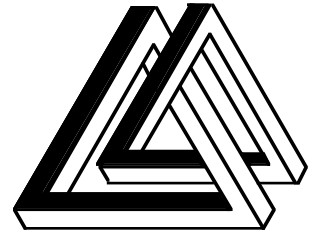


FAMILY THERAPY INSTITUTE MIDWEST INC

Recognized Experts in Family Therapy

2601 W 6th St, Suite C
Lawrence, KS 66049



Child/Adolescent (under 18) Information Form

Client Name	<input type="text"/>	<input type="text"/>	<input type="text"/>
	First	Middle	Last
Address	<input type="text"/>		Is Address?: <input type="radio"/> Home <input type="radio"/> Other
City	<input type="text"/>	State	<input type="text"/>
		Zip	<input type="text"/>
Home ☎	<input type="text"/>	Office ☎	<input type="text"/>
		Mobile ☎	<input type="text"/>
			<input type="radio"/> ATT <input type="radio"/> Sprint <input type="radio"/> T-mobile <input type="radio"/> Verizon
Email	<input type="text"/>		
	Please DO NOT include phone numbers or email addresses at which you do not want to be reached under any circumstances		
DOB	<input type="text"/>	Age	<input type="text"/>
		SSN#	<input type="text"/>
Family Role	<input type="text"/>	Sex	<input type="radio"/> Male <input type="radio"/> Female
M Status	<input type="text"/>	Income	<input type="text"/>
		Years of Education	<input type="text"/>
Employer or School	<input type="text"/>	Work/ School Status	<input type="text"/>
Referred By	<input type="text"/>	Emergency Contact*	<input type="text"/>

*Please provide a name and phone number for someone who could be contacted in case of a serious health emergency. By providing this number you are authorizing FTI Midwest to contact this person under these unusual circumstances

Insurance Information

Clients who qualify by diagnosis, and wish to do so, may choose to have their treatment reimbursed by a medical insurance carrier. You may do this by receiving a bill and forwarding it to your insurance company, or by having us bill the company directly. In either case it is likely to be necessary for us to have some contact with the company to provide information necessary for billing. By signing this form you are agreeing to allow us to provide whatever information is legally allowed to assure reimbursement for services we may render. Typically this will include diagnosis, but some insurance companies ask for treatment plans, and goals and objectives. Insurance companies are bound by Federal laws guiding confidentiality, but FTI Midwest cannot be responsible for any records once they are released to your company. To learn more about your insurance company's policies on these matters, please contact them directly.

PLEASE NOTE: WE DO NOT ACCEPT MEDICARE AS PRIMARY OR SECONDARY INSURANCE. EVEN IF A CLIENT HAS ANOTHER INSURANCE POLICY, IF THEY ALSO HAVE MEDICARE WE CANNOT SEE THEM because we will not be reimbursed and the client cannot pay us directly. Due to increasing costs of billing and unfair state recoupment procedures, we no longer accept MEDICAID for any services.

Relationship of client to policyholder: Self Spouse Child Other

Does more than one insurance company cover this client? Yes* No

*If "yes" you must complete a second form with insurance information. Please ask your therapist for this form.

If you are the insurance policyholder, you may put "same" in any box that you have already filled out on page 1. If you are not the policyholder you must complete all of the following information for us to bill the insurance company on behalf of the client.

Policy Holder			
	First	Middle	Last
Address			Is Address?: <input type="radio"/> Home <input type="radio"/> Other
City		State	
		Zip	
Home ☎		Office ☎	
		Other ☎	
Please do not include phone numbers at which you do not want to be reached under any circumstances			
DOB		Age	
		SSN#	
M Status		Sex	<input type="radio"/> Male <input type="radio"/> Female
Employer or School		Work/ School Status	
Insurance Co Name		Ins ID Number	
		Group Number	
Insurance Co Address		Insurance Co Phone ☎	

I have read the above statement or had it explained to me and my questions have been answered. I agree to release FTI Midwest to provide all information necessary to my insurance carrier in order to process my claim and, if FTI-Midwest is billing my company directly, have all benefits assigned to FTI-Midwest.

Client

Date

Clinical Information

For us to give the best service possible, we must have the following information about the child you are bringing for therapy. Please answer all of the questions below. If you do not know how to answer a question, put a "?" in the blank and your intake counselor will discuss it with you.

