Karen S. Welch, M.A, M.F.T.

17772 Irvine Blvd. Suite 101, Tustin, Ca. 92780
(714) 470-3087
License # MFC 48513

PATIENT INFORMATION

Client's Name: _____ Sex: ☐ Male ☐ Female

Date of Birth: _____ Age: _____ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home Address: _____

Home Phone: (_____) _____ Cell Phone (_____) _____

Occupation: _____ ☐ Student

Employer (School, if student): _____ Work Phone: (_____) _____

E-mail Address: _____ Fax Phone: (_____) _____

SPOUSE/PARENT INFORMATION (If applicable)

Spouse/Parent Name: _____ Date of Birth: _____

Home Address: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Occupation: _____

Employer: _____ Work Phone: (_____) _____

E-mail Address: _____

INSURANCE BILLING: I use an outside service to bill insurance. If I am in network, your insurance company will reimburse me directly. Co-pays are due at each session. If I am out of network you must pay **full fee at the time of the session**. If we are an out of network provider and you would like us to bill your insurance for you we will be happy to do so. In this situation they will reimburse you directly. Patients/Responsible parties are responsible for all charges whether or not they are covered by your insurance. _____ initial

PAYMENT POLICY: Payment may be made by cash or personal check or credit card. As clients are expected to maintain a zero balance, I do not send statements on a regular basis. Accounts need to stay current in order to maintain ongoing treatment. Unpaid accounts over 90 days old are routinely reviewed for submission to a collection agency. _____ initial

FEES CHARGED: My fee for the initial and subsequent 75 minute session(s) for marital or family therapy is $225.00. My fee for 45 minute session (for couples and individuals) is $135.00. Group therapy is $75.00/person. All fees are due either prior to or at the end of each session. Monthly payments submitted at the start of the month are also possible. If I am required to make a court appearance for any reason, my fee is $185.00/45 minutes whether it is for preparation, travel and actual court time expended. My fee for any letters or reports (school, job etc.) is billed at my regular rate of 135.00./45 minutes. Sessions off site are billed 185.00/45 minute session; travel time is calculated into the session fee for offsite sessions. _____initial

APPOINTMENT CANCELLATION POLICY: In order to insure a full practice, and because your consistent presence is critical to effective treatment, I require that cancellations for scheduled appointments be received **24 hours in advance**. **If you are unable to keep your scheduled appointment and do not cancel within 24 hours the credit card on file will be charged the full session fee.** I will bill this during the week you were absent so you can anticipate seeing the charge soon after your missed appointment. Your credit card will be charged automatically. Insurance companies do not pay for unkept appointment fees and the patient/responsible party is held fully accountable for this charge. _____ initial

CONFIDENTIALITY: All communication is confidential. This means no one has rights to information we discuss unless released with your consent. Exceptions to this involve steps I must take regardless of your willingness to release information that is mandated by law. These include instances where you may be suicidal, homicidal or where child/elder abuse is involved. _____initial

CONSENT FOR TREATMENT OF MINORS:

This agreement, signed by the parents or legal guardians of the minor, gives me permission to provide counseling and psychotherapy services for the minor. I consider conversations with minors to be confidential, unless superseded by laws concerning mandated reporting or where release is authorized by the minor. _____initial

I have read and understand the above stated policies.

Signature of Responsible Party (s) **(required): _____**

_____

REFERRAL SOURCE _____ Phone #_____

Do I have your permission to thank them for referring you? (If applicable) Yes_____ No_____

Credit Card Authorization

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

I _____ am authorizing Karen Welch, M.F.T. **to bill my credit card for my scheduled sessions.**

In the case of late cancellations and/or no-shows for scheduled sessions (where I did not receive at **least 24 hours' notice**) you will be charged the full session fee.

I, _____am authorizing Karen Welch, M.F.T. the use of
(Print name)
My credit card in the event that I do not notify her of my inability to attend a scheduled therapy

appointment and/or do not cancel my appointment at least 24 hours in advance as agreed to in his Financial

Arrangement policies.

Card Type (circle one): Visa MasterCard American Express Discover

Card #: _____ Expiration Date: _____

Name as Printed on Card: _____

Verification/Security Code (3-digit code on back by signature line) _____

Billing Address: _____

(Street, City, State & Zip)

Signature: _____ Date: _____

Further Explanation:

It is important that you fully understand and agree to my cancellation policy.

I require 24 **hours' notice** and have **no exceptions**. I do this to insure enough time to fill the session time you were scheduled to meet with me. I often have a waiting list and this gives me the ability to keep my practice full and serve other patients when you can't make it. In addition, the 24 hours' notice also reflects your commitment to the therapy process. Therapy can be hard work and it is tempting to cancel sessions for this reason.

It is also important to note that cancellation **for any reason** after the 24 hour time frame will result in a billing for that session. The charge will be billed to your credit card at the end of the week you were scheduled to meet with me. So you will see this automatically charged to your card, which will be prior to our next scheduled meeting time.

If you are unwilling to assume the risk of the 24 hours' notice, please let me know and I will provide referrals to other qualified therapists.

I fully understand and agree to provide 24 hours cancellation for any therapy session. If I do not provide 24 hours' notice, I will bear the responsibility for the fee for that session. I understand my credit card will be billed immediately at the end of the week of our scheduled appointment time. I have discussed this with Karen and agreed to this policy.

Signed: _____ Date: ____/____/____

Signed: _____ Date: ____/____/____