# FOOTHILLS COUNSELING & WELLNESS LLC
# MINOR CLIENT INTAKE PACKET

## MINOR CLIENT PERSONAL INFORMATION

Name ______________________________________________ Date ______________

Address ___________________________________________ Apt ______________

City _____________________________ State ________ Zip Code ______________

Date of Birth ______/______/________ Age ______ Birth Sex ___ Male ___ Female

Gender Identity
___ Male ___ Female
___ Transgender Male ___ Transgender Female
___ Additional Gender Category ________________

Preferred Gender Pronouns
___ He/Him/His
___ She/Her/Hers
___ They/Them/Theirs

Name of School Attending ___________________________________________________

## PARENT/GUARDIAN CONTACT INFORMATION

Name _________________________________________ Relationship __________________

Cell Phone _____________________________________
OK to contact? YES NO
OK to leave voicemail? YES NO
OK to text appointment reminders? YES NO

Work Phone __________________
OK to contact? YES NO
OK to leave voicemail? YES NO

E-mail _________________________________________
OK to contact? YES NO
OK to email appointment reminders? YES NO

## PERMISSION TO LEAVE MESSAGES

By signing below, I give the staff at Foothills Counseling & Wellness LLC, permission to leave detailed appointment information verbally on my answering machine at the phone numbers that I have indicated above. I also give them permission to send an appointment reminder email, or text, if indicated above. I understand that I have the right to revoke this authorization at any time.

Parent/Guardian Signature ____________________________________________ Date ___________

## EMERGENCY CONTACT INFORMATION (PLEASE PROVIDE TWO CONTACTS)

Name ______________________________ Relationship _____________ Phone # _________________

Name ______________________________ Relationship _____________ Phone # _________________

## CONSENT TO TREAT A MINOR CLIENT

Consent is given to Foothills Counseling & Wellness LLC, and rendering provider to provide necessary services including; assessment procedures, mental health counseling, treatment planning, and summoning emergency services if needed. In case of emergency, I authorized providers of the Foothills Counseling & Wellness LLC, staff or their designees, to make a professional judgment if necessary with and/or without me being present. I/we voluntarily consent that Foothills Counseling & Wellness LLC, being the holder of confidential privilege, – the right to withhold disclosure of private information about my child within the limits set by the ICA and ACA Code of Ethics. However, in the interest of developing a trust relationship between the provider and my/our child(ren), I/we give Foothills Counseling & Wellness LLC permission to reveal or withhold information that in his/her clinical judgment is necessary to best help and protect my/our child(ren).

The only exception to this discretion would be in the following:

In cases where there are legal custody arrangements: If parents have joint custody, both parents have a legal right to access their child(ren)s medical records. If there is a divorce or separation arrangement/ agreement, Foothills Counseling & Wellness LLC needs to obtain a copy of the arrangement/ agreement and only the parent listed as the primary guardian (unless under joint custody) will have legal authority to participate in client's treatment and/or have access to their child(ren)s medical records. Medical records are confidential and copies of medical records will not be released unless it is in the minor client's best interest to do so, or if there is a court order mandating that copies of medical records be made and released to a designated parent, guardian, or officer of the court.

I hereby acknowledge that no guarantees have been made to me as to the effect of such treatment on my child(ren)s condition.

I understand that at least one parent/guarding must be involved in the counseling of my minor child and will need to be on premises during counseling.

Parent/Guardian Signature __________________________________________ Date ______________

Minor Client Signature ______________________________________________ Date ______________
(If 14 years old or older)

## INFORMED CHOICE AND CONSENT FOR SERVICES

As a client of Foothills Counseling & Wellness LLC, I am aware that I have a choice of providers for counseling services, and I have chosen Foothills Counseling & Wellness LLC to provide these services. I have read and signed the enclosed intake paperwork and understand that Foothills Counseling & Wellness LLC is available to provide services consistent with psychological concerns. These services include preventative, diagnostic, therapeutic, rehabilitative, and palliative care. As a client of Foothills Counseling & Wellness LLC I understand that I may choose to refuse or discontinue services at any time without any judgement or negative repercussions.

