

**V. WHITE & ASSOCIATES, INC.**

**Veronica Y. White, Ph.D., LMHC, NCC**

1850 Lee Road, Suite 210

Winter Park, Florida 32789

407.478.5125/office

407.386.8900/fax

Email: [drvwa@aol.com](mailto:drvwa@aol.com)

Website: [vwhiteassociates.org](http://vwhiteassociates.org)

**CONSENT FOR MENTAL HEALTH SERVICES**

I, \_\_\_\_\_ (parent/guardian) of \_\_\_\_\_  
authorize Veronica Y. White, Ph.D., to conduct psycho-educational assessments, counseling,  
psychotherapy, and/or related mental health services/ treatment interventions with this provider.  
I understand that Confidentiality and HIPAA laws protect my privacy and the privacy of my  
Health records.

\_\_\_\_\_  
PRINT NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE

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**RELEASE OF INFO-BILLING**

Kindly accept a photocopy of this authorization as if it were an original executed authorization. I authorize the release of any payment and medical information necessary to process this claim or any related claims including claims of minor children, if applicable.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

**ASSIGNMENT OF BENEFITS AGREEMENT**

I hereby authorize payment directly to Dr. Veronica White, Ph.D., or V. White & Associates, Inc. for the insurance benefits otherwise payable to this provide for professional services. I understand that I am financially responsible to Dr. Veronica White for charges not covered by this assignment.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

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**CLIENT INFORMATION**

Date: \_\_\_\_\_

Referred by: \_\_\_\_\_

Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/ZIP: \_\_\_\_\_

Phone No. (H/C) \_\_\_\_\_ Phone No. (W): \_\_\_\_\_

Education: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Years Married: \_\_\_\_\_ No. of Previous Marriages: \_\_\_\_\_

Religion: \_\_\_\_\_ Active? \_\_\_\_\_

Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/ZIP: \_\_\_\_\_

Phone No.: (H/C) \_\_\_\_\_ Phone No. (W) \_\_\_\_\_

Education: \_\_\_\_\_ Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Years Married: \_\_\_\_\_ No. of Previous Marriages: \_\_\_\_\_

Religion: \_\_\_\_\_ Active? \_\_\_\_\_

**IMMEDIATE FAMILY**

Name(s)	Relationship	Age	Place of Residence
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What is the nature of your problem?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Gone through previous Counseling/Psychotherapy? With Whom and When?

\_\_\_\_\_

\_\_\_\_\_

**MEDICAL INFORMATION**

Personal/Family Physician(s): \_\_\_\_\_ Phone No. \_\_\_\_\_

Current Medication(s):	Prescribed by:
_____	_____
_____	_____
_____	_____

**INSURANCE INFORMATION**

Does your insurance provide outpatient mental health coverage benefits? \_\_\_\_\_

Does your insurance provide family benefits? \_\_\_\_\_

Name on Insurance card: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Company Address: \_\_\_\_\_ Company Phone No. \_\_\_\_\_

Member Policy No. \_\_\_\_\_ Member Group ID: \_\_\_\_\_

**FEES AND CHARGES**

1. Initial session is **\$175.00** for **self-pay** clients and **contracted rates apply** for clients using **commercial insurance**.
2. Telephone consultations and other professional activities rendered on behalf of the client are billed at the hourly rate or specific rate schedule. Client short telephone “check in or scheduling coordination telephone calls are billed.
3. Payments, including co-pays, are due at time of service.
4. We accept cash or checks. Please make checks payable to: V. White & Associates, Inc.
5. **RETURNED CHECKS ARE SUBJECT TO \$35.00 PROCESSING FEE.** Payment receipts and future appointment notices will be provided.
6. There will be a **\$25.00 minimum NO SHOW FEE** if we are not notified 24 hours prior to your appointment unless it is an emergency or serious illness.
7. If any legal or mental health documents are needed, please allow 7 to 14 business days for completion of medical record requests or mental health reports. **Requests for medical records are subject to usual and customary fees. There is a fee of \$175.00 (minimum) that must be paid at time of the request for clinical/legal reports.**
8. In a circumstance where problems are encountered in receiving payment for services rendered, you may be billed additional charges to cover the cost of time and expenses incurred to obtain payment.
9. Who, if other than you or the insurance company, will make payments for the services rendered? (Please provide address, name(s) and telephone number(s) where party can be reached).

Family Member (mother, father, uncle, etc)     Attorney

Other: \_\_\_\_\_  Agency (children and family agency or other)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone No. : \_\_\_\_\_

SIGNATURE OF RESPONSIBLE PARTY(S):

\_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_

Date: \_\_\_\_\_