Soultenders INC.

Provider: _____

41 East Foothill Blvd ● Arcadia, CA 91006

Life History Questionnaire *(All files are held in strict confidence)*

Date _____ SSN: _____-_____-_____ Health Insurance Provider_____

First Name _____ MI ____ Last Name _____ Maiden _____

Age _____ Date Of Birth _____ Gender: ☐ Male ☐ Female

Home Address	City	State	ZIP

Home Phone ☐ May We Leave A Message? Cell Phone ☐ May We Leave A Message?

Email Address ☐ May We Send A Message? Education Level:

Employer Name Work Phone ☐ May We Leave A Message?

Work Address	City	State	Zip

Ethnicity ☐ Asian/Pacific Islander ☐ Caucasian ☐ Native American ☐ Latino ☐ Other: _____ ☐ African American

Relationship Status ☐ Single ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Please indicate who referred you to the Counseling Center

Referral Type ☐ Friend ☐ Advertisement ☐ Other Therapist ☐ Healthcare Provider ☐ Other

Referral Name / Source

Please read the following questions and mark those to which you would respond "yes."

☐ Have you previously been involved in counseling?

Therapist Name: _____

Reason: _____

Dates: _____

Outcome: _____

☐ Have you ever been hospitalized for mental health reasons?

Hospital Name: _____

Reason: _____

Dates: _____

Outcome: _____

☐ Do you currently use alcohol or other non-prescription drugs?

What: _____

Amount: _____

How long have you used: _____

☐ Are you currently taking any prescription medications?

What: _____

Amount/How Long: _____

Prescribing MD: _____

☐ Is there a history of mental health problems in your family?
☐ Have you ever been physically abused?
☐ Have you ever been emotionally abused?
☐ Are your concerns interfering with your daily life?
☐ Have you ever been in legal trouble?
☐ Have you ever been sexually abused or assaulted?
☐ Is there a history of alcohol or drug problems in your family?
☐ Have you ever attempted suicide?

Briefly explain your need for counseling now:

How long has this problem persisted?	Under what condition do your problems get worse? better?

Please use the following scale to answer the next three questions:	1 Not at all	2 Mildly	3 Moderately	4 Highly
1. How serious do you consider your present concern(s)?	☐	☐	☐	☐
2. How motivated are you to resolve your concern(s)?	☐	☐	☐	☐
3. How optimistic are you that your concern(s) can be resolved?	☐	☐	☐	☐

Family History:

Mother's Age _____ If deceased, how old were you when she died? _____

Father's Age _____ If deceased, how old were you when he died? _____

If your parents are separated, how old were you when they separated? _____

Number of brother(s) _____

Name: _____ Age _____

Name: _____ Age _____

Name: _____ Age _____

Name: _____ Age _____

Number of sister (s) _____

Name: _____ Age _____

Name: _____ Age _____

Name: _____ Age _____

Name: _____ Age _____

Name of Spouse/Significant Other: _____ Years Together: _____

Age _____ Date Of Birth _____ Gender: ☐ Male ☐ Female

Education Level

Occupation

Previous Marriages: _____ Name of Previous Spouse: _____ Years Married _____

Nature of Relationship (i.e. friendly, distant, physical/emotional abuse, loving, hostile)

Number of Children _____ What are their ages? _____ _____ _____ _____ _____ _____

Names: _____

Please mark all of the following that apply

Feelings

- ☐ Helpless
- ☐ Depressed
- ☐ Shameful
- ☐ Angry
- ☐ Guilty
- ☐ Hopeless
- ☐ Lonely
- ☐ Sad
- ☐ Stressed
- ☐ Unhappy
- ☐ Other _____
- ☐ Anxious
- ☐ Out of Control
- ☐ Afraid
- ☐ Numb
- ☐ Relaxed
- ☐ Happy
- ☐ Excited
- ☐ Hopeful
- ☐ Inferiority Feeling
- ☐ Mood Shifts

Thoughts

- ☐ Confused
- ☐ Unintelligent
- ☐ Worthless
- ☐ Unmotivated
- ☐ Unattractive
- ☐ Unlovable
- ☐ Confident
- ☐ Worthwhile
- ☐ Homicidal
- ☐ Other _____
- ☐ Racing
- ☐ Obsessive
- ☐ Distracted
- ☐ Disorganized
- ☐ Paranoid
- ☐ Suicidal
- ☐ Sensitive
- ☐ Honest