# Financial Information and Agreement

## INSURANCE PROVIDER

PRIMARY INSURANCE

Insurance Provider ______________________________ Employer ________________________________

Minor Client's Relationship to Policy Holder ___ CHILD ___ OTHER ___________________________

Policy Holder's Name _______________________________ Date of Birth ____/____/____ Sex M F

Policy Holder's Address __________________________________________ Phone # __________________

Member ID ______________________________ Group # _______________________________________

## FINANCIAL AGREEMENT AND RELEASE OF INFORMATION FOR BILLING

Counseling fees are $90-$175 depending on the type and duration of the session: intake, crisis, 45 minute, 60 minute, etc.

All fees are due at the time of service. If you are utilizing your insurance benefits, Foothills Counseling & Wellness LLC will bill your insurance company. Please take the time to inform yourself of what services your individual insurance plan provides. **Please note that in the event that your insurance provider does not pay for services, you are responsible for all fees.** For questions involving payments and insurance, please contact the office.

Many insurance plans are managed care plans. Under a managed care plan, the insurance company periodically requires your counselor to submit your diagnosis, progress, and treatment plan to their reviewer, who then determines if further treatment is medically necessary. We want you to know that if you have a managed care insurance plan; this information will be released to the reviewers. If you don't want to release this information, you can choose not to use your insurance coverage and pay for services yourself at the time of each visit.

Your signature below authorizes Foothills Counseling & Wellness LLC to release your confidential information to your insurance carrier for the purposes of verifying benefits, billing, and other requests for information requested by your insurance carrier. It also indicates that you understand that you are responsible for all fees that are not reimbursed by the insurance carrier.

---

Parent/Guardian Signature ___________________________________________ Date ____________

## Minor Client Medical Information

### MINOR CLIENT PRIMARY CARE INFORMATION

Primary Care Physician/Pediatrician ________________________ Office Phone # _________________

Office Address _____________________________ City ____________ State _______ Zip _______

**Current medications (other than for mood/mental health?)** YES NO

Name of Medication ______________________________ Purpose __________________________

________________________________________________ __________________________

________________________________________________ __________________________

### MINOR CLIENT PSYCHIATRIC HEALTH and HISTORY

**Has the client ever been hospitalized for psychiatric reasons?** YES NO If YES, when: ____________

Reason for hospitalization

___ Psychiatric ___ Danger to Self ___ Danger to Others ___ Drug/Alcohol ___ Other ______________

**Is the client currently a patient with any Mental Health Providers?**

Psychiatrist YES NO Psychologist YES NO Developmental Therapy YES NO

Case Management YES NO OTHER _____________________

Name of Provider ________________________ Office Address ________________________________

Office Phone # ________________________

**Currently mood/mental health/psychiatric medications?** YES NO

Name of Medication ______________________________ Purpose ___________________________

________________________________________________ ___________________________

________________________________________________ ___________________________

## MINOR CLIENT MEDICAL HISTORY

**Minor Client Medical Conditions** (please list current and past surgeries, major illness, allergies):

What ______________________________________ When ________ Doctor's Name _____________

What ______________________________________ When ________ Doctor's Name _____________

What ______________________________________ When ________ Doctor's Name _____________

**Family History Medical Conditions**:

**Family History Medical Conditions** (Mental Illnesses)

Maternal Side ______________________________________________________________________

Paternal Side ______________________________________________________________________

Siblings ______________________________________________________________________

---

## ***How did you hear about us?***

___ Friend/Family Name ____________________________________

___ Doctor/Other Provider Name _____________________________

___ Insurance Company/EAP

___ Foothills Counseling & Wellness Website (FOOTHILLSBOISE.COM)

___ Psychology Today (PSYCHOLOGYTODAY.COM)

___ Foothills Counseling & Wellness Facebook Page

___ Other Name __________________________________________

THIS PAGE INTENTIONALLY LEFT BLANK

# Information Disclosure and Informed Consent

## Purpose of This Form:

***1. It tells you what to expect from counseling:*** Your first visit will help us get a general understanding of your situation in order to determine how we might best help you. Because we want you to participate actively in planning your counseling, do not hesitate to ask questions.

