

**Jose Morell, LMHC, LPC, LADC I, LLC.**

260 Washington Street, Suite 2-3 2734 Beaver Run Boulevard, Suite B #160

 Pembroke, MA 02359 Myrtle Beach, SC 29575

781-277-3300

Fax 781-205-1877

Thank you for choosing my practice for your counseling needs. Please review the information below and contact my practice manager, Javier Morell with any questions you may have at the following number: 781-312-9911.

**Instructions for completing the New Client registration forms**

Please complete the New Client Registration forms prior to your schedule intake visit. Please have this information sent via e-mail to the following e-mail address: Jmorell@Josemorelllmhc.com

The following information will require your revision and signature:

* Client Registration Form
* Client Consent (Client and Counselor Service Agreement)
* Privacy Notice
* Telehealth Consent (audio and visual visits)
* Release of Information
* Credit Card Authorization (If co-payment is required)
* We will need a copy of your insurance card to keep on file, so please forward a copy of the front and back of your insurance card.

Your journey and passage to emotional wellness starts here. We look forward to working with you to help promote change, growth, wellness, recovery and healing through psychotherapy.



**Client Registration Form**

**Clinician: Jose A. Morell, LMHC, LPC, LADC I, LLC**

 **Administrative Support Staff: Javier Morell**

Patient: Sex:

DOB: Marital status:

Address: Employment:

City/State: PCP release:

Zip Code: Languages:

Mobile: Emergency contact:

Home Phone: Appt. reminder: E-mail \_\_\_

Work phone: Phone \_\_\_

Other phone: Text­\_\_\_

Email address:

**Billing**

Payer (plan name): ID Number:

Policy Group ID: Employer/School:

Co pay amount: Responsible party for billing:

Deductible amount: Reason for counseling:

**Delivery of Service**

In- Person \_\_\_

Video/Audio \_\_\_

Telephone \_\_\_



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*Consent to Treatment and Insurance Authorization*

Client-Counselor Service Agreement

Welcome to my practice. This document contains important information about my professional services, fee policy, agreement and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Counseling is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in counseling, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your counselor, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Confidentiality

I understand that information about me will be kept confidential. I understand that my therapist will not release my information outside of the practice without my written consent or the written consent of my authorized representative, except where the release is in accordance with applicable law and privacy practices. Similarly, I understand that my therapist will not request information from others without my written consent. I have been informed of the legal limitation on my confidentiality information, including, without limitation, that disclosure may occur in certain circumstances regarding legal situation or legal proceedings in the case of medical emergency, or to protect myself of others from serious harm, neglect, or abuse. I give the below named clinician permission to share records with and discuss my mental health/substance use with my other caregivers including, without limitation, the staff of any facility where I reside or attend school, a hospital where I am a patient, outpatient treatment or day program, and my primary care physician.

Insurance Authorization

I authorize the release of any mental health, or other information to any payer source, including but not limited to, the Medicare program, MassHealth, other commercial and private third-party health insurers, their agents, intermediaries or carriers as necessary to process any claims for all occasions of services to me provided by the practice.

Goals of counseling

The goal is to tailor treatment goals specifically to the client’s best interest. There can be many goals for the counseling relationship. Some of these will be long term goals such as improving the quality of your life, learning to live with mindfulness and self-actualization. Others may be more immediate goals such as decreasing anxiety and depression symptoms, developing healthy relationships, changing behavior or decreasing/ending drug use. Whatever the goals for counseling, they will be set by the clients according to what they want to work on in counseling. The counselor may make suggestions on how to reach that goal but you decide your path to emotional health and wellness.

Risk/Benefits of counseling

Counseling is an intensely personal process which can bring unpleasant memories or emotions to the surface. There are no guarantees that counseling will work for you. Clients can sometimes make improvements only to go backwards after a time. Progress may happen slowly. Counseling requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

However, there are many benefits to counseling. Counseling can help you develop coping skills, make behavioral changes, reduce symptoms of mental health disorders, improve the quality of your life, learn to manage anger, learn to live in the present and many other advantages.

