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Intake Form - Adult

Douglas Gotel, LICSW, RPT-S

**Identifying Information**

Name DOB / / Age Gender

Top of Form

Preferred Phone: ☐Cell ☐Home ☐Work ☐Other:

Bottom of Form

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Communication ☐Cell ☐Home ☐Work ☐Email\*

May I use email to confirm appointments/ send required forms to?\* ☐Yes ☐No

*\*Note: Email and electronic forms of communication are not 100% secure forms of communication*.

Okay to leave a message on my: ☐Home ☐Cell ☐Work number ☐Other

Residential Address City Zip

May I send mail to this address? ☐Yes ☐No

Employer Type of Work

Relationship Status:

 ☐Single ☐Married ☐Partnership ☐Divorced ☐Separated ☐Widowed ☐Other

Emergency Contact Relationship Phone

What prompted you to seek therapy?

Who is impacted by the issue?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Phone | Fax | Email |
| 50 E Street SE, Ste. 300 Washington, DC 20001  | (202) 430-5461  | (202) 543-2332 | info@douglasgotel.com  |

What have you tried to help manage your current problem? How was it helpful?

**Others Living In the Home:**

|  |  |  |
| --- | --- | --- |
| **Name** | **Age**  | **Relationship to Client** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Life Experiences (check all that apply):**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Relationship problems  |  | Natural Disaster |  | Witnessed | Experienced Physical Abuse |
|  | Experienced sexual abuse  |  | Death of someone close |  | Rape |
|  | War  |  | Abortion |  | Few Friends |
|  | Physical Injury/Accident  |  | Witnessed/Experienced emotional abuse |  | Witnessed | Experience Physical Assault |

Is there anything else you think would be helpful for me to know about you or your situation?

Have you had any prior counseling or psychiatric treatment?\_\_\_\_ No \_\_\_Yes

If yes**:** When? Where?

Reason for and length of counseling:

***Check one:*** Therapy was \_\_\_\_ helpful \_\_\_ not helpful. Please explain:

**FAMILY HISTORY**

Have any family members (parents, grandparents, sisters/brothers, children, aunts/uncles, cousins, etc.)

had any prior counseling or psychiatric treatment?\_\_\_\_ No \_\_\_Yes

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member’s relationship to you in the space provided (father, grandmother, uncle, etc.).

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Alcohol/Abuse |  | Substance Abuse |  | Anxiety  |
|  | Depression |  | Domestic Violence |  | Eating Disorders |
|  | Bipolar Disorder |  | Obsessive/Compulsive Disorder |  | Schizophrenia |
|  | Suicide Attempts |  | Hoarding Disorder |  | ADHD |
|  | Obesity |  | Hypertension  |  | Diabetes |

**MEDICAL HISTORY**

Name, address and phone number of your primary care physician:

If you would like me to coordinate care with another provider, do I have your permission to discuss or receive treatment records and/ or to receive diagnostic records from your past or current therapist, psychiatrist, and/ or physician to disclose and/or share our clinical information with your past or current therapist, psychiatrist, and/ or physician? Yes\_\_\_\_ No\_\_\_\_

Date of your last physical exam

Have you been under a physician’s care for any reason in the last five years? If yes, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE CHECK BEHAVIORS AND SYMPTOMS YOU CURRENTLY EXPERIENCE**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Panic attacks |  | Fatigue |  | Suicidal Thoughts |
|  | Phobias/Fears |  | Alcohol Use |  | Thoughts Disorganized |
|  | Poor Judgment |  | Flashbacks  |  | Dizziness |
|  | Self-esteem Problems |  | Grief  |  | Memory Impairment |
|  | Self-mutilation or harm |  | Anxiety |  | Drug Dependence |
|  | Sexual difficulties |  | Anger |  | Mood Swings |
|  | Sleep problems |  | Hallucinations |  | Eating Disorder |
|  | Cyber addiction |  | Chronic Pain |  | Obsessive thoughts |
|  | Hyperactivity Depression |  | Heart Palpitations |  | Disorientation  |
|  | Impulsivity  |  | Compulsive Behavior |  | Unresolved Trauma |
|  | Irritability Distractibility |  | High blood pressure |  | Worrying |
|  | Loneliness |  | Concentration problems |  | Aggression |
|  | Trembling |  | Hopelessness |  | Social withdrawal |
|  | Weight Gain/Loss |  | Other (Describe): |

Are you currently taking any medications? **Yes No**

If yes, please list names and amounts:

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** | **Purpose and Side Effects** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

What would you like as a desired outcome from seeking counseling?