Symptoms/Behaviors

- ☐ Eating Less
- ☐ Procrastinating
- ☐ Attempting Suicide
- ☐ Poor Concentration
- ☐ Crying
- ☐ Withdrawing Socially
- ☐ Skipping Classes
- ☐ Binge Drinking
- ☐ Injuring self
- ☐ Compulsivity
- ☐ Career/Major Choice
- ☐ Acting Out Sexually
- ☐ Acting Aggressively
- ☐ Disorganization
- ☐ Impulsivity
- ☐ Recklessness
- ☐ Irritability
- ☐ Passivity
- ☐ Sexual Problems
- ☐ Socializing
- ☐ Marital Relationships
- ☐ Parent/Child Conflicts
- ☐ Lack of Ambition/Goals
- ☐ Poor Peer Relationships
- ☐ Nightmares
- ☐ Worries About Body Image
- ☐ Spiritual Problems
- ☐ Dating Concerns
- ☐ Finances
- ☐ Other _____

Physical Symptoms

- ☐ Insomnia
- ☐ Tired
- ☐ Weight Gain or Loss
- ☐ Pain
- ☐ Headaches
- ☐ Tightness In Chest
- ☐ Dizziness or Light-headedness
- ☐ Numbness or Tingling
- ☐ Vomiting
- ☐ Rapid Heart Beat
- ☐ Dry Mouth
- ☐ Excessive Sleep
- ☐ Loss of Memory
- ☐ Eating Problems
- ☐ Other _____

Please describe any medical conditions you have:

Anything else you would like us to know about you:

Emergency Contact: _____ Relationship: _____ Phone: _____

Address: _____City: _____ State: _____ ZIP: _____

Name of Physician: _____ Phone: _____

Address: _____City: _____ State: _____ ZIP: _____

_____ _____

Signature Date

Notice of Privacy Practices

I. THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. I HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

I am legally required to protect the privacy of your PHI, which includes information that can be used to identify you that I've created or received about your past, present, or future health or condition, the provision of health care to you, or the payment of this health care. I must provide you with this Notice about my privacy practices, and such Notice must explain how, when, and why I will "use" and "disclose" your PHI. A "use" of PHI occurs when I share, examine, utilize, apply, or analyze such information within my practice; PHI is "disclosed" when it is released, transferred, has been given to, or is otherwise divulged to a third party outside of my practice. With some exceptions, I may not use or disclose any more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made. And, I am legally required to follow the privacy practices described in this Notice.

However, I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI on file with me already. Before I make any important changes to my policies, I will promptly change this Notice and post a new copy of it in my office and on my website (www.soultenders.com). You can also request a copy of this Notice from me, or you can view a copy of it in my office or at my website, which is located at (www.soultenders.com).

III. HOW I MAY USE AND DISCLOSE YOUR PHI.
I will use and disclose your PHI for many different reasons. For some of these uses or disclosures, I will need your prior written authorization; for others, however, I do not. Listed below are the different categories of my uses and disclosures along with some examples of each category.

A. Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I can use and disclose your PHI without your consent for the following reasons:

1. For Treatment. I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I can disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are involved in your care. For example, if a psychiatrist is treating you, I can disclose your PHI to your psychiatrist to coordinate your care.

2. To Obtain Payment for Treatment. I can use and disclose your PHI to bill and collect payment for the treatment and services provided by me to you. For example, I might send your PHI to your insurance company or health plan to get paid for the health care services that I have provided to you. I may also provide your PHI to my business associates, such as billing companies, claims processing companies, and others that process my health care claims.

3. For Health Care Operations. I can use and disclose your PHI to operate my practice. For example, I might use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided such services to you. I may also provide your PHI to my accountant, attorney, consultants, or others to further my health care operations.

4. Patient Incapacitation or Emergency. I may also disclose your PHI to others without your consent if you are incapacitated or if an emergency exists. For example, your consent isn't required if you need emergency treatment, as long as I try to get your consent after treatment is rendered, or if I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) and I think that you would consent to such treatment if you were able to do so.

B. Certain Other Uses and Disclosures Also Do Not Require Your Consent or Authorization. I can use and disclose your PHI without your consent or authorization for the following reasons:

1. When federal, state, or local laws require disclosure. For example, I may have to make a disclosure to applicable governmental officials when a law requires me to report information to government agencies and law enforcement personnel about victims of abuse or neglect.

2. When judicial or administrative proceedings require disclosure. For example, if you are involved in a lawsuit or a claim for workers' compensation benefits, I may have to use or disclose your PHI in response to a court or administrative order. I may also have to use or disclose your PHI in response to a subpoena.