1. Was this child adopted? No Yes (age at adoption: _____)
2. Who does the child live with? Mother Father Relative Foster home Other : ____
3. Who has legal custody of the child?: _____
4. Who cares for the child during the day?: _____
5. Who disciplines the child at home?: _____
6. Have there been divorces, separations, deaths, or serious illness in the family since the child's birth? No Yes
7. To the best of your knowledge has this child been **sexually** abused?
No Yes Possibly
8. To the best of your knowledge has this child been **physically** abused?
No Yes Possibly
9. Has this child ever been removed from the home by social services or law enforcement? No Yes

10. School Information

Name of School: _____ Grade: _____
 Teacher: _____ Counselor: _____

11. Medical & Psychiatric Information

Child's Doctor: _____
 Date of last physical exam or treatment: _____
 Is the child being treated for any medical or surgical conditions? No Yes
 Has the child ever had an injury to the head requiring medical treatment? No Yes
 Does the child have allergies or bad reactions to medications or other substances? No Yes

Please list: _____

Current Medications

Name	Indication	Dose/Frequency	Start Date	Prescriber

Where Did you Find Contact Information on Family Therapy Institute Midwest?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> AT&T Yellow Pages | <input type="checkbox"/> Yellowbook | <input type="checkbox"/> School Personnel | <input type="checkbox"/> Internet |
| <input type="checkbox"/> My Insurance Company | <input type="checkbox"/> Doctor's Referral | <input type="checkbox"/> Poster | <input type="checkbox"/> A Local Agency |
| <input type="checkbox"/> Court or Attorney | <input type="checkbox"/> Newspaper Column | <input type="checkbox"/> Friend's Referral | <input type="checkbox"/> Another Therapist |

12. Counseling and Psychiatric Information

Treatment Dates	Diagnosis	Inpatient	Outpatient	Medications	Clinician/Facility

Does the child get social security disability benefits for a psychiatric condition or have they been applied for?
 No Yes

Has the child ever taken tranquilizers, antidepressants, pain or sleeping pills, or similar medications?
 No Yes

Please list: _____

Has a teacher or doctor ever suggested that this child might have Attention Deficit Hyperactivity Disorder (ADHD)? No Yes

13. The child's family:

Parents:	Age	Current Location	Health Status	Mental Health/SA Hx.
Mother				
Father				

Siblings Name(s)	DOB/Age	Living with (Other than parent)	Medical Problems	Mental Health/ Substance Abuse Tx.

Please write below anything else about the child's family that you feel would be useful in treatment:

14. Early Childhood Information

Mother's age at child's birth: _____ Father's age at child's birth: _____

Length of pregnancy: _____ Child's birthweight: _____

Which of the following happened to the mother during the pregnancy?

- a. serious illness No Yes
- b. spotting blood No Yes
- c. severe vomiting/nausea No Yes
- d. frequent alcohol use No Yes
- e. use of prescription medication No Yes
- f. use of marijuana No Yes
- g. use of cocaine, crack or similar drug No Yes
- h. use of other drugs or medications No Yes
- i. other problems: _____

Which of the following occurred during the birth of this child?

- a. difficult labor No Yes
- b. born other than head first No Yes
- c. blue or yellow color at birth No Yes
- d. problems breathing No Yes
- e. Rh blood problem No Yes
- f. other problems: _____

Which of the following occurred when this child was a baby?

- a. Difficulty with breast or bottle feeding No Yes
- b. Difficulty eating solid food No Yes
- c. Difficulty giving up bottle or pacifier No Yes
- d. Wanted to eat too much or too little No Yes
- e. Had colic No Yes
- f. Failure to thrive No Yes
- g. other problems: _____

Which of the following occurred before age 5?

- a. Stomachaches or vomiting No Yes
- b. Problems in potty training No Yes
- c. Slow sitting up or walking alone No Yes
- d. Slow learning to talk or difficult to understand No Yes
- e. Clumsiness No Yes
- f. Accident prone No Yes
- g. other problems: _____