**CONSENT FOR SERVICES**

**I give consent to receive assessment/psychotherapy services.**

**Signature (required) Date (required)**

# DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

# Name: Age: Sex:  Male  Female Date:

*If this questionnaire is completed by an informant*, **what is your relationship with the individual? In a typical week, approximately how much time do you spend with the individual? \_ hours/week**

**Instructions:** The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems? | **None** Not at all | **Slight** Rare, less than a day or two | **Mild** Several days | **Moderate** More than half the days | **Severe** Nearly every day | **Highest Domain Score** (clinician) |
| I. | 1. Little interest or pleasure in doing things? | 0 | 1 | 2 | 3 | 4 |  |
| 2. Feeling down, depressed, or hopeless? | 0 | 1 | 2 | 3 | 4 |
| II. | 3. Feeling more irritated, grouchy, or angry than usual? | 0 | 1 | 2 | 3 | 4 |  |
| III. | 4. Sleeping less than usual, but still have a lot of energy? | 0 | 1 | 2 | 3 | 4 |  |
| 5. Starting lots more projects than usual or doing more risky things than usual? | 0 | 1 | 2 | 3 | 4 |
| IV. | 6. Feeling nervous, anxious, frightened, worried, or on edge? | 0 | 1 | 2 | 3 | 4 |  |
| 7. Feeling panic or being frightened? | 0 | 1 | 2 | 3 | 4 |
| 8. Avoiding situations that make you anxious? | 0 | 1 | 2 | 3 | 4 |
| V. | 9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)? | 0 | 1 | 2 | 3 | 4 |  |
| 10. Feeling that your illnesses are not being taken seriously enough? | 0 | 1 | 2 | 3 | 4 |
| VI. | 11. Thoughts of actually hurting yourself? | 0 | 1 | 2 | 3 | 4 |  |
| VII. | 12. Hearing things other people couldn’t hear, such as voices even when no one was around? | 0 | 1 | 2 | 3 | 4 |  |
| 13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking? | 0 | 1 | 2 | 3 | 4 |
| VIII. | 14. Problems with sleep that affected your sleep quality over all? | 0 | 1 | 2 | 3 | 4 |  |
| IX. | 15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)? | 0 | 1 | 2 | 3 | 4 |  |
| X. | 16. Unpleasant thoughts, urges, or images that repeatedly enter your mind? | 0 | 1 | 2 | 3 | 4 |  |
| 17. Feeling driven to perform certain behaviors or mental acts over and over again? | 0 | 1 | 2 | 3 | 4 |
| XI. | 18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories? | 0 | 1 | 2 | 3 | 4 |  |
| XII. | 19. Not knowing who you really are or what you want out of life? | 0 | 1 | 2 | 3 | 4 |  |
| 20. Not feeling close to other people or enjoying your relationships with them? | 0 | 1 | 2 | 3 | 4 |
| XIII. | 21. Drinking at least 4 drinks of any kind of alcohol in a single day? | 0 | 1 | 2 | 3 | 4 |  |
| 22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco? | 0 | 1 | 2 | 3 | 4 |
| 23. Using any of the following medicines ON YOUR OWN, that is, without a doctor’s prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]? | 0 | 1 | 2 | 3 | 4 |

**LIMITS OF CONFIDENTIALITY**

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client’s legal guardian. Noted exceptions are as follows:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Duty to Warn and Protect**

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

**Abuse of Children and Vulnerable Adults**

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

**Prenatal Exposure to Controlled Substances**

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

**Minors/Guardianship**

Parents or legal guardians of non-emancipated minor clients have the right to access the clients’ records.

**Insurance Providers** (when applicable) Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

*I agree to the above limits of confidentiality and understand their meanings and ramifications.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature (Client’s Parent/Guardian if under 18)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date

**Authorization for Use or Disclosure of Protected Health Information**

Page 1 of 2

You may consent for personal information contained within your clinical record held by Douglas Gotel, LICSW, RPT to be disclosed to the person and/or agencies identified below for the following reasons:

* Planning and monitoring appropriate treatment.
* Case review and consultation with your physician and/or healthcare providers.
* Support and/or involvement of family member(s) or significant other in treatment.
* Information that is required to file a claim with your insurance company or managed care company.
* Information required by your employer if your supervisor refers you to treatment.

Your signature indicates that you authorize **Douglas Gotel, LICSW, RPT-S,** to release /receive information to the parties named below. Your may revoke this consent at any time by providing written notice. I understand that this authorization is voluntary that the information to be disclosed is protected by the law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Name of Party/Agency:

Address:

Phone: Fax:

This authorization will expire 90 days after consent or upon the happening of the following

event:

**Authorization for Use or Disclosure of Protected Health Information**

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|  |
| --- |
| **Information to Be Released (Check all requested)** |
|  | Psychotherapy Notes  |
|  | Treatment Plan/Summary |
|  | Diagnostic Summary/Psychological Assessment |
|  | Educational Record |
|  | Medical Records |
|  | Other:  |

Print Client’s Name: DOB

Client’s Signature: Date:

Parent/Guardian Signature: Date:

Witnessed By: Date:

**PATIENT RIGHTS AND HIPAA AUTHORIZATIONS**

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (“HIPAA”).

