Blissful Path Therapy

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MINOR RELEASE

CONSENT FOR PSYCHOTHERAPEUTIC COUNSELING SERVICES

Parent/Legal Guardian Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _ Cell Phone: _____

Email: _____

Which number can we call to confirm your appointment? ❍Home ❍Work ❍Cell
Can we leave a message if no one answers? ❍Yes ❍No Can we text to confirm? ❍Yes ❍No

Date of Birth: _____ Social Security #: _____

Spouse (or ex-spouse)'s Name: _____

Referred by: _____

Emergency Contact: _____ Phone: _____

IN ORDER FOR MINOR CHILDREN/ADOLESCENTS TO RECEIVE PSYCHOTHERAPEUTIC COUNSELING SERVICES, IT IS NECESSARY FOR THE PARENT OR LEGAL GUARDIAN TO GRANT PERMISSION FOR SUCH SERVICES TO OCCUR.

MINOR: _____ DOB: _____

I hereby swear that I have the legal right to obtain and authorize psychotherapeutic services for the above-named minor. I, parent and/or legal guardian, will be financially responsible for fees incurred for treatment. I understand that payment is due at the time the service is rendered.

I hereby give consent to Blissful Path Therapy Services, LLC to provide psychotherapeutic services to the above- named minor. This release will remain in force until termination of treatment.

Signature: _____ Date: _____
(parent/legal guardian)

Blissful Path Therapy Services, LLC * Karie A Bliss, M.Ed., LMHC * 561-849-4071
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CHILD/ADOLESCENT DEVELOPMENTAL HISTORY

Client Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____ **Gender:** ❑Male ❑Female

What was your child's birth weight?
_____ lbs. _____ oz. ❑Unknown

Was delivery normal?
❑Yes ❑Unknown ❑No; specify _____
_____
_____

Did the birth mother experience any physical or emotional problems during pregnancy?
❑No ❑Unknown ❑Yes; specify _____
_____
_____

Were medications taken during pregnancy?
❑No ❑Unknown ❑Yes; specify _____
_____
_____

Did the birth mother consume alcoholic beverages or abuse any street drugs during pregnancy?
❑No ❑Unknown ❑Yes; specify _____
_____
_____

Did the baby experience any problems immediately after birth?
❑No ❑Unknown ❑Yes; specify _____
_____
_____

Has your child ever required hospitalization?
❑No ❑Unknown ❑Yes; specify _____
_____
_____

At what age did your child do the following?
(Italicized areas reflect normal development)
_____ smiled *(6 mths)*
_____ sat alone *(6 to 10 mths)*
_____ talked in sentences *(30 to 36 mths)*
_____ walked by self *(12 mths)*
_____ held head up (*3 to 4 mths)*
_____ fed self *(2yrs)*
_____ crawled *(6 to 10 mths)*
_____ rode a bike *(6 yrs)*
_____ rolled over *(6 mths)*
_____ talked in single words *(18 to 24 mths)*
_____ pulled up *(6 to 10 mths)*
_____ established toilet training *(2 ½ to 4 yrs)*

How would you describe your child's approach to new situations?
❑Positive, jumps right in
❑Withdrawn, tends not to participate
❑Slow to warm up; cautious

How would you generally describe your child's overall mood?
❑Positive (happy, laughing, upbeat, hopeful)
❑Negative (depressed, cranky, angry, hostile)
❑Mixed but more positive, than negative
❑Mixed but more negative than positive

Which school is your child currently attending?
_____

Is your child currently receiving special services in this school?
❑No ❑Yes; specify _____
_____
_____

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Is there any history of physical, sexual or emotional abuse?
❑ No ❑Unknown ❑Yes; specify _____

Is there a history of prolonged separations or traumatic events?
❑ No ❑Unknown ❑Yes; specify _____

Has your child ever failed a class or been held back for academic reasons?
❑ No ❑Yes; specify _____

Is your child expected to pass this school year?
❑ Yes ❑No; specify _____

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PAYMENT AGREEMENT

RESPONSIBILITY OF THE CLIENT:

- PAYMENT IS DUE THE DAY SERVICE IS RENDERED. Cash is accepted. Checks should be made payable to Blissful Path Therapy Services, LLC. Credit cards (Visa, MasterCard, AMEX, and Discover) are accepted with a minimum charge of $25.00. Money transfers through app services are also accepted (Zelle, Venmo, CashApp, Apple Pay) with communication in accordance with your clinician. As a service to our Clients, we provide the option of paying for services with a credit card. Even if you do not intend to use the credit card, we require having this information on file in the event of lack of payment by the Client or insurance company. By accepting this agreement, you understand that payment is due at the time of service, including treatment expenses not covered by insurance, report writing/reviewing, missed appointments (e.g. late cancels, no-shows, etc.), and copays/co-insurance. You have the option of paying with cash, check, or credit card at the time of service. If there is an outstanding balance or a missed appointment, you authorize Ingram & Associates to use credit card information as payment for services as stated in the Notice of Privacy Practices, Informed Consent for Psychotherapy, and/or Practice Policies.
- The fee is $120.00 for a 53-minute session. If using insurance, your copay and/or co-insurance is due the day service is rendered. (Insurance information must be presented before the service is rendered. We will not bill insurance retroactively.) All phone calls lasting more than 5 minutes will be charged at full session fee in 15-minute increments.
- Cancellation of a session must be made at least 24 hours (one business day, or by Friday for a Monday appointment) prior to the scheduled appointment, or you will be billed a **$120.00 no-show/late cancellation fee.** ***Appointment confirmation calls/texts/e-mails are a courtesy. If you do not receive a confirmation call or text, you are still responsible for your scheduled appointment***. Clients who miss two consecutive appointments will not be rescheduled until the no-show/late cancellation fees are paid.
- A **$35 NSF charge** will be assessed to all returned checks in addition to the amount of the check. We report to the local district attorney's office checks that are not paid within two weeks of being returned to our office.
- If Blissful Path Therapy Services, LLC receives a witness/records subpoena, the Client will be notified so that his/her attorney can take whatever action is deemed necessary. If the Client desires the subpoena be honored, a signed release is required. Fees associated with any court proceeding are $250 per hour with a minimum of two (2) hours, paid in advance. If a court date is cancelled within 72 business hours, a fee of $250 will be charged.
- A signed release is required for any record or information to be released from Blissful Path Therapy Services, LLC to the court, another counselor, family members, attorneys, doctors, etc.
- ***If Client's insurance changes for any reason, it is Client's responsibility to alert I&A and provide our office with a copy of the new card. Blissful Path Therapy Services, LLC will not retroactively bill insurance companies***. Client is fully responsible for any charges not covered for any reason by their insurance carrier. If not paid according to terms, the Client understands that our office reports to an outside collection agency. In the event that your account is turned over for collections, Client agrees to pay all additional fees assessed in the collection of debt. These fees include collection agency and attorney fees. An invoice may be sent to your home for any outstanding balance.

