NOLA Art Therapy and Counseling, LLC

▪ 1000 Veterans Memorial Blvd, Suite 310, Metairie, LA 70005 ▪ phone: 504-220-1483 ▪ fax: 888-248-7189
▪elizabeth@nolaarttherapy.com▪

Client Name: _____

ADMISSION AGREEMENT

CONSENT TO TREATMENT

I acknowledge that I have received a satisfactory explanation and understand the information about my therapy including problems, goals, and methods of treatment. I do hereby consent to take part in treatment with the above therapist. I understand that assessment, development of a treatment plan with this therapist, and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process. No guarantees have been made to me about the outcomes of this care. How long therapy lasts tends to vary depending on the issues and goals each client has. I understand that my therapist will recommend a number of sessions. I acknowledge that I have the right to stop treatment at any time.

CONFIDENTIALITY

Clients are entrusted to the care of the staff and are given the assurance that all information is held in strict confidence. Any information about a patient's condition, care or treatment must not be discussed with anyone, either at or away from the office, except with the patient's written consent. What we discuss in treatment is confidential.

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Mental health professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

If, in the professional judgment of the mental health provider, information contained in the record would be harmful to the client, that information may be withheld from him/her and/or the legal guardian/ caretaker except under court order.

If records are requested, clients or legal guardians/ caretakers shall contact the office to set an appointment to review the records. Original records cannot be removed from the office. Copies can be made if necessary. There is a maximum of 10 copies at no charge. There will be a charge of 25 cents for each copy over 10.

I understand and agree to the limits of confidentiality and understand their meanings and ramifications.

Client/Guardian Signature: _____ Date:_____

Additional Guardian Signature (if applicable) _____ Date:_____

*Please have all legal guardians sign this consent to treatment form.

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CLIENT REGISTRATION FORM

Please provide the following information and answer the questions below. Please note that any information you provide here is protected as confidential information.

Date _____ Primary Care Physician: _____

CLIENT INFORMATION

Name: _____
(Last) (First) (Middle)
Name of parent/guardian (if under 18 years): _____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Sex: ☐ Male ☐ Female SSN:_____

Marital Status: ☐ Single/ Never Married ☐Domestic Partnership ☐Married ☐ Separated ☐Divorced ☐Widowed

Address: _____
(Street and Number)
_____
(City) (State) (Zip)

Please explain visitation schedule with other caretakers and list their address: _____
_____

Home Phone: (___)___-_____ Cell/Other Phone: (___)___-_____
May we leave a message on the voicemail/ answering machine or with anyone who answers the phone? ☐Yes ☐No

E-mail: _____ May we email you? ☐ Yes ☐No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

PREVIOUS MENTAL HEALTH SERVICES

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)? ☐ Yes ☐No
If yes, previous therapists/practitioners: _____

Explain service dates, type, and diagnoses_____
_____
_____
Did client have a positive experience in previous treatment? ☐Yes ☐No
Explain: _____
_____
Was client compliant with treatment recommendations and/or medication? ☐Yes ☐No
Explain:_____
_____

MEDICAL HISTORY

Does client report taking any medications for any reason? ☐**Yes** ☐**No**
Please list medications currently using:

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Name of Medication Dosage Administration Condition_____

_____
_____
_____
_____

Any Allergies or Special Precautions: ☐Yes ☐No
If yes, list allergies and / or special precautions: _____
_____

PRESENTING PROBLEM

Chief Complaint: _____
_____
_____
Symptoms (mental, emotional, and/or behavior problems):_____
_____
_____
Date of Onset, frequency, duration, and progression of symptoms:_____
_____
_____
Stressors:_____
_____
_____

Does client **currently** have thoughts, plans, intent, or behaviors indicative of suicide:
☐Yes ☐No If yes, explain: _____
_____
In the **past**, has client had thoughts, plans, intent, or behaviors indicative of suicide:
☐Yes ☐No If yes, explain: _____
_____
Does client **currently** have thoughts, plans, intent, or behaviors indicative of homicide:
☐Yes ☐No If yes, explain: _____
_____
In the **past** has client had thoughts, plans, intent, or behaviors indicative of homicide:
☐Yes ☐No If yes, explain: _____
_____

EDUCTATION

1. School: _____
2. Current grade: _____
3. Number of schools attended: _____
4. History of (if yes, explain in the space provided):
   a. Academic problems: ☐Yes ☐No
   Describe: _____
   _____
   b. Academic strengths: ☐Yes ☐No
   Describe: _____
   _____
   b. Behavior problems: ☐Yes ☐No
   Describe behavior problems and if child has been suspended or expelled: _____
   _____
   d. Special education placement: ☐Yes ☐No
   If yes, explain (504, IEP, accommodations):_____
   _____