3. When law enforcement requires disclosure. For example, I may have to use or disclose your PHI in response to a search warrant.

4. When public health activities require disclosure. For example, I may have to use or disclose your PHI to report to a government official an adverse reaction that you have to a medication.

5. When health oversight activities require disclosure. For example, I may have to provide information to assist the government in conducting an investigation or inspection of a health care provider or organization.

6. To avert a serious threat to health or safety. For example, I may have to use or disclose your PHI to avert a serious threat to the health or safety of others. However, any such disclosures will only be made to someone able to prevent the threatened harm from occurring.

7. For specialized government functions. If you are in the military, I may have to use or disclose your PHI for national security purposes, including protecting the President of the United States or conducting intelligence operations.

8. To remind you about appointments and to inform you of health-related benefits or services. For example, I may have to use or disclose your PHI to remind you about your appointments, or to give you information about treatment alternatives, other health care services, or other health care benefits that I offer that may be of interest to you.

C. Certain Uses and Disclosures Require You to Have the Opportunity to Object.

1. Disclosures to Family, Friends, or Others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

D. Other Uses and Disclosures Require Your Prior Written Authorization. In any other situation not described in sections III A, B, and C above, I will need your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke such authorization in writing to stop any future uses and disclosures (to the extent that I haven't taken any action in reliance on such authorization) of your PHI by me.

IV. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

You have the following rights with respect to your PHI:

A. The Right to Request Restrictions on My Uses and Disclosures. You have the right to request restrictions or limitations on my uses or disclosures of your PHI to carry out my treatment, payment, or health care operations. You also have the right to request that I restrict or limit disclosures of your PHI to family members or friends or others involved in your care or who are financially responsible for your care. Please submit such requests to me in writing. I will consider your requests, but I am not legally required to accept them. If I do accept your requests, I will put them in writing and I will abide by them, except in emergency situations. However, be advised, that you may not limit the uses and disclosures that I am legally required to make.

B. The Right to Choose How I Send PHI to You. You have the right to request that I send confidential information to you to at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). I must agree to your request so long as it is reasonable and you specify how or where you wish to be contacted, and, when appropriate, you provide me with information as to how payment for such alternate communications will be handled. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

C. The Right to Inspect and Copy of Your PHI. In most cases, you have the right to inspect and copy the PHI that I that I have on you, but you must make the request to inspect and copy such information in writing. If I don't have your PHI but I know who does, I will tell you how to get it. I will respond to your request within 30 days of receiving your written request. In certain situations, I may deny your request. If I do, I will tell you, in writing, my reasons for the denial and explain your right to have my denial reviewed.

If you request copies of your PHI, I will charge you not more than $.25 for each page. Instead of providing the PHI you requested, I may provide you with a summary or explanation of the PHI as long as you agree to that and to the cost in advance.

D. The Right to Receive a List of the Disclosures I Have Made. You have the right to receive a list of instances, i.e., an Accounting of Disclosures, in which I have disclosed your PHI. The list will not include disclosures made for my treatment, payment, or health care operations; disclosures made to you; disclosures you authorized; disclosures incident to a use or disclosure permitted or required by the federal privacy rule; disclosures made for national security or intelligence; disclosures made to correctional institutions or law enforcement personnel; or, disclosures made before April 14, 2003.

I will respond to your request for an Accounting of Disclosures within 60 days of receiving such request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date the disclosure was made, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no charge, but if you make more than one request in the same year, I may charge you a reasonable, cost-based fee for each additional request.

E. The Right to Amend Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that I correct the existing information or add the missing information. You must provide the request and your reason for the request in writing. I will respond within 60 days of receiving your request to correct or update your PHI. I may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by me, (iii) not allowed to be disclosed, or (iv) not part of my records. My written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have the right to request that your request and my denial be attached to all future disclosures of your PHI. If I approve your request, I will make the change to your PHI, tell you that I have done it, and tell others that need to know about the change to your PHI.

F. The Right to Receive a Paper Copy of this Notice. You have the right to receive a Paper copy of this notice even if you have agreed to receive it via e-mail.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES

If you think that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI, you may file a complaint with the person listed in Section Vl below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W.,Washington, D.C. 20201. I will take no retaliatory action against you if you file a complaint about my privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of The Department of Health and Human Services, please contact me at:

Wendy L. Bencosme PhD, LMFT
Soultenders, INC
41 East Foothill Boulevard
Suite 102
Arcadia, CA 91006
(626) 701-4249
www.soultenders.com

VII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices* that I have given to you. My *Notice of Privacy Practices* provides information about how I may use and disclose your protected health information. I encourage you to read it in full.