RESPONSIBILITY OF THE PROVIDER:

- Providers work according to the guidelines of the State of Florida. Mental health counseling results cannot be guaranteed.

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- The provider will listen, analyze, evaluate and suggest alternative courses of action in any given difficulty.
- The counselor/Client relationship is one of trust and confidentiality. Therefore, all records shall be accessible only to the counselor unless ordered by the Court. Under ethical standards, the provider will break confidentiality if Client is in danger to self or others; is involved in criminal action; if ordered by the Court; or when it is at the best interest of a child who is a victim of abuse, according to Florida Statutes.
- Counseling sessions will be held to 53 minutes. Because of scheduling, this will be strictly enforced.
- The acceptance of Clients is at the sole discretion of the counselor and in accordance with the policies herein.
- Outside assignments may be made by the counselor for the express purpose of directing the Client toward development of both the physical and spiritual body and are regarded as a necessary part of healing.

Signature: _____ Date: _____

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INSURANCE AUTHORIZATION FORM

Client Name: _____ Gender: 0Male 0Female

Date of Birth:_____ Client SS#: _____

Insurance Carrier: _____

Client Insurance ID: _____Group #: _____

Client Relationship to Insured: _____

Insured Name: _____ Gender: 0Male 0Female

Date of Birth:_____ Insured SS#: _____

Address: _____

City, State, Zip: _____

Insured Employer: _____

Insurance Carrier: _____

Insured Insurance ID: _____Group #: _____

Blissful Path Therapy Services, LLC will bill most insurance carriers for you if proper paperwork is provided to us. Any outstanding balances, co-payments and deductibles are due prior to you appointment. Since your agreement with your insurance is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you.

TO SUBMIT CLAIMS TO INSURANCE: I hereby authorize Blissful Path Therapy Services, LLC to apply for benefits on my behalf for covered services rendered by the practice, and request that payments are made directly to Ingram & Associates. I certify that the information I have reported with regard to my insurance coverage is correct. I further authorize the release of any necessary information, including medical information, for any related claim. I permit a copy

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of this authorization to be used in place of the original. I understand and agree that all co-payments are due at the time of service. I have read the above financial policy for payments for professional fees and understand and agree to pay for services not covered by my insurance company for any reason.

Signature: _____ Date: _____

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Coordination of Care between Health Care Providers and Release of Information

Date: _____

Primary Care Physician (PCP) or Psychiatrist: _____

Address: _____

Phone: _____ **Fax:** _____

Re: _____ **Client's DOB:** _____
(Client)

Dear Dr. _____:

The above-named client has identified you as their PCP/Psychiatrist. We have discussed the importance of coordinating an individual's total health care across health care professionals. This client has given their consent for me to contact you, introduce myself as the behavioral health care practitioner and work directly with you when necessary.

At the present time, this client has been in care with me since _____.

The above-named PCP/Psychiatrist is authorized to release protected health information related to the evaluation and treatment of the abovementioned client.

Client Authorization
I hereby authorize above-named PCP/Psychiatrist to release verbally and/or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified Client. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. This consent expires upon the termination of treatment.

Disclosure may include the following verbal and/or written information:

❑ **Summary of treatment records and contact dates.**

❑ Other _____

❑ I hereby refuse to give authorization for any release of information.

_____ _____

Signature of Client, Parent, Guardian or Authorized Representative **Date**

If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under state law (i.e. Power of Attorney, Living Will, or Guardianship papers, etc.)

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Credit Card Payment Authorization Form

By signing this form you authorize Blissful Path Therapy Services, LLC to debit your account for the amount indicated on or after the date of service.

Please complete the information below:

I _____ authorize Blissful Path Therapy Services, LLC
(cardholder name)

To charge my credit card account indicated below. This payment is for therapy sessions, records requests, report writing, no-show/late cancellation fees, and/or outstanding balances pertaining to

_____.
(client name)

Billing Address _____

City, State, Zip _____ Phone# _____

Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ America Express ☐ Discover

Cardholder Name _____

Account Number _____

Expiration Date _____

CVV (3 digit number on back of card/ 4 digit number on front of AMEX card) _____

SIGNATURE _____ DATE _____

I authorize Blissful Path Therapy Services, LLC to charge the credit card indicated on this authorization form according to the terms outlined above. 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. I understand that my information will be saved to file for future transactions on my account.

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