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EMPLOYMENT

☐ Not currently employed ☐ Employed

1. Employer:_____ 2. Job description/occupation:_____

3. Describe any job related stress:_____

Employer Phone Number: (___)___-_____
May we leave a message on the voicemail/ answering machine or with anyone who answers the phone? ☐Yes ☐No

SOCIAL

Is client able to form and maintain relationships? ☐Yes ☐No
Preferred social activities or Describe any leisure activities or hobbies: _____
_____
Girl or boyfriend: ☐Yes ☐No
If yes, for how long? _____
Current problems with intimate relationships? ☐Yes ☐No
On a scale of 1-10, how would you rate your relationship? _____
Sexually active: ☐Yes ☐No
Gang involvement: ☐Yes ☐No

LEGAL HISTORY

☐ Yes, complete this section
☐ No, go to Developmental History

☐ Arrest charges pending ☐ Probation ☐ Restitution ☐ Previous Arrests
☐ Detention ☐Family Court / Status Offenses / FINS / TASC
If yes, explain (include dates, charges, convictions, terms of probation, next court date and probation officer) _____
_____

DEVELOPMENTAL/BIRTH HISTORY

☐ Information not available. Proceed to Infant Temperament Section.
☐ All early development issues are reported within normal limits. Proceed to Infant Temperament Section.
☐ There are some development issues worth noting. Please complete all items below that you answer "yes" to and include age of onset.

Were there complications with the pregnancy? ☐Yes ☐No
Discuss complications, prenatal care, and planned / unplanned pregnancy: _____
_____
_____
Were there any delays in meeting developmental milestones? ☐Yes ☐No
If yes, explain: _____
_____
Were there any issues with infant temperament (difficult to comfort, quiet, aloof, irritable, overactive, feeding issues) ? ☐Yes ☐No
If yes, explain: _____
_____

GENERAL MEDICAL HISTORY

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Overall general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Information not available
Neurological issues: ☐Yes ☐No
Chronic Pain: ☐Yes ☐No
Explain any areas selected above and add others not listed; identify if issues are current or in the past:
_____
_____

ADDICTION HISTORY

Addiction History
Does client have a history of **substance abuse**? ☐Yes ☐No
If yes, explain: _____
_____
Other Addictions: ☐Yes ☐No
If yes, explain: _____
_____
Does client currently live with anyone with substance abuse issues? ☐Yes ☐No
If yes, explain: _____
_____

FAMILY HISTORY

Are there family issues which need to be addressed in treatment?
☐Yes ☐No
If yes, explain: _____
_____
Positive relationship with parents?
☐Yes ☐No
If no, explain: _____
_____
Positive relationship with siblings?
☐Yes ☐No
If no, explain: _____
_____

Number of persons, other than client, currently living in the home:
Household Members

Name	Age	Relationship

Form of discipline used in home?_____

Current Support Systems:
Describe client's current support systems (family, friends, Mentor, etc)? _____
_____
List Abilities/ Strengths: _____
_____
List Needs/ Weaknesses: _____
_____

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Preferences (those things the person served thinks will enhance his/her treatment): _____
_____

Past Significant Events (Check any of the following that occurred during childhood):

☐ Significant medical condition of parent / caregiver
☐ Medical condition of child
☐ Post-partum adjustment problems of mother
☐ Mental illness of parent / caregiver
☐ Substance abuse of parent / caregiver
☐ Separation / divorce of parent / caregiver
☐ Adoption
☐ Abandonment by significant adult caregiver
☐ Death of parent / caregiver
☐ Mental retardation of parent / caregiver
☐ Incarceration of parent / caregiver
☐ Attempted / completed suicide of family member
☐ Trauma:_____

Comments:_____
_____

Has client ever lived in any of the following settings? ☐Yes ☐ No If yes, check below

☐ Relative's home
☐ Foster family
☐ Orphanage
☐ Group home
☐ Therapeutic foster care
☐ Halfway house
☐ Emergency shelter
☐ Correctional facility
☐ Residential substance abuse facility
☐ Detention facility
☐ Homeless shelter
☐ Residential treatment center
☐ Hospital
☐ Other_____

Comments: _____
How many times has client's residence changed in the last two years? _____

Family Medical History
Please explain family history related to Psychiatric/ Mental Health (Abuse, Neglect, Anxiety, Depression, Domestic Violence, Eating Disorders, Obesity, Obsessive Compulsive Behavior, Schizophrenia, Suicide Attempts, Personality Disorders, Developmental Disorders), Alcohol/Substance Abuse, and Physical Illness.