Appointments, Cancellations, and Termination

Appointments will ordinarily be 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. Intake (initial evaluation) appointments are 60 minutes. Our time together is valuable, and if I have many clients with varying expectations about the professional relationship we embark. Please remember that someone else may want this time and I do not have standing appointments. If you need to cancel or reschedule a session, I ask that you provide me with 24-hour notice. My office hours are by appointment, emergency phone calls are not accepted while in a counseling session. My voicemail is available 24 hours for messages. I check messages regularly. If there is a life-threatening emergency, please report to your local emergency room, call 9-1-1 or contact the national suicide hotline at 1-800-273-8255 immediately

If you miss a session without canceling, or cancel with less than 24-hour notice, you will be charged a cancellation fee of $75 [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the cancelation fee. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time. Termination of treatment decisions are made mutually among the clinician and the client. If a decision to terminate is made, the clinician will discuss the termination with the patient in session or will attempt to notify the patient either by phone or in writing. Please note that two or more consecutive missed appointments without a prior 24-hour notice could constitute termination of services. Please note that cases inactive for more than 30 days may be subject to termination.

For group therapy (if applicable), sessions are scheduled at an agreed day, time, frequency, and duration as determined by the specific group. Once committed to a therapy group, participation on a regular basis is important for group cohesiveness and both individual and group progress, and you are agreeing to consistently attend group sessions.

Confidentiality

Your counselor will make every effort to keep your personal information private. If you wish to have information released, you will be required to sign a consent form before such information will be released. There are some limitations to confidentiality to which you need to be aware. Your counselor may consult with a supervisor or other professional counselor in order to give you the best service. In the event that your counselor consults with another counselor, no identifying information such as your name would be released. Counselors are required by law to release information when the client poses a risk to themselves or others and in cases of abuse to children or the elderly. If your counselor receives a court order or subpoena, she may be required to release some information. In such a case, your counselor will consult with other professionals and limit the release to only what is necessary by law.

Confidentiality and Group therapy

The nature of group counseling makes it difficult to maintain confidentiality. If you choose to participate in group therapy, be aware that your counselor cannot guarantee that other group members will maintain your confidentiality. However, your counselor will make every effort to maintain your confidentiality by reminding group members frequently of the importance of keeping what is said in group confidential. Your counselor also has the right to remove any group member from the group should she discover that a group member has violated the confidentiality rule.

Confidentiality and Technology

Some clients may choose to use technology in their counseling sessions. This includes but is not limited to online counseling via Zoom, telephone, email, text or chat. Due to the nature of online communication, there is always the possibility that unauthorized persons may attempt to discover your personal information. Your counselor will take every precaution to safeguard your information but cannot guarantee that unauthorized access to electronic communications could not occur. Please be advised to take precautions with regard to authorized and unauthorized access to any technology used in counseling sessions. Be aware of any friends, family members, significant others or co-workers who may have access to your computer, phone or other technology used in your counseling sessions. Should a client have concerns about the safety of their email, your counselor can arrange to encrypt email communication with you. In an effort to safeguard your information and ensure that your sessions are kept confidential, audio and video recording is not permitted or allowed.

Record Keeping

Your counselor may keep records of your counseling sessions and a treatment plan which includes goals for your counseling. These records are kept to ensure a direction to your sessions and continuity in service. They will not be shared except with respect to the limits to confidentiality discussed in the Confidentiality section. Should the client wish to have their records released, they are required to sign a release of information which specifies what information is to be released and to whom. Records will be kept for at least 7 years but may be kept for longer.

Medication Management

Medication can be an essential part of your treatment. I do not prescribe medication. However, I do help refer and connect you to medication prescribers in or around the local surrounding community as part of your treatment if necessary.