***2. This form serves as an Agreement between you and the counselors of Foothills Counseling & Wellness LLC.*** All counselors at Foothills Counseling & Wellness LLC are independent contractors, with their own private practice; not employees of Foothills Counseling & Wellness LLC. Foothills Counseling & Wellness LLC contracts with counselors for office space, scheduling, billing, insurance verification and file storage. All business associates who are contracted by Foothills Counseling & Wellness LLC have signed a confidentiality waiver and are required to keep all information confidential. All counselors keep their files separate from each other. You may revoke (cancel) this Agreement in writing at any time. That revocation will be binding on the counselor listed in writing of Foothills Counseling & Wellness LLC unless we have already relied on this agreement to take action, or if your health insurer requires a counselor of Foothills Counseling & Wellness LLC to send information needed in order to process claims made for your services, or if you have not paid your bill in full.

***3. This form also contains information about a federal law that affects your privacy rights***. HIPAA (Health Insurance Portability and Accountability Act) regulates the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. HIPAA requires that we give you a Notice of Privacy Practices. The Notice, included in this Agreement, explains HIPAA's application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information. We will give you a copy of this Agreement, including the Notice.

***4. This form explains our policies.*** Please let your counselor know if you have concerns or questions about these policies.

## COUNSELING PURPOSE

Counseling is a way of talking through your problems in order to begin resolving them. The counseling process is a collaboration between the counselor and the client, working as a team towards implementing healthy goals. You will need to take an active part in counseling by working on, and thinking about the things you talk about with your counselor. Counseling has been shown to have many benefits. However, there are no guaranteed results, and at times, a counseling session may leave you with unhappy feelings. When it is effective, counseling often leads to better relationships, solutions to specific problems, and feeling much less distressed. Not every counselor will be a good fit for every client. If there is a desire to end counseling before goals are met, an appropriate referral to another counselor can be made.

## APPOINTMENTS

Individual and family sessions last 45 to 60 minutes and can be scheduled through your counselor, the Foothills Counseling & Wellness LLC office staff or on TherapyPortal.com. We require a credit/debit card be placed on file in order to schedule an appointment. Once the appointment is made, the time is set aside for you. **If you cancel an appointment, we require you to provide notice at least 24 hours before the session. If 24 hour notice is not given, or there is a "no show", there will be a $60-$175 missed appointment fee shall be charged to the card on file. Insurance does not cover charges for reserved time; you are personally responsible for any such charges.** If you are over 15 minutes late, your counselor may cancel your appointment, and missed appointment fees will apply. There are times when your counselor may be unable to start your session on time. If your counselor is late, you will be given your full session time.

## BILLING INSURANCE

Medical insurance that provides mental health and counseling benefits do so based on a medical model. This means your counselor will be required to provide your insurance with a medical diagnosis. Benefits are limited to those that are "medically necessary." Many social, family and marriage problems are not deemed medically necessary and are therefore NOT covered by many insurance plans. Please talk with your counselor if you have questions regarding diagnosis and medical necessity.

## PROFESSIONAL STANDARDS

Counselors are required to adhere to the professional code of ethics adopted by the Idaho Counselor Licensing Board. If you have reason to believe your counselor has acted in an unethical manner you have the right to file a complaint in writing to the Idaho Bureau of Occupational Licenses located at 1109 Main Street, Suite 220; Boise, ID 83702, or by phone at (208) 334-3233.

You may, at any time seek a second opinion, or request to see another counselor. If you are dissatisfied with your counselor, it is your right and responsibility to seek another counselor, or to terminate treatment (unless treatment has been court ordered). A referral to another counselor will be given upon request.