1. Tell your mental health professional if you don’t understand this authorization, and they will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.
5. If this office initiated this authorization, you must receive a copy of the signed authorization.
6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes***. HIPAA provides special protections to certain medical records known as “Psychotherapy Notes.” All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client’s medical records to maintain a higher standard of protection. “Psychotherapy Notes” are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual’s medical records. Excluded from the “Psychotherapy Notes” definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release “Psychotherapy Notes” to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

**Authorization Release for Consent to Record and**

**Use of Recorded Material**

Video and audio recording are commonly used for consultation, training and research in individual, group and family therapy. In order to record sessions, your written consent is required. The recording of sessions will likely enhance the effectiveness of your or your child’s treatment, but is not required. You may decline to have sessions recorded.

***Confidentiality***

For any of the uses agreed to below, the strictest confidentiality will be maintained, and there will be no sharing of the recorded material beyond the limits specified below. Except for your first names and your voice and/or image on the recording, there will be no information that could identify you. The recording will never knowingly be shared with anyone who knows you. Mental health professionals who may view or hear recorded material of your session (if permission is given here) are bound by law and by code of ethics to the same obligation to protect your confidentiality. Except as noted below, the existence of this recording will not

be discussed with anyone at any time.

|  |
| --- |
| Indicate preference by initialing below |
| Video & Audio | Audio Only |

**How Recorded Material May Be Used**

*\_\_\_\_\_\_ \_\_\_\_\_\_* **Consultation**

The recording may be shared with a clinical consultant who has been engaged to provide expert clinical consultation regarding the therapy process. This consultation s a vital source of professional development and accountability; it provides additional clinical expertise as a resource to your treatment and increases its effectiveness.

**Training**

*\_\_\_\_\_\_ \_\_\_\_\_\_* A brief recording excerpt may be used by D. Gotel in the training of

child and family therapists to demonstrate concepts and techniques of treatment. No information that could identify you, beyond the content of the tape, will be shared.

*\_\_\_\_\_\_ \_\_\_\_\_\_* **Session Review Only**

The recording may be reviewed privately by D. Gotel prior to the subsequent session. It will not be kept beyond the subsequent session and no recording will be kept beyond the conclusion of treatment.

**Freedom to withdraw consent**

I understand that I may withdraw previously granted consent at any time without giving a reason, and that this will not affect my or my child’s treatment or relationship with the therapist in any way.

**Authorization Release for Consent to Record and**

 **Use of Recorded Material**

**Clients Under Age 18**

I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby give consent to Douglas Gotel LICSW, RPT-S to

 Parent/Guardian

video record counseling sessions with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_for the purposes indicated above.

 Child Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Douglas Gotel, LICSW, RPT Date

**Adult/Family**

I give my consent to Douglas Gotel, LCSW, RPT to record individual/family sessions for the purposes indicated above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Douglas Gotel, LICSW, RPT Date

**CANCELLATION POLICY**

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment with less than a 24-hour notice.

The therapist reserves the right to terminate services after two consecutive missed or cancelled appointments.

Thank you for your consideration regarding this important matter.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature (Client’s Parent/Guardian if under 18)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date

|  |
| --- |
| Douglas Gotel, LICSW, RPT-S |
| 50 E Street SE, Suite 300 Washington, DC, 20003 | Phone: 202-430-5461 | Fax: 202 – 543-2332 | E Mail: info@douglasgotel.com  |

**Credit Card Payment Authorization Form**

This form authorizes regularly scheduled charges to your credit card for services rendered. You will be charged the amount indicated below each session. A receipt for each payment will be emailed to you and the charge will appear on your bank or credit card statement as an “ACH Debit.” You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

**Please complete the information below:**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize **Douglas Gotel, LICSW** to charge my credit card

 (full name)

indicated below for **$180** on the scheduled date of each session for payment of therapeutic services.

Billing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Credit Card**

|  |
| --- |
| [ ]  Visa [ ]  MasterCard [ ]  Amex [ ]  DiscoverCardholder Name **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Account Number **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Exp. Date **\_\_\_\_\_\_\_\_\_\_\_\_** CCV: **\_\_\_\_\_\_\_\_\_\_\_\_** *(3 digit number on back of card)* |

**SIGNATURE** **DATE**

I understand that this authorization will remain in effect until I cancel it in writing or upon termination of therapeutic services, and I agree to notify Douglas Gotel, LICSW in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates.

I understand that I am financially responsible for any balance due. I authorize that my credit card be used for balances on my account. In the event that I do not cancel an appointment within 24 hours and my appointment cannot be rescheduled that same week, I authorize that my credit card be charged the **$180** cancellation fee.

In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that Douglas Gotel, LICSW may at its discretion attempt to process the charge again within 30 days, and agree to an additional **$36** charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.  I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.