.L.E. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. **The Notice of Privacy Practices is in the waiting area for review in its entirety.** I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

If you have any questions about this notice, please contact Privacy Officer at 573-214-2253.

_____ _____
Client signature Date

_____ _____
Parent/Legal Representative Date

_____ _____
Witness signature Date