Checklist of Concerns

15. Check how often these problems have happened to the child during the last six months?

	Rarely or Never	Sometimes	Often
1. Constipation or diarrhea			
2. Vomiting			
3. Fainting spells			
4. Seeing or hearing things that aren't there			
5. Loss of consciousness/blacking out			
6. Confusion or not knowing where he or she is			
7. Eye trouble/blurred vision			
8. Hearing problems			
9. Severe headaches			
10. Heart trouble			
11. High/low blood pressure			
12. Chest pain			
13. Shortness of breath/chronic cough			
14. Cramping or swelling of feet or lower legs			
15. Joint swelling			
16. Severe bruising			
17. Anemia/unusual bleeding			
18. Liver disease/jaundice			
19. Big weight loss or gain			
20. Diabetes			
21. Painful urination			
22. Female problems/pregnancy			
23. Seizures/convulsions			
24. Cancer			
25. Thyroid problem			
26. Problems going to sleep or staying asleep			
27. Fear of sleeping alone or fear of the dark			
28. Nightmares			
29. Sleep walking			
30. Banging head while sleeping			
31. Bed wetting			
32. Soiling or wetting during day			
33. Is clumsy			
34. Accident prone			
35. Picks at body (nails, fingers, skin)			
36. Sucks or chews (thumb, clothing, blanket)			
37. Shyness or fear of new situations			
38. Cries easily			
39. Steals			
40. Tells lies or makes up false story			
41. Breaks or destroys things			
42. Gets into more trouble than other children			
43. Problems making or keeping friends			
44. Acts bossy to other kids			
45. Picks fights or quarrels			
46. Has tantrums			

	Rarely or Never	Sometimes	Often
47. Gets picked on by other kids			
48. Acts without thinking			
49. Is excitable			
50. Has problems learning			
51. Deliberately hurts animals or people			
52. Clings to one or both parents			
53. Sulks or pouts			
54. Worries more than other children			
55. Does very strange things			
56. Seems very sad			
57. Has problems showing or accepting love			
58. Uses alcohol			
59. Uses marijuana or other illegal drugs			
60. Has attempted suicide or had suicidal ideas			
61. Daydreams or stares "into space"			
62. Thinking seems sluggish			
63. Takes along time to start a task			
64. Lethargic (slow, drowsy, doesn't do much)			
65. Seems to be confused or in a fog			
66. Can't remember simple things (daily routine, etc.)			
67. Withdrawn, prefers to be alone			
68. Avoids classroom activities			
69. Fidgets with hands or feet or squirms in seat			
70. Can't stay in seat when asked			
71. Is easily distracted by things around him/her			
72. Can't wait for his/her turn in a game			
73. Blurts out answers before hearing whole question			
74. Can't follow instructions well			
75. Can't keep attention focused on games or tasks			
76. Goes from one thing to another without finishing			
77. Can't play quietly when asked			
78. Talks excessively			
79. Interrupts or intrudes on others			
80. Doesn't listen to what's being said to him/her			
81. Loses things (books, toys, pencils, assignments)			
82. Does dangerous things (e.g., runs into street, etc.)			
83. Loses temper			
84. Argues with adults			
85. Refuse adult requests or rules			
86. Does things to annoy people			
87. Blames others for own mistakes			
88. Is touchy or easily annoyed by others			
89. Is angry and resentful			
90. Tries to get back at others			
91. Swears or uses obscene language			

Child/Adolescent Consent to Treatment

(For children under 14, must be signed by custodial parent or legal guardian)

For us to consider providing services to you, you must *read and sign* this consent form. This *is not* a contract. It just allows us to see you. You may withdraw this consent to treatment at any time and ask that your file be closed. You should also know that this is not an agreement by FTI Midwest to provide services to you. You may wish to talk with your therapist about your consent to treatment during intake session. He or she will answer your questions.

Understanding Psychotherapy. Psychotherapy and psychiatric services are designed to help your child change. Sometimes this kind of change is difficult because it raises feelings, thoughts, and worries that children try to keep inside. The benefits of to your child may include improved behavior, relationships, and mood. S/he may learn to communicate better with you and with others. You should know that this is not a precise science. In many cases we are successful in helping people to change. In some cases we are not. FTI Midwest cannot guarantee the success of any treatment.

As a parent your involvement in therapy is very important. Usually change in a child involves change in the family. This is why we often ask parents and other family members to come to therapy. This shows support for your child and your interest in helping him or her. It can also help you to handle problems with your child and understand him or her better. Many parents find they can learn new ways of dealing with their families and children through psychotherapy.

FTI Midwest is owned and operated by persons of several professions, psychology, social work, and nursing. Each does psychotherapy with clients. None of our professionals is a medical doctor, though Mary Lu Egidy and Elaine Rolfs are Advanced Registered Nurse Practitioners (ARNP) and thus able to do psychiatric intakes and prescribe medications under the contracted oversight of Manuel Morales, MD a physician licensed by the Kansas Healing Arts Board.