## CONFIDENTIALITY AND CLIENT RECORDS: NOTICE OF PRIVACY POLICIES AND PRACTICES

Federal and State laws governing confidentiality can be quite complex. This Notice explains some specific Patient Rights that you have under these laws.

**CLIENT RECORDS—**All counselors at Foothills Counseling & Wellness LLC maintain a Clinical Medical Record file on your case, which is the property of Foothills Counseling & Wellness LLC, and your provider. Foothills Counseling & Wellness LLC utilizes electronic medical records files. Check with your counselor to discuss how they are keeping their files secure. These files contain a copy of this intake paperwork, insurance/billing information, a medical record documenting your session with your counselor, medical records received by other providers, and any medical releases you have signed. Counselors and Staff at Foothills Counseling & Wellness LLC respect the confidentiality of other provider's client files and do not access files other than their own.

You may examine and/or receive a copy of your file *if* you request it in writing *and* the request is signed by you *and* dated not more than 60 days from the date it is submitted. There may be a charge for writing reports or for copying materials. All requests to release medical records will need to be approved by your provider.

**PLEASE NOTE:** If you are being seen in couples, group, or family therapy, Idaho laws concerning confidentiality are not clear. Foothills Counseling & Wellness LLC will not release information to other parties without the written permission of all individuals involved in the therapy session, except when allowed or required to do so by State or Federal law, unless a court order requires us to release information about your case.

**CONFIDENTIALITY—** Information provided by and to a client during therapy sessions is legally confidential if the counselor is a licensed counselor, or reasonably believed by the client to be so. If the information is legally confidential, the counselor cannot be forced to disclose the information without the client's consent with the following exceptions: Information may be released to parents of minor children who have the legal right to access their children's medical information; When authorized by other state laws; If the counselor is a defendant to a civil, criminal, or disciplinary action arising from therapy; The client is a defendant in a criminal proceeding, and the use of confidential information would violate the defendant's rights to a compulsory process.

You may choose to engage in electronic communications with your counselor. If you and your counselor choose to do so, it is important for you to understand that confidentiality may be difficult to guarantee in that format. However, your counselor will follow guidelines as outlined in the ACA Code of Ethics, as well as HIPAA security requirements.

## COURT APPEARANCES

At times, a client may ask a counselor to appear in court on their behalf or the behalf of their children. Counseling is primarily a therapeutic relationship with the goals focused on personal growth and healing, with all the information shared in session being confidential. **Therefore, it is the policy of counselors at Foothills Counseling & Wellness to refuse all requests to appear in the court on behalf of any client.** In the case where a counselor of Foothills Counseling & Wellness LLC is subpoenaed to testify in court, an hourly fee of $250 will be assessed, with a minimum of four hours of services to be paid prior to the court appearance.

## ACCESS TO CARE AND AFTER-HOURS CRISIS

Foothills Counseling & Wellness LLC does not offer after-hours crisis services. If you experience a life-threatening mental health emergency, call 9-1-1 or go to the nearest Emergency Room. If you are in crisis, but not an imminent threat to yourself or another person during office hours, your counselor will contact you within 24 hours to assess your symptoms and devise a safety plan.

# HIPAA and Your Protected Health Information (PHI)

## USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Foothills Counseling & Wellness LLC may *use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes* with your *consent*. To help clarify these terms, here are some definitions: *"PHI"* refers to information in your health record that could identify you. "Treatment, Payment and Health Care Operations":