	Biological Parents	Step Parents	Extended Family
Psychiatric/ Mental Health			
Drugs/Alcohol			
Physical Illness			

Therapist Signature: _____

Client/ Caretaker Signature:_____

Date:_____

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Symptoms Worksheet

Please check all that apply. Caretakers, please discuss with minor client if needed.

Mood:

Describe general mood:

Mood symptoms:

- ☐ Excessive boredom
- ☐ Difficult to Concentration
- ☐ Decreased energy
- ☐ Weight loss
- ☐ Insomnia
- ☐ Grandiosity
- ☐ Thoughts of death
- ☐ Increased energy
- ☐ Decreased appetite
- ☐ Mood swings / emotional outbursts
- ☐ Impulsivity
- ☐ Decreased need for sleep
- ☐ Irritability
- ☐ Increased appetite
- ☐ Tearfulness
- ☐ Weight gain
- ☐ Hypersomnia
- ☐ Racing thoughts

Describe any symptoms: _____

_____

Anxiety Symptoms:

- ☐ Excessive worries
- ☐ Avoidances
- ☐ Obsessions
- ☐ Flashbacks
- ☐ Excessive fears
- ☐ Extreme startle
- ☐ Compulsions

Describe any symptoms: _____

_____

Psychosis Symptoms:

- ☐ Auditory Hallucinations
- ☐ Bizarre thinking
- ☐ Visual hallucinations
- ☐ Paranoia
- ☐ Delusions

Describe any symptoms: _____

_____

Oppositional and Conduct Symptoms:

- ☐ Argues with adults
- ☐ Bullies others
- ☐ Blames others for mistakes
- ☐ Sets fires to cause damage
- ☐ Cruel to animals
- ☐ Often annoyed
- ☐ Spiteful and vindictive
- ☐ Ran away
- ☐ Often angry
- ☐ Initiate fights
- ☐ Steals significant items

Describe any symptoms: _____

_____

Attention Deficit/ Hyperactivity Symptoms:

Symptoms at *home*:

- ☐ Fidgets
- ☐ Difficulty concentrating
- ☐ Difficulty taking turns
- ☐ Interrupts people
- ☐ Excessive energy
- ☐ Difficulty remembering due to poor attention

Describe any symptoms: _____

_____

Symptoms at *school/work*:

- ☐ Fidgets
- ☐ Difficulty concentrating
- ☐ Difficulty taking turns
- ☐ Interrupts people
- ☐ Excessive energy
- ☐ Difficulty remembering due to poor attention

Describe any symptoms: _____

_____

Eating disorders:

☐ Yes ☐ No

Describe any symptoms: _____

_____

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Authorization to Disclose Information to Primary Care Physician

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. If not previously revoked, this consent will terminate upon completion of the specific purpose as stated below.

I, _____, Date of Birth _____
(patient's name)

hereby authorize NOLA Art Therapy and Counseling . *(please check one)*

_____ To release any and all applicable information to my Primary Care Physician.

_____ NOT to release information to my Primary Care Physician.

_____ I do not have a Primary Care Physician

for the specific purpose of coordinated treatment.

_____ _____
Client's signature, Date
Guardian or Responsible Party

Primary Care Physician's Name, Address & Phone:

_____

_____

_____

_____

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Health Insurance Portability and Accountability Act (HIPPA)
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed. It also describes how you can access this information.

Please read carefully.

Privacy Notice Introduction. This Notice tells you about the ways health information is used. It describes your rights and our obligations regarding the use and disclosure of heath information. Over time your therapist may change this Notice. If changed, your therapist is required to inform you of our new privacy policy by making a revised Notice available to you.

Your therapists reserve the right to change this notice and make the new provisions effective for all Protected Health Information that we maintain.

General Privacy Information. When you contract to be under the care of a therapist, a record is usually kept. These records contain demographic information (such as name, address, telephone number, Social Security Number, birth date, and health insurance information). The records may also contain other information including how you say you feel, what health problems you have, treatments you may have received, observations by health care providers, diagnosis and plan of care. **This is known as Protected Health Information, or PHI**, and is used for a number of purposes explained in detail in this document.

Your PHI may be used and/or disclosed by your therapist for the purpose of providing health care services, to pay or obtain payment for your health care treatment, to inform you about other health-related options, to comply with the law.