Grievance Procedure. At times clients in psychotherapy may find themselves in conflict with their therapist about some aspect of treatment. This may come from a misunderstanding between client and therapist, or a genuine disagreement in how treatment should proceed. We attempt to resolve any conflicts in a manner that is suitable to our clients, while maintaining important treatment standards. If you reach a point of conflict in your child's treatment, you should first attempt resolution with your assigned therapist. If this does not solve the conflict and you are seeing another therapist or nurse practitioner, you should speak with them about the issue. They will attempt to resolve the conflict with your assigned therapist. If your child is not seeing another provider at FTI, please contact Heather Falley, practice manager. She will assign the grievance to a staff member who is not involved with your family. If the conflict cannot be resolved in this manner, we may assign a different therapist or suggest seeking services elsewhere. If the conflict cannot be resolved by the FTI grievance procedure.

Second Opinions and Service Referral. Clients are entitled to a second opinion at either this agency or another. A second opinion may be helpful when you do not agree with an FTI diagnosis or treatment finding. FTI Midwest does not usually make specific recommendations about where or when to seek a second opinion. At times however, FTI Midwest may find that we do not have adequate training, experience, or services to properly address your needs. In this case we may recommend other resource that are more suitable.

Confidentiality. For therapy to be effective, child and adolescent clients must feel they are able to speak freely without consequence of disclosure to their parents or authorities. Thus, all services provided are *strictly confidential*. We cannot release any information about your child to anyone outside FTI Midwest without your written consent. In order to help your child and family we do share information between staff at FTI Midwest. For example, your therapist may talk to a colleague in our organization in order to better understand your child's case.

For teenagers age 14 to 17, FTI expects families to assent to allow the therapist to keep most discussions between the teen and therapist confidential even from family members. Teens should be aware that parents can file court action to open their records. FTI discourages this practice and reserves the right to decline services for parents who will

not assent to allow the therapist to disclose only what is necessary to further the case. FTI will disclose information to parents if 1) the child is at serious risk of harming self or others; 2) the child is involved in potentially self-destructive behavior like heavy drug use or unprotected sex; 3) there exist situations that may severely hamper treatment. In the latter case, FTI may choose not to share the specifics of the information, but may refuse to continue the case if the child will not self-disclose.

Many times the therapist will use information shared by the child to guide and direct the parents toward more effective parenting. However, FTI will not routinely disclose to parents issues of minor drug use, protected and safer sex practices, legal infractions, or violations of house rules that are unbeknownst to the parents. To be clear, therapy cannot be effective if children believe the therapist is an information conduit to their parents. If parents wish to discuss this matter with the therapist, they are encouraged to do so before any individual time is scheduled with the child.

Breaking Confidentiality. Beyond that noted above, *there are three exceptions to confidentiality for all clients.* By law all therapists must break confidentiality: (1) if a client is threatening to hurt himself/herself or someone else in order to protect the client or the other person; (2) if we suspect that a child is being abused; and (3) if a court of law subpoenas (demands to see) the records. If this happens, we will attempt to invoke *privileged communication* (a legal protection of your right to therapeutic confidentiality) if you or your attorney asks us to do so. However, under some circumstances, the court can override privileged communication and order us to disclose these records.

Email or Fax Contact. At your discretion you may contact you or your child may contact the therapist via email for the same purpose you would initiate phone contact. However, for therapy you are advised against using unsolicited fax transmissions as they are not monitored as closely. FTI does not consider email contact to be therapy and does not bill it as such. It is instead considered administrative and supportive contact. By initiating email contact you are accepting this understanding and agreeing to act accordingly. For evaluations, both email and fax contact are acceptable but are considered part of the evaluation. By initiating this contact you are accepting this understanding and agreeing that the email may be used in your evaluation.

You are advised that email communication is protected by federal law, but should not be considered secure. It is possible that someone on the Internet might read your communication or our communication back to you. By initiating this sort of contact you are waiving this level of confidentiality unless you specify in your email a limitation of the expected response (e.g., "please don't reply"). Fax communication for evaluations is secure within our office and within the limits of electronic security in general (e.g., someone could be wiretapping phone lines but this would also be a federal offense). If you are especially concerned about this issue, please discuss it with your therapist at intake.