- *Treatment* is when Foothills Counseling & Wellness LLC provides, coordinates and manages your health care and other services related to your health care.
- *Payment* is when Foothills Counseling & Wellness LLC obtains reimbursement for your healthcare. Foothills Counseling & Wellness LLC may use collections agencies, an accountant, a billing manager, and technical support service for our billing software. As required by HIPAA, these businesses have signed contracts with us in which they promise to maintain the confidentiality of protected health information except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with the names of these organizations and a blank copy of the contract.
- *Health Care Operations* are activities that relate to the performance and operation of Foothills Counseling & Wellness LLC.
- *"Use"* means activities within Foothills Counseling & Wellness LLC's practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. Your counselor practices with other mental health professionals and also employs support staff. In most cases, your counselor needs to share information with support staff for purposes such as billing, scheduling, and quality assurance. Also, Foothills Counseling & Wellness LLC and clinical staff routinely consult with each other concerning our clients. Please let your counselor know if you would prefer that other clinical staff not be consulted about your case. During consultations, your therapist makes every effort to avoid revealing the identity of patients. The other professionals are also legally bound to keep the information confidential. All of the professional staff members are bound by the same rules of confidentiality, and all support staff have training in privacy rules and have agreed not to release any information outside of the practice without permission of a professional staff member. The therapist will note all consultations in your Clinical Record.
- *"Disclosure"* means activities outside of our office, such as releasing, transferring, or providing access to information about you to other parties. Your therapist may find it helpful to share information with your primary care physician or other health and mental health professionals who are currently treating you.

## USES AND DISCLOSURES REQUIRING AUTHORIZATION

Your counselor may use or disclose PHI for purposes outside of treatment, payment, and health care operations when authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when your therapist is asked for information for purposes outside of

treatment, payment and health care operations, she/he will obtain a written authorization from you before releasing this information. Your therapist will also need to obtain a separate authorization before releasing your psychotherapy notes.

*"Therapeutic notes"* are notes your counselor has made about your conversations during a private, group, joint, or family counseling session, which your counselor has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time. Foothills Counseling & Wellness LLC reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that is maintained. Foothills Counseling & Wellness LLC will provide you with a revised notice by posting the revisions in the waiting room for your inspection. You may not revoke an authorization to the extent that (1) your counselor has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

## USES AND DISCLOSURES WITH NEITHER CONSENT OR AUTHORIZATION

**Your therapist may use or disclose PHI without your consent or authorization in the following circumstances:**

- **Child Abuse:** If your therapist knows or suspects that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired person under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect, she/he is required by law to report that knowledge or suspicion to the Idaho Department of Health and Welfare, or a municipal or county peace officer.
- **Elder Abuse:** If your therapist has reasonable cause to believe that an elder is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, she/he is required by law to immediately report such belief to the Idaho Department of Health and Welfare Adult Protection Agency.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by the psychologist-client (or counselor-client) privilege law. Foothills Counseling & Wellness LLC cannot provide any information without your (or your personal or legal representative's) written authorization. However, if a court orders Foothills Counseling & Wellness LLC to disclose information, we are required to provide it. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
- **Serious Threat to Health or Safety:** If your counselor believes that you pose a clear and substantial risk of imminent serious harm to yourself or another person, she/he may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to your counselor an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and your therapist believes you have the intent and ability to carry out the threat, then she/he is required by law to take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s).
- **Worker's Compensation:** If you file a worker's compensation claim, your counselor may be required to give your mental health information to relevant parties and officials.
- **If the client is a minor:** Both parents have access to the minor client's complete medical record, including counseling notes, unless there is a court order prohibiting one of the parents from access.
- **If a government agency** (such as Medicaid/Medicare) is requesting the information for health oversight activities, Foothills Counseling & Wellness LLC may be required to provide it to them.
- **If a client files a complaint** or lawsuit against Foothills Counseling & Wellness LLC or any of its counselors or staff, Foothills Counseling & Wellness LLC may disclose relevant information regarding that patient in order to defend itself.
- **Foothills Counseling & Wellness LLC and staff may present** disguised case material in seminars, classes, or scientific writings; in this situation, all identifying information and Protected Health Information is removed and client anonymity is maintained.

• **Your health insurance plan** has the right to review your clinical records for any services you have asked them to pay for. Unless your treatment is being paid for by a worker's compensation plan, a health insurance company is *not* entitled to see counseling notes, which are detailed notes your counselor may make concerning what you have talked about in therapy. However, they *are* entitled to see PHI in your clinical record, including information about dates of therapy, symptoms, your diagnosis, your overall progress towards those goals, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier.