My *Notice of Privacy Practices* is subject to change. If I change my notice, you may obtain a copy of the revised notice from me by contacting me at [**626-701-4249**].

If you have any questions about my Notice of Privacy Practices, please contact me at: [**41 East Foothill Boulevard, Suite 102, Arcadia, CA 91016 (626) 701-4249**].

I acknowledge receipt of the *Notice of Privacy Practices* of [**Soultenders, INC and Wendy L. Bencosme, Ph.D., LMFT**].

Signature: _____ Date: _____
(*patient/parent/conservator/guardian*)

INABILITY TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I made good faith attempts to obtain my patients acknowledgement of his or her receipt of my Notice of Privacy Practices, including.

_____
_____

However, because of_____
_____
I was unable to obtain my patient's acknowledgement.

Signature of Provider: _____ Date:_____

OFFICE POLICY AND PROCEDURES

TREATMENT PHILOSOPHY: During the initial evaluation period, you and your provider will clarify together the nature of the problems for which you are seeking treatment. To achieve the greatest progress in therapy, your therapist will work to provide the best and most appropriate therapy for you and your family. You can facilitate this process by maintaining motivation, complying with recommendations and policies, and communicating openly and honestly. The length and frequency of sessions as well as the duration of treatment varies significantly, and can be discussed at the beginning and throughout the course of therapy.

Because success or satisfaction with treatment cannot be guaranteed, you are requested to inform your therapist if you do not feel satisfied with your progress. You and your therapist may then be able to work through the issues, modify treatment, or negotiate a new therapeutic contract. In some instances, this may mean making an appropriate referral or terminating therapy. You may choose to leave therapy at any time; however, leaving therapy is best accomplished in consultation with your therapist

WHAT TO EXPECT: There are benefits and risks in seeking individual, marital or family therapy. Some of the potential benefits of therapy include developing your ability to handle or cope with your relationships and providing you with greater insight into your personal goals and values. In working to achieve these benefits, however, you may address issues or make changes that you may experience as distressing. These risks of therapy include, but are not limited to: feelings or circumstances becoming worse before they get better; changes in your emotional state, such as feelings of depression or anxiety; the possibility of hallucinations or dissociations; changes in perception or behavior; and changes in occupational, social, or personal relationships. In short, treatment may be emotionally painful at times.

EMERGENCIES: If you are in imminent danger call 911, or your nearest police department or emergency room. Your provider's policy regarding emotional crises and his/her availability/policy should be discussed during your first appointment.

CONFIDENTIALITY: All information between Therapist / Doctor and patient is held strictly confidential unless:

1. You authorize release of information with your signature (or parent/guardian)
2. You present a danger to others
3. You present a physical danger to self
4. Child or elder abuse is suspected
5. Any sexually explicit image of a minor or any minor taking, sending, or receiving, a sexually explicit image of a minor is illegal.

In the latter two cases, we are required by law to inform potential victims & legal authorities so that protective measures can be taken.

RECORDS: Your clinical file will consist of (a) legal forms such as this document, (b) a record of visits and payments, and (c) clinical progress notes. These progress notes will contain enough information about your treatment to justify it, should such justification ever become an issue.

PROVIDERS: Counseling is provided by licensed clinical psychologist, licensed clinical social workers, licensed marriage and family therapists as well as counselors who are in training (interns/trainees) to become licensed marriage and family therapists. Please ask your provider to clarify their licensure level before beginning treatment. Those in training are supervised weekly by licensed marriage and family therapists who have been licensed for at least two years and who take regular continuing education courses in supervision. If you have any further questions or concerns, you may contact Dr. Wendy Ludecke Bencosme, M.A., Ph.D. direct at (626) 737-6034.

YOUR RIGHTS: In a private practice such as this, treatment is entirely voluntary, and you have the right to terminate treatment at any time. If for any reason your treatment has been ordered by a third party, you will be fully informed of this. In all cases, professional treatment never includes sexual contact with the treatment provider.

ELECTRONIC COMMUNICATIONS POLICY

EMAIL COMMUNICATIONS: We use email communication and text messaging only with your permission and only for administrative purposes unless we have made another agreement. That means that email exchanges and text messages with our office should be limited to things like setting and changing appointments, billing matters and other related issues. Please do not email us about clinical matters because email is not a secure way to contact us. If you need to discuss a clinical matter with your provider, please feel free to call your provider to discuss it on the phone or wait so you can discuss it during your therapy session. The telephone or face-to-face context simply is much more secure as a mode of communication.