We will not respond to emails from teenagers if we believe the email is being monitored by anyone. Thus, if parents routinely check a child's email account, this needs to be disclosed to the therapist. These conversations are considered just as confidential as a discussion in the office and the same rules of disclosure apply.

Text Messaging. Some therapists have found that text messaging can be a very helpful tool in keeping in touch. Please provide your text information OR advise the front office if you DO NOT want to be contacted by text messaging.

Minor's Access to Treatment. Kansas Statute 59-2949 allows minors age 14 and up to make written application on their own behalf to a treatment facility "without the consent or written application of their parent, legal guardian or any other person." The statute also states that a youth 14 and up "makes written application on their own behalf and is admitted as a voluntary patient, the head of the treatment facility shall promptly notify the child's parent, legal guardian or other person known to the head of the treatment facility to be interested in the care and welfare of the minor of the admittance of that child." This position was upheld and clarified in Attorney General's opinion 2004-22. Thus minors 14 and up may access treatment by signing this document, without the consent of their parents, though their parents must be notified of the contact. Such minors carry most of the same rights as adults in seeking therapy including the right to protect their records. FTI Midwest believes that the best treatment occurs when families work together with their children, while recognizing that under some specific circumstances it may at times be best for a competent minor to admit him or herself. We suggest you discuss this issue with your therapist if you have any concerns.

Divorced Families. FTI Midwest serves many families in which there has been divorce. Be advised that FTI Midwest will not routinely see minor children without advising the parenting that is not presenting the child for therapy. While the presenting parent may legally consent to treatment under most custody agreements, the other parent retains a right to know about and participate in treatment. That parent has the right to object to treatment, but typically FTI Midwest can see a child with unilateral consent until the court orders otherwise. However, FTI Midwest will usually expect to obtain contact information for the non-presenting parent and will contact them by letter after the initial intake. Although there are exceptions, we also believe that most children are best served by involvement of both parents in treatment, even if this does not include conjoint sessions. This has been proven out in numerous cases over the years and we would ask you to consider carefully before pursuing unilateral treatment consent.

Crisis Intervention. Family Therapy Institute specializes in working with teens, children and families, including challenging and difficult cases. Thus we offer after-hours crisis intervention and support to our ongoing clients. If we come to believe that your child's level of crisis exceeds our capacity to respond, we may refer you for additional services. You can still continue at FTI Midwest and we will coordinate closely with the crisis service provider. Many times outside crisis intervention is covered under state-funded Medicaid programs and/or your insurance provider. However, FTI Midwest no longer accepts Medicaid and you will still be responsible for your copay if you want to continue at our agency.

In the vast majority of cases we can manage crises "in-house" as they arise through cell phone contact. You can ask your therapist about this phone number, or s/he may offer it. Cell phone numbers are also available by calling FTI Midwest and asking a front office staff member or patching through to your therapist's voicemail. You should **never** use office voicemail to leave emergency messages. Always use the cell phone number given you by the office or your therapist. If the crisis is life threatening, always call 911 and report to the LMH emergency room. You can contact your therapist from there for further consultation.

Working with your child's physician. It is often in your clinical best interest for FTI staff to work with your child's physician. This is especially true when you are being seen here for medication. By signing this document you are agreeing to have us contact your child's physician as necessary to coordinate treatment. If you **do not wish** to have us contact your physician please mark this box:

I AM WITHOLDING PERMISSION FOR FTI MIDWEST TO CONTACT MY CHILD'S PHYSICIAN REGARDING HIS/HER CASE

Payment

(Please read this carefully)

Obligation. By signing this document, you are agreeing to pay for the services your child receives at FTI Midwest. We pride ourselves on making our services affordable for families and we will work closely with you to keep your account current. We offer interest-free payment plans for clients who place a credit card or checking account number on file at our office. However, we also retain a bill collection agency for outstanding accounts that become delinquent. By signing this document you are releasing us to refer your account to collections in the event that you do not make timely payment. Please read each of the following paragraphs to assure your understanding of our billing procedure and ask your intake therapist if you have any questions about these procedures.