Professional Fees

You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by cash, credit card or check. Returned checks will be subject to a charge of $35.00. Unpaid balances over 30 days will be the basis of for terminating services. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required. **These fees apply to clients who are not using insurance to pay for services.** Court Fees are as followed: If I am called to testify, the fee for court testimony or depositions start at $200.00 per hour, except in cases involving children, the fee is $300.00 paid in advance. Fees are subject to change. The fees cover preparation, travel and writing time.

Fee Schedule

Initial evaluation (intake, 60 minutes) $140

Individual psychotherapy (45-50 minutes) $120

If a different amount has been negotiated, enter it here: \_\_\_\_\_\_\_\_\_\_

Clients who ask to fill out additional documentation beyond what insurance plans require will be charged a $20.00 processing fee. Insurances will not pay for correspondence. This includes any government forms, housing letter, court letters, educational references, etc.

Co-payments

Please note that third-party payer systems require co-payments to be collected at the time that services are rendered. Under no circumstances can the co-payment be waived and it must be paid at each session. The co-payment amount is often your only out-of-pocket expense unless you have a deductible amount.

Insurance

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes. You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information which will become part of the insurance company files. By signing this agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover counseling fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee to be covered by the patient. Either amount is to be paid at the time of the visit by check or cash. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. Please be aware that you may be responsible for any out of pocket expenses not covered by your insurance.

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

Services Not-Covered

Regardless of the nature of your third-party payer, some of the services you receive may not be covered under your mental health benefits. Responsibility for payment for those services rests with you. However, non-reimbursable services will be thoroughly discussed with you before they are provided, and you will have full opportunity to refuse such services and to consider alternatives.

Contacting me

When I am unavailable by phone, you may leave a message on my confidential voicemail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If you feel you cannot wait for a return call or it is an emergency situation, please go to your local hospital or call 911. For all other administrative matters, please contact us at 781-277-3300 or 781-312-9911.

Consent to Counseling

Your signature below indicates that you have read this Agreement and agree to its terms.

Clients Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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**Consent for release of Information/Request for Information**

Date:

I hereby authorize: Jose Morell, LMHC, LPC, LADC I to release or receive the following information:

[ ] Complete Medical Record [ ] Emergency Contact

[ ] Psychosocial Assessment/Evaluations/Screens [ ] Drug/Alcohol Abuse

[ ] Diagnosis and Treatment Recommendations [ ] Medication Management

[ ] Treatment Progress [ ] Aftercare Treatment

[ ] Labs [ ] Psychiatric intake

[ ] Referral [ ] Other: \_\_\_\_\_\_\_\_\_\_\_

This information will be released to/from:

Organization/Person:

Address:

Phone:

Fax:

I understand that I can withdraw my authorization of my personal health information (PHI) at any time by informing my therapist in writing as long as my PHI has not yet been released. I understand my HPI requested through this authorization may be released to a third party and thus will no longer be protected by the HIPAA privacy rules. I understand that refusing to sign

this form will not result in the denial of care and/or my payment or health plan enrollment and eligibility will not be affected.

Patient signature: Date:

Guardian Signature: Date:

This information has been disclosed to you from records protected by Federal confidentiality rules (Title 43, Part 2, Code of Federal Regulations (42 C.F.R. Part 2). The Federal rules prohibit

you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the individual to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.



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**Telehealth Consent and Disclosure**

Telehealth Informed Consent

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby consent to engage in telehealth therapy with Jose Morell, LMHC, for my psychotherapy treatment. I understand that telehealth includes the practice of health care including mental health delivery, diagnosis, consultation, treatment and education using HIPPA compliant interactive audio and video.

In addition to the Consent for Treatment I signed when initially beginning psychotherapy, I understand that I have the following rights with respect to telehealth:

(1) I have the right to refuse telehealth at any time without affecting my right to future care or treatment.