Treatment. Your therapist will use and disclose your protected health information to provide, coordinate, or manage your care and any related services. This includes the coordination or management of your health care with a third party for treatment purposes. For example, we may disclose your protected health information to a pharmacy to fulfill a prescription or to a subcontracted provider who is also providing services for you. Your therapist may also disclose protected health information to physicians who may be treating you or consulting with the treating therapist with respect to your care. In some cases, we may also disclose your protected health information to an outside treatment provider for purposes of the treatment activities of the other provider.

Payment. Your PHI will be used and disclosed, as needed, to obtain payment for the services provided by your therapist. This may include certain communications to your health insurer to get approval for the treatment that are recommended by your therapist. For example, if a certain level of service is recommended, we may need to disclose information to your health insurer to get prior approval for the level of service. We may also disclose protected health information to your insurance company to determine whether you are eligible for benefits or whether a particular service is covered. In order to get payment for your services, we may also need to disclose your protected health information to your insurance company to demonstrate the medical necessity of the services or to demonstrate that required documentation exists. Your therapist may also disclose patient information to another provider involved in your care for the other provider's payment activities.

Operations. Your therapist may use or disclose your PHI, as necessary, for to support the health care operations of the therapist's practice. Health care operations include but are not limited to:

- Quality assessment and improvement activates
- Employee review activities
- Training programs including those in which students, trainees, or practitioners in healthcare learn under supervision
- Accreditation, certification, licensing or credentialing actives
- Review and auditing, including compliance reviews, medical reviews, legal services and maintaining compliance programs.

In certain situations, we may also disclose consumer information to another provider or health plan for their health care operations.

Other Uses and Disclosures. As part of treatment, payment and healthcare operations, your therapist may also use or disclose your protected health information for the following purposes:

- To remind you of an appointment including messages left on answering machines
- To inform you of potential treatment alternatives or options
- To inform you of heath-related benefits or services that may be of interest to you.

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Uses and Disclosures Beyond Treatment, Payment, and Health Care Operations Permitted Without Authorization or opportunity to Object: The HIPAA Privacy Rule also allows your therapist to use or disclose your PHI without your permission or authorization for a number of reasons including the following:

When Legally Required. Your therapist will disclose your PHI when required to do so by any Federal, State or local law.

When there are Risks to Public Health. We may disclose your PHI for the following public activities and purposes:

- To prevent, control, or report disease, injury or disability as permitted by law
- To report vital events such as birth or death as permitted or required by law
- To conduct public health surveillance, investigations and interventions as permitted by law
- To collect or report adverse events and product defects, track FDA regulated products, enable product recalls, repairs or replacements to the FDA and to conduct post marketing surveillance
- To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law
- To report to employer information about an individual who is a member of the workforce as legally permitted or required.

To Report Abuse, Neglect Or Domestic Violence. Your therapist may notify government authorities if we believe that a consumer is the victim of abuse, neglect or domestic violence. This disclosure will be made only when specifically required or authorized by law or when the client agrees to the disclosure.

To Conduct Health Oversight Activities. Your therapist may disclose your protected health information to a health oversight agency for activities including audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight as authorized by law. Your therapist will not disclose your health information if you are the subject of an investigation and your health information are not directly related to your receipt of health care or public benefits.

In Connection With Judicial and Administrative Proceedings. Your therapist may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a signed authorization (in a format approved by the Louisiana Court Administrator).

For Law Enforcement Purposes. Your therapist may disclose your PHI to a law enforcement official for law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries
- Pursuant to court order, court-ordered warrant, subpoena, summons or similar process
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person
- Under certain limited circumstances, when you are the victim of a crime
- To a law enforcement official if the therapist has a suspicion that your death was the result of criminal conduct
- In an emergency in order to report a crime.

To Coroners, Funeral Directors, and for Organ Donation. Your therapist may disclose protected health information to a coroner or medical examiner for identification purposes, to determine cause of death or for the coroner or medical examiner to perform other duties authorized by law. Your therapist may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

For Research Purposes. Your therapist may use or disclose your protected health information for research when the use or disclosure for research has been approved by an institutional review board or privacy board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.

In the Event of A Serious Threat To Health Or Safety. Your therapist may, consistent with applicable law and ethical standards of conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions. In certain circumstances, the Federal regulations authorize your therapist to use or disclose your protected health information to facilitate specified government functions relating to military and veterans activities, national security and intelligence activities, protective services for the President and others, medical suitability determinations, correctional institutions, and law enforcement custodial situations.

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For Worker's Compensation. Your therapist may release your health information to comply with worker's compensation laws or similar programs.

Uses and Disclosures That You Authorize: Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we have taken action in reliance upon the authorization.