Insurance: If your child has insurance, we will submit claims on your behalf if you authorize us to do so on the insurance form (page 2). However, you must pay all costs insurance does not cover including copayments, coinsurance, deductible and no-show fees (see below). Under Kansas law, most in-state insurance companies must pay 100% of the first \$100 of services, and 80% of the second \$100. Thereafter, insurance companies may pay as much as 90% and as little as 50%. Some require you to meet your healthcare deductible. Some companies (Cigna, Coventry, Humana, etc.) have set rates that they have contracted with us to pay after the first session. You are responsible for verifying your coverage by calling the number on your insurance card. Some companies REQUIRE YOU TO CALL to get an authorization number before your first session. If you do not make this call, you may end up with a bill that your insurance company will not reimburse. For some diagnoses some insurance companies require you to pay into your healthcare deductible. You are encouraged to discuss this with your therapist. Deductible costs must be paid in full or on a payment plan as discussed below.

Billing Arrangements. In order to keep serving our clients FTI Midwest must keep billing costs to a minimum, while helping you keep your costs for our services affordable. Typically FTI Midwest expects and receives payment at time of service. However, we also offer payment plans that allow zero percent financing for costs not covered by insurance. To qualify for a monthly payment plan you must place on file at FTI Midwest either **a valid credit card or checking account number** for monthly withdrawal and authorize us to bill that account each month until outstanding charges are paid off. If your bank fails to honor this account or you withdraw your authorization without providing another method of payment, your account will be considered delinquent and a collection action undertaken. If an unexpected balance is incurred (e.g., a healthcare deductible), you must sign up for one of these payment methods or your account will become delinquent 60 days after settlement with the insurance company. We DO NOT make monthly payment plans under any other system.

Guarantors. If someone else is guaranteeing payment of your child’s bill, we must have their billing information and they must agree to one of these arrangements. Please ask the front desk for a guarantee form to be sent to this individual. By signing this form you are releasing us to contact your guarantor for the purpose of payment – but not release of medical record. Be aware that if the guarantor does not pay your bill, you will be ultimately responsible for its payment and subject to collections.

EVERYONE MUST READ AND CHECK ONE OF THE FOLLOWING BILLING OPTIONS:

- Self Pay:** I do not have or do not wish to use my insurance. I am paying all fees in full by cash, check or credit card at time of service. I understand that no payment plans are available for self-pay clients. **If you do not always accompany your child to his/her session you must send payment with your child or set up a credit card or checking account deduction.**
- EAP:** I have contracted EAP through my place of employment and have requested services be provided at FTI Midwest. I agree to cover all charges not paid through my EAP including charges incurred if my EAP refuses to pay for these services for any reason. If I continue at FTI Midwest after exhausting my EAP services, I understand that additional charges will apply which may or may not be paid by my insurance company. I agree to pay any costs not paid by insurance as described in the next section.

The contact phone number for my EAP service provider is: _____.

The authorization number for my session(s): _____.

(This section is continued on the next page)

- Health Insurance:** My child is covered by active health insurance. I have contacted my insurance company for authorization (if necessary) and believe they will pay for these services. I agree to pay all costs not covered by insurance including refused claims, deductible, copay, no-show fees, or coinsurance by one of the following methods. I understand that FTI Midwest no longer issues monthly statements, but that I may request a statement for my records. I have selected the following payment method for balances not covered by insurance **(you must select one of the following access services at FTI Midwest):**
 - Payment in Full at Time of Service.** I agree to pay all costs due when my child attends his/her appointment including deductible, copayment, and no-show fees. If I am not sure of my copayment, I will make a minimum payment of \$20 until the actual amount is determined and will then make up any difference or receive a refund at my next appointment. I agree to payoff any remaining balance within 60 days of my last appointment at FTI Midwest or my account will be considered delinquent. **If I do not always accompany my child to his/her session I will send payment or set up a credit card or checking account deduction as described below.**
 - Monthly Credit Card or Checking Account Deduction For BALANCE DUE or FLAT-RATE*.** I agree to pay all incurred charges each month by placing a valid credit card or checking account number on file with this office. That number will be kept in a secure file and used for any amounts not paid by insurance after insurance has cleared. **Please complete the auto-withdrawal agreement forms on the next page to set up your payment plan. NO PAYMENT PLANS WILL BE OFFERED WITHOUT AUTO-WITHDRAWAL.**

EVERYONE MUST CHECK AND AGREE TO BOTH OF THE FOLLOWING:

