

Synchrony of Visalia, Inc.
APPLICATION FOR COUNSELING SERVICES

Child's Name: _____ Male
 Female

Address: _____
Last First Middle
Street City State Zip

Parent/Guardian Name: _____
Last First Middle

Primary phone: _____ Secondary Phone: _____

Other Parent Name and Address and Phone: _____
(If not at above address) _____

In case of emergency, contact: _____ Phone: _____

Child's Date of Birth: _____ Child's Social Security #: _____ - _____ - _____

Parent/Guardian Marital Status: Divorced Married Widowed Never Married
 Married, but currently separated Other _____

Parent/Guardian Employer: Where: _____ Occupation: _____

Total **gross** family yearly income: \$ _____

Primary Insurance Carrier: _____

Name of Primary Insured: _____ SSN of Primary Insured: _____

Brief statement of problems: _____

Symptoms:
 Anxiety Depression ADD/ADHD Manic
 Phobias Family Eating Disorders Other
 Conduct Problems School Problems RAD

Ethnicity: African-American Asian Caucasian Hispanic Native American Other

School attended: _____ Grade: _____

What individual or agency referred you to Synchrony? _____

Are you currently receiving services from any other agency? _____

Previous Counselor: _____ Approx. dates _____

Is your child disabled? No Yes If so, what is the disabling condition? _____

Physician's Name: _____ Phone: _____

Medications Taken: _____

I hereby authorize Synchrony to release any information related to processing my insurance claim and (or) third party payor claim for treatment rendered to my minor child or me. By signing this release, I authorize Synchrony of Visalia, Inc to treat my child _____.

(Parent / Guardian Signature) _____ (date)
Please indicate relation: biological parents parent with legal custody guardian conservator other _____

****Please see reverse side****

Synchrony of Visalia, Inc.
COUNSELING AGREEMENT

Insurance / Payment Source

Unless other arrangements are made in advance, or your insurance is a managed care contract, all fees are due at the time services are rendered. Synchrony will provide the necessary billing statement to be sent with your claim form. In the event of a **returned check**, a **\$25.00 fee** in addition to any **bank charges** will be assessed.

Cancellations and Failed Appointments

Appointments are scheduled for 50 minutes and must be canceled 24 hours in advance to avoid being charged for the missed session. **If you miss a scheduled appointment or cancel an appointment less than 24 hours in advance you will be charged for the session.** You may leave a message with the answering service should you need to call after business hours. Individuals in group therapy will be charged for all group sessions while a member of the group, including failed appointments.

Letter, Reports, and Other Written Materials

When requesting letters, reports, and other written information regarding sessions, clients are asked to submit their request *seven (7) days in advance* of the date the material is needed. Account balances, if any, must be **paid in full** prior to the release of the requested material, unless other arrangements are made in advance. **There is a charge for any narrative reports and/or assessments.**

Babysitting

We regret that due to limited space and staff we cannot provide babysitting. ***We are not responsible for any child left unattended.***

Confidential Information

Under California law, the content of mental health treatment is confidential except in certain specific situations. This means that we cannot release any information about you to anyone, including family members, without your written consent, with the following exceptions: The staff of Synchrony is required to report situations in which the health and safety of others may be at risk. Reports do not contain information not related to the condition reported. Your therapist has a list of specific conditions and would be pleased to review this with you. It is also understood that in the event your account balance remains unpaid after reasonable efforts to collect have been made, your account will be turned over to a collection agency. Information provided will be limited to your name, address, and phone number and account information. Your therapist, upon using reasonable professional judgment, may discuss aspects of your case with other mental health professionals who would be providing coverage or consulting with him/her for professional purposes.

If you have questions regarding any aspect of the above, please do not hesitate to ask the office staff and/or your therapist.

I have read and understand all of the above and agree to the terms contained in the Application for Counseling Services.

By my signature I am also acknowledging receipt of Synchrony's Notice of Privacy Practices entitled "Important Information About Your Mental Health Information and Privacy."

Signature: _____

Date: _____

Client may have a copy upon request