## CLIENT'S RIGHTS

• *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, your counselor is not required to agree to a restriction you request.
• *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, if you don't want family members to know you are seeing a counselor, you can have your bills sent to an alternate address.
• *Right to Inspect and Copy* – You have the right to inspect and/or obtain a copy of your, or your minor child's, PHI and counseling notes in your counselor's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. There will be a charge for copies made.
• *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your counselor may deny your request.
• *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization.
• *Right to a Paper Copy* – You have the right to obtain a paper copy of the Privacy Notice from your counselor upon request, even if you have agreed to receive the Notice electronically.

## COUNSELOR'S DUTIES

• Your counselor is required by law to maintain the privacy of PHI and to provide you with a notice of their legal duties and privacy practices with respect to PHI.
• Foothills Counseling & Wellness LLC reserves the right to change the privacy policies and practices described in this notice. Unless your counselor notifies you of such changes, however, the counselor is required to abide by the terms currently in effect.
• If Foothills Counseling & Wellness LLC revises their policies and procedures, they will be posted in the waiting room for your inspection, at your convenience.

## COMPLAINTS

Initial complaints should be addressed with your counselor. However, if you are concerned that your counselor has violated your privacy rights, or you disagree with a decision your counselor made about access to your records, you may contact the Idaho Department of Occupational Licenses. If you have any questions about this Notice, please contact:

Privacy Officer: Laura Siney
Phone: 208-429-3854
Address: 1819 W State St
Boise, ID 83702
Email: Admin@FoothillsBoise.com

## EFFECTIVE DATE

This notice is effective January 7, 2021

THIS PAGE INTENTIONALLY LEFT BLANK

# Agreements

**Please sign below after you have read the previous pages and keep pages 7-11 for your records.**

The full text of this agreement is also available in the waiting area/front desk at the address below and is available for download from our website: www.FoothillsBoise.com.

FOOTHILLS COUNSELING & WELLNESS LLC
1819 W State St
Boise, ID 83702

If you have questions regarding these forms, please ask your counselor or contact Foothills Counseling & Wellness LLC at 208-429-3854.

**INFORMATION DISCLOSURE, INFORMED CONSENT, CLIENT RIGHTS, AND HIPAA AND YOUR PROTECTED HEALTH INFORMATION (PHI)**

***______ I have read and reviewed this informed consent. I understand and agree to all the terms as they are written. In addition, I have been offered a copy of this form for my own records.***

***_______ I have read, understand, and accept my rights as a client of Foothills Counseling & Wellness LLC regarding both privacy practices, and the scope of services available.***

***_______ My signature below indicates that I have read the attached agreement and agree to its terms, and serves as an acknowledgement that I have received the HIPAA notice of privacy practices.***

Parent/Guardian Signature ________________________________________ Date ____________

Minor Client Signature ____________________________________________ Date ____________
(If 14 years old or older)

**Counselor** Signature ______________________________________________ Date ___________

## Credit/Debit Card Authorization

Sign and complete this form to authorize FOOTHILLS COUNSELING & WELLNESS LLC to charge/debit your card listed below.

By signing this form, you give us permission to debit your account.

---

I, ______________________________, authorize FOOTHILLS COUNSELING & WELLNESS LLC to charge my credit/debit card indicated below on or after the date of ____________ for the professional services and fees as follows:

*Initial both statements below to indicate agreement.*

________ To charge my card for any balance owed, including fees not paid at the time of service or not covered by my insurance company.

________To charge my card for any Missed Appointment or Late Cancellation fees which I may incur.

*Complete Address info only if card billing address is different from what we have on file as your home address:*

Billing Street Address:________________________________________________

City, State, Zip: ________________________________________________

Account Type: ☐ Visa ☐ MasterCard ☐ Discover

Cardholder Name ____________________________________

16 Digit Card Number ______________

Expiration Date ______________

Security Code ______________

SIGNATURE ________________________________ DATE ______________

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for up to the amount indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.