- I understand that all missed appointments and late cancellations incur a charge of \$50. This fee may be changed with notice posted on the monitor in the FTI Midwest lobby. A missed appointment is any appointment not cancelled. A late cancel is any appointment not cancelled with 24 hours notice. Fees for missed or late-cancelled appointments due to legitimate emergencies may be waived. FTI Midwest may offer reminders to clients, but failure to send a reminder does not release me from paying a no-show fee. I understand that repeated no-shows and/or unpaid no-show fees are grounds for termination of therapy.
- I understand that I must pay all costs not paid by my insurance carrier. If I have another party (guarantor) paying my bill, I understand that I remain *primarily responsible*. This means that if that person does not pay outstanding charges, I remain liable for them. I also understand that I am subject to collection action if my child's account becomes past due and I have not placed a credit card or checking account number on file to make regular payments. By signing this document I am releasing FTI Midwest to provide necessary information to its designated collection agency. I also understand that if I move or relocate without making arrangements with FTI for future billing, I am subject to immediate collection action. I also understand that if my check is returned, fees up to 25% of the face value of the check will be added to any delinquent account placed for collection.

DIVORCED PARENTS MUST READ AND CHECK THE FOLLOWING:

- I am a divorced parent who is not fully responsible for paying medical and mental health care bills of my child. By signing this document I am agreeing to pay all charges incurred as described above regardless of designations made by any court for division of medical expenses. If the other parent is a court-designated payer of mental health or medical services, I understand that he or she is considered a guarantor and I am responsible for obtaining a signed guarantor form authorizing payment. As the presenting parent I understand that I cannot receive services for my child at FTI Midwest if I do not keep my child's account current, regardless of the other parent's attention to the account.

I have read the above statement or had it explained to me and my questions have been answered. I consent to receive services from FTI Midwest if they are offered under these terms. I realize that these are the core issues of informed consent and that others may come up during my therapy. If that happens, I am free to talk to my therapist about these issues.

Client

Date of Birth

Today's Date

Witness

Today's Date

AUTHORIZATION AGREEMENT FOR ELECTRONIC DEBIT

Checking Account Authorization

I hereby authorize Family Therapy Institute Midwest Inc. to initiate a debit to my Checking Account indicated below at the depository financial institution named below. If this item is returned unpaid, I authorize an additional returned check fee of the maximum amount as allowed by the state to be charged to this account. Please attach a voided copy of your personal check to this authorization form, since your check will identify the routing transit number and normally your account number.

Bank: _____

Branch: _____ Address: _____

Name on Account: _____

Routing Number: _____ Account Number: _____

Date for monthly withdrawal: _____

Amount Approved:

Total balance due up to a: \$ _____ maximum charge each month.

Exactly: \$ _____ each month until balance due is paid in full.

This authorization is to remain in full force and effect until my account is closed or until Family Therapy Institute Midwest Inc. has received written notification from me of its termination, in such time and such manner as to afford Family Therapy Institute Midwest Inc. and my bank a reasonable opportunity to act on it. I understand that if I cancel this agreement without making another payment arrangement my account will be considered delinquent and may be referred for collection action.

Authorized Signature: _____ Date Signed: _____

Credit Card Authorization

I hereby authorize Family Therapy Institute Midwest Inc. to initiate a debit to the following credit card:

Visa Mastercard

-- -- --

Expiration Date: /

Back of Card Security Code:

Date for monthly withdrawal: _____

Amount Approved:

Total balance due up to a: \$ _____ maximum charge each month.

Exactly: \$ _____ each month until balance due is paid in full.

This authorization is to remain in full force and effect until my account is closed or until Family Therapy Institute Midwest Inc. has received written notification from me of its termination, in such time and such manner as to afford Family Therapy Institute Midwest Inc. a reasonable opportunity to act on it. I understand that if I cancel this agreement without making another payment arrangement my account will be considered delinquent and may be referred for collection action

Authorized Signature: _____ Date Signed: _____

Notice of Family Therapy Institute Midwest's Inc. (FTIM) Policies and Practices to Protect the Privacy of Your Health Information

I and/or my legal guardian have been offered an office copy of the FTI Midwest privacy policy or I have declined to review said policy. I agree to direct any questions or concerns about said policy to FTI Midwest staff for clarification. Upon reviewing or declining to review the policy:

- I wish to receive a copy of the FTI Midwest Privacy Policy.
- I DO NOT wish to receive a copy of FTI Midwest Privacy Policy.

Client signature

Date

Parent or legal guardian signature

Date

Relationship to client

Witness

Date