Change of Mind, LLC

Client Information Sheet

Date_____

NAME (of client)_____

ADDRESS_____

CITY_____ STATE _____ ZIP_____

PHONE: HOME _____WORK _____CELL_____

E-MAIL:_____

DATE OF BIRTH _____

RELATIONSHIP TO INSURED: __SELF __SPOUSE __CHILD __OTHER

STATUS: __SINGLE __MARRIED __OTHER ___MALE ___FEMALE

__EMPLOYED __FULL-TIME STUDENT __PART-TIME STUDENT

IS CONDITION RELATED TO:

EMPLOYMENT: __ YES __NO IF YES: CURRENT ____ PREVIOUS _____

AUTO ACCIDENT: __YES __NO __STATE OTHER ACCIDENT: __YES __NO

INSURED'S NAME _____
(if you, the client are also the insured, write: Same as Above. If you, the client are not the insured, please fill in)

ADDRESS_____

CITY_____ STATE_____ ZIP_____

PHONE: HOME _____WORK _____

DATE OF BIRTH_____ SOCIAL SECURITY#_____

OFFICE USE ONLY:

Dx:_____

CPT:_____

Fee: _____ FIRST DATE OF SERVICE:_____

BILLING PRACTICES ACKNOWLEDGEMENT/FEE AGREEMENT

IDENTIFY SERVICE(S):	IDENTIFY CHARGE FOR SERVICE(S):
All Services	**Per Insurance Company Schedule or**
	Agreed upon private pay rate

Actual charges for services will be based upon the Change of Mind published fee schedule. Change of Mind may be willing to provide services to individuals unable to pay full fee, depending on the number of pro bono or reduced fee clients currently carried. Charges will be assessed based upon a review of the individual's or family's circumstances.

FEE AGREEMENT

Actual charges for services will be based upon the above fee schedule with the sliding scale fee applied where applicable. If you do not have insurance, you understand that fees for the treatment services will be 100 % of the fees listed above. _____INITIAL

ASSIGNMENT OF BENEFITS (insurance only)

I authorize payment of Blue Cross / Blue Shield, Medicaid, and other Third Party Payors to process my insurance claim for services rendered. _____INITIAL

RELEASE INFORMATION (insurance only)

I authorize the release of any medical or other information necessary to Blue Cross / Blue Shield, Medicaid, and any other third Party Payor to process my insurance claim for services rendered.
_____INITIAL

1st CLIENT SIGNATURE	DATE	2nd CLIENT SIGNATURE	DATE

PARENT/GUARDIAN SIGNATURE (if required) DATE

Therapist DATE

INFORMED CONSENT AND AGREEMENT TO PARTICIPATE IN SERVICES PROVIDED BY CHANGE OF MIND, LLC

I, _____ agree to participate in services provided by Change of Mind, LLC" on behalf of

(*check one or both*) ____ Myself ____ The following minor child(ren):

Minor child _____ _____
(*name*) (*date of birth*)

Minor child _____ _____
(*name*) (*date of birth*)

Minor child _____ _____
(*name*) (*date of birth*)

Minor child _____ _____
(*name*) (*date of birth*)

I agree to cooperate with my/our/their mental health professional, to take an active part in the development of my/our/their service plan, and to work toward my/our/their goals by doing the tasks outlined in the service plan in order to accomplish my/our/their stated objectives.

I understand that I have a legal right to privilege of confidentiality for all therapeutic information with the following exceptions:

(1) When the therapist has a suspicion of abuse of a child, an elderly person, or a disabled person.
(2) When the therapist has reason to believe that a known individual is under imminent threat of harm or death.
(3) When records are required to be released by a court order.
(4) When a client gives written and verbal authorization to release information to a specific third party.
(5) When records are requested by a legal guardian of a client.

This consent or authorization for release of information shall be effective the date of signature and shall expire:
___ ninety (90) days from the date of signature for a one time release of information OR
___ one (1) year form the date of signature for ongoing service provision.

_____ _____
Signature of Adult Client or Guardian DATE

_____ _____
Therapist DATE

Acknowledgment of Cancellation/No-Show Policy
Change of Mind, LLC

I agree to notify Change of Mind, LLC of cancellation of appointment prior to 24 hours before the appointment time.

Notification of cancellation within 24 hours or failing to show up for an appointment is considered a no-show. If a client no-shows two times within one year, that client will be given the option of discharge and referral to another mental health provider, or reimbursement for the appointment missed. Please note that some insurance companies do not allow no-show appointments and in this case the client will be discharged and referred to another mental health provider. The fee for a no-show appointment is $50 and will be charged on the second missed appointment.

Notifications must be in the form of a phone call to 772-284-6030. This number does not accept text messages. Exceptions for unavoidable occurrences such as family emergency, illness, last minute car trouble, etc. may be made at Change of Mind's discretion.

Name of Client or Adult: _____

Signature of Client or Adult: _____ **Date:** _____

Signature of Witness: _____