CONSENT FOR TREATMENT Tonya Meeks, LMFT 53591

1106 Second Street #250 Encinitas Ca 92024
415-571-0682 | www.tonyameeks.com | tonya@flyingstandbyhome.com

1. **SCHEDULED SESSIONS:** Our time together is 50 minutes for individual sessions and 90 minutes for group sessions. Tele Health Session and will review when in person session resume.

2. **FEE:** We have agreed on a per session fee of $200.00 only for private pay clients. If you cancel without 48 hours notice will be charged this fee. Sessions, when extended upon the agreed time, will be charged accordingly. I will accept Credit On File for Client Billing through Square. Additional fees will be charged to the client in the event of necessary legal work or hospital visits. You are responsible for all fees not covered by insurance. If fees for services are not paid in full, utilization of a collection agency may be necessary. Or you may pay with credit card in office or keep one on file.

3. Credit Card on File for Payment for private pay or cancellation less than 48 hours. Square Charges 3.5 percent and 1.50 per card.

   CC Number: _____

   Security Code: _____

   Exp Date: _____

   Billing Zip Code: _____

4. **INSURANCE:** If you have health insurance please send front and back of insurance card, DOB, SSN, billing address, and primary insurer DOB, SSN, and address of primary insurrance.

   a. Insurnace Plan Name & Number & Group Number

   b. Address on Insurance Card

   c. DOB & SSN

   d. If client is under primary person include their data here as well.

      i. Name, DOB, SSN, ADDRESS

5. **CANCELLATION:** Please inform me of your cancellation at least 48 hours in advance or you will be charged for the session.

6. **TELEPHONE CALLS/EMERGENCY PROCEDURES:** If you need to reach me between visits, please leave a message on my voice mail or text 415-571-0682. However, I will need to charge you at the regular rate for frequent conversations or those over 10 minutes, which will be considered, phone sessions. In the event of an emergency, contact 911 or go to the nearest hospital.

Client Information

Tonya Meeks, LMFT 53591
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Encinitas Ca 92024
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Client Name: _____Marital Status:_____

Age: _____Date of Birth: _____Social Security Number: _____

Address:_____

Home _____Cell Phone: _____Work: _____

Name and Ages of Children:_____

Name of person to contact in case of emergency:_____

Phone: _____Relationship: _____

Serious Illnesses, Accidents, Operation and Allergies: _____

_____

Previous Psychiatric Treatment:_____

What brings you here at this time? _____

_____

Previous Therapy Experiences: _____no _____yes

Therapist: _____Amount of time:_____

Psychiatric Hospitalization: _____no _____yes

Hospital: _____Amount of time:_____

Family or Significant Other(s) Psychiatric Hospitalization: _____no _____yes

Hospital: _____Amount of time:_____

Use of Alcohol _____no _____yes

(if yes)Times per: _____day _____week: Type _____Amount_____

Use of Drugs: _____no _____yes

(if yes) Times per: _____day _____week: Type _____Amount _____

Eating Disorder: _____no _____yes

(if yes) Type _____For how long _____

History of Sexual Abuse: _____no _____yes

_____ sexual intrusion _____ molestation_____ rape _____sexual harassment_____

_____other

Gambling: _____no _____yes

(if yes) Type_____ for how long_____

Suicidal Tendency: _____no _____yes

(if yes) Explain_____

Significant Other Suicidal Tendency: _____no _____yes

(if yes) Explain_____

Additional Information: _____

Referred By_____

Signature of Client: _____Date: _____

Signature of Patient (if minor): _____Date: _____

CLIENT RIGHTS

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Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In The following circumstances, we ma disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For purpose of public health and safety;
- To government agencies for purpose of their audits, investigations, other oversight activities.
- To government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas and otherwise required by the law.

Clients Rights. As our client you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request what we communicate with you in confidence;
- To request that we amend your health information;
- To receive notice of our privacy practices.

Read By: _____

Date: _____

Insurance Information _____

Insurnace Name _____

Insurance Plan Name_____

Date of Birth of Client _____

Date of Birth of Primary Insurer_____

SSN of Client _____

SSN of Primary Insurer _____

Phone Number Plan _____

Co Pay Mental Health Therapy _____