(2) The laws that protect the confidentiality of my medical information also apply to telehealth and that the information disclosed by me in therapy is confidential with exception of the mandatory reporting laws that include but are not limited to: child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim, imminent risk of harm to myself, and where I make my mental or emotional state an issue in a legal proceeding. (Refer to the Office Policies and HIPPA notice of Privacy Practice forms provided to you for more details of confidentiality and other practice procedures)

(3) I understand that the dissemination of any personally identifiable images or information from our telehealth interaction shall not occur without my written consent.

(4) I understand that telehealth sessions are not being recorded, and separate written approval and consent is needed in order to videotape a session

(5) I understand that there are risks from telehealth that may include but are not limited to: the possibility despite all reasonable efforts by my provider, the transmission of medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or misunderstandings may occur more easily, particularly when care is delivered in an asynchronous manner.

(6) I also understand that while there is an empirical evidence base supporting the efficacy of telehealth, it may not yield the same results as face-to-face services. I understand that if my provider believes that I would be better served by another form of therapeutic service (such as face to face) I will be referred to a therapist in my area who can provide such a service.

(7) I understand that in the event of technical failure, I will provide a phone number for follow up contact if a plan for technical failures has not already been arranged with my provider.

(8) I understand that any form of psychotherapeutic service carries risks and benefits and that despite my efforts and my providers efforts, my condition may not improve and in some cases may worsen.

(9) I understand that results from telehealth cannot be guaranteed or assured. The benefits of telehealth may include but are not limited to: increased ability to express thoughts and feelings, transportation and travel barriers are reduced, and time constraints are minimized which may offer a greater opportunity to prepare for sessions in advance and may lead to fewer cancellations.

(10) I understand that I have access to my medical information and copies of medical records in accordance with MA laws. I understand that these services may not be covered by insurance and that I may be responsible for any fees incurred during psychotherapy which incorporates TMH.

I understand that I may revoke this authorization at any time by giving my written notice. I may specify the date, event or condition on which this consent expires. If none is stated, and if no prior notice of revocation is received, this consent will expire one year after the date it was initiated.

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

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 5/1/15 and will remain in effect until further notification. **THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made applicable changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations for the following reasons:

**Treatment**: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment**: We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations**: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization**: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

**To Your Family and Friends**: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved in Care**: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person’s involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services**: We will not use your health information for marketing communications without your written authorization.

**Required by Law**: We may use or disclose your health information when we are required to do so by federal or state law.

**Abuse or Neglect**: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security**: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials’ health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders**: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, texts, or letters).

**PATIENT RIGHTS**

**Access**: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so.

*You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, $15.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.*

**Disclosure Accounting**: You have the right to receive a list of instances in which we have disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 1, 2013. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction**: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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Credit Card Authorization Form

CREDIT CARD “on file” AUTHORIZATION FORM for my convenience of payment of deductibles, co-payments, private pay fees and cancellation fees, to Jose Morell, LMHC, LADC I for services rendered, I am providing my credit card, debit card or health spending flex card information to be kept on file and to be billed to my account within two business days of receiving services or upon incurring fees. Confirmation of payment can be made available upon request. I understand that credit card information will be kept confidential and will be loaded into a HIPPA electronic medical record platform. It is my responsibility to provide an updated card information as needed. This is an optional service. I am not required to provide this information. If I choose not to provide this information, I understand that all deductibles, co-payments, private pay and cancellation fees must be paid at the time of treatment by check to Jose Morell, LMHC as an alternative to keeping an authorized card on file. Cash will be accepted in exact amounts only. I understand that this practice requires a zero-balance due at all times. I understand that his authorization expires upon termination of treatment.

Name on Card:

Client name:

Credit Card #

CCV (3-digit code behind credit card):

Expiration date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing address associated with credit card: Zip code

I am agreeing to the terms and conditions set forth above.

Client/guardian signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider signature:­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_­­­\_\_ ­­

I understand that if I decline this service, I will keep a zero balance by paying fees by check or cash at time of service or when fees are incurred.