TEXT MESSAGING: Because text messaging is a very unsecure and impersonal mode of communication, providers do not text message to nor do respond to text messages from anyone in treatment. So, please do not text message providers unless other arrangements have been made.

SOCIAL MEDIA: We do not communicate with, or contact, any of our clients through social media platforms like Twitter and Facebook. In addition, if we discover that we have accidentally established an online relationship with you, we will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you.

CONSENT FOR TREATMENT/ACCEPTANCE OF POLICIES

Your provider has attempted to answer your questions about treatment satisfactorily. If you have further questions or concerns, your provider will do his or her best to answer them or find answers for you.

Your signature represents a statement that you have read and understood the information above and as outlined by your provider, have received a copy of this Informed Consent form, have been made aware of your rights and the privacy practices of this office, agree to comply with fees and policies, and consent to the therapy process as described above. You have the right to withdraw your consent for treatment at any time.

Print Patient name: _____

Signature of Patient: _____ Date: ____/____/_____

Signature of guardian(s): _____ Date: ____/____/_____

Signature of guardian(s): _____ Date: ____/____/_____

FEDERAL TRUTH IN LENDING DISCLOSURE STATEMENT FOR PROFESSIONAL SERVICES

The staff at **SOULTENDERS, INC.** are committed to providing caring and professional mental health care to all of our clients. As part of the delivery of mental health services we have established a financial policy which provides payment policies and options to all consumers. The financial policy of **Soultenders, INC.** is designed to clarify the payment policies as determined by the management of this office.

PROFESSIONAL FEES: The hourly fee is $_____. In addition to weekly appointments, this amount is charged for other professional services you may need. Other services include report writing, telephone conversations lasting longer than 15 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of Soultenders, Inc.. If you become involved in legal proceedings that require your provider's participation, you will be expected to pay for the provider's professional time even if the provider is called to testify by another party. [Because of the difficulty of legal involvement, the charge is $_____ per hour for preparation and attendance at any legal proceeding.]

CANCELLATIONS/MISSED APPOINTMENTS: A scheduled appointment means that time is reserved only for you. **A fee of $_____ is charged for missed appointments or cancellations with less than 24 hours' notice**. Frequent cancellations may result in the termination of your treatment; your compliance in keeping appointments and active participation in the treatment process are vital.

BILLING AND PAYMENTS: You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, **SOULTENDERS, INC**. has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. [If such legal action is necessary, its costs will be included in the claim.] In most collection situations, the only information **SOULTENDERS, INC**. will release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT: In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. **SOULTENDERS, INC.** will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course **SOULTENDERS, INC**. will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, **SOULTENDERS, INC**. will be willing to call the company on your behalf.

As a service to you, **SOULTENDERS, INC**. will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amounts covered, and is not responsible for the collection of such payments. In some cases insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. We charge our clients the usual and customary rates for the area. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied non-emergency service unless charges have been preauthorized to an approved credit plan, charge card, or payment at the time of service.

Payments, co-payments, and deductible amounts are due at the time of service. Balances accumulated more than 3 sessions payments will be assessed a $25 late fee. Payment methods include check, cash, or the following charge cards: Visa, Mastercard or PayPal. All payments made by a credit card or debit card will be charged a $1 Surcharge per transaction. There is a $25 fee for returned item checks.

Clients using Insurance please complete the following:

Name of insured: _____ Birthdate:_____ SS#: _____ - _____ - _____

Employer of insured: _____ Address:_____

City:_____ State: _____ Zip: _____ Work Phone: ( ) _____ — _____

Relationship to Patient: _____ Primary Insurance Name: _____

Insurance Co. Phone:( ) ____ — _____ Identification #: _____ Group # _____

Authorization Number: _____

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Person responsible for account: _____ Date: ____/____/_____

Release of Information Authorization to Third Party

I (we) authorize SOULTENDERS,INC. and/or Wendy Ludecke Bencosme, M.A., Ph.D, to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly to SOULTENDERS,INC. and/or Wendy Ludecke Bencosme, M.A, Ph.D.

I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person(s) responsible for account: _____ Date: ____/____/_____

Person(s) receiving services: _____ Date: ____/____/_____

Person(s) or guardian(s): _____ Date: ____/____/_____