Your Rights: You have the following rights under HIPAA regarding your health information: You have the right to inspect and copy your PHI. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation or used in a civil, criminal, or administrative action or preceding and PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction of your PHI. This means that you may ask your therapist to not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state that specific restrictions requested and to whom you want the restriction to apply.

Your therapist is not required to agree to a restriction that you request. If the therapist believes it is in your best interest to permit use and disclose of your PHI. Your PHI will not be restricted you then have the right to use another health care professional.

You have the right to have your therapist amend your PHI. If your request for amendment is denied, you have the right to file a statement of disagreement. Your therapist may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Request for amendments must be directed to the Privacy Officer. In this written request you must also provide a reason to support the requested amendments.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

Complaints. You may complain to your therapist if you believe your privacy rights have been violated.

Your signature below is acknowledgement that you have received this notice of Privacy Practices.

Print Name: _____Signature: _____Date: _____

Parent/Legal Guardian Name:_____ Signature: _____ Date: _____

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Insurance Form

Client Information					
Client's Name:			DOB:		
Member ID #:			Sex:	M	F
Group #:			SSN:		
Address:					
Phone:			Other Phone:		
Email address:					
Is this client covered by insurance?	Yes	No			
Primary Insurance Company					
Primary Insurance Company Name:			Co- payment:		
Insurance Phone:					
Insured					
Insured's Name:			DOB:		
Member ID #:			Sex:	M	F
Group #:			SSN:		
Address:					
Phone:			Other Phone:		
Email address:					
Occupation:			Employer:		
Employer Address:					
Employer Phone:			Insured's Relation to client:		
Secondary Insurance Company					
Secondary Insurance (if applicable):			Co- payment:		
Insurance Phone:					
Insured					
Insured's Name:			DOB:		
Member ID #:			Sex:	M	F
Group #:			SSN:		
Address:					
Phone:			Other Phone:		
Email address:					
Occupation:			Employer:		
Employer Address					
Employer Phone:			Insured's Relation to Client:		

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Billing, Payment, and Insurance Information & In Case of Emergency Contact and Consent

OFFICE BILLING AND INSURANCE POLICY

1. I authorize use of this form on all of my insurance submissions.
2. I authorize the release of information to my insurance company and Therapy Appointments for billing purposes.
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to my service provider.
5. I herby permit a copy of this to be used in place of an original.
6. It is your responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by your insurance. The day and time serviced is provided.
7. Be advised that a notice of unpaid balances will be mailed to the address on this form.
8. There will be a $35.00 service charge for all returned checks.
9. In event that your account goes to collections, there will be a 20% collection fee added to your balance.
10. There is a 24-hour cancellation policy, which requires that you cancel your appointment 24-hours in advance between the hours of 8 a.m. - 5 p.m. Monday –Friday to avoid being charged a missed appointment fee.

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the therapist. I understand that I am financially responsible for any balance. I also authorize NOLA Art Therapy and Counseling or insurance company to release any information required to process my claims. I understand that my diagnosis will be provided to my insurer. I understand that my insurance company may request additional clinical information regarding my treatment in order to authorize sessions and/or payment. I authorize NATC to provide such information as necessary. I authorize NATC to contact the in case of emergency person listed above as needed to assist in a crisis situation.

_____ _____

Client/Guardian signature *Date*

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Cancellation Policy and Credit Card Form

This form is mandatory in order to receive services at NATC.

If you do not show up for your scheduled therapy appointment, and you have not notified us at least 24 hours in advance, you will be required to pay a cancellation fee. Insurance will not cover the cost of missed appointments. The fee will be the lesser of the insurance company's contracted rate for the session or $95.

I, _____ am authorizing NOLA Art Therapy and Counseling to charge my credit card in the event I fail to show up for my scheduled appointment and do not notify NATC staff of my inability to attend a scheduled appointment at least 24 business hours in advance. I agree to pay the above-mentioned cancellation fee for any session cancelled without 24 business hours in advance. I will not dispute the charges for the sessions I have received or that I have not cancelled less than 24 business hours in advance. I further authorize NATC staff to disclose information about my attendance/ cancellation to my credit card company if I dispute a charge. In addition, I authorize this card to be used to pay balance on any outstanding balance should my insurance lapse or have a deductible.

Card Type: _____ Visa_____Mastercard_____Discover_____American express

Full Name on Card: _____

16 Digit Card Number: _____ Exp Date:_____

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

Billing Zip Code:_____

Signature:_____ Date:_____

*Please note: This form will be securely stored in your clinical file and may be updated upon request at any time. Your credit card will not be charged unless the following conditions apply: no show for a scheduled appointment, cancellation less than 24 business hours in advance, or an outstanding unpaid balance for services received at NATC.