



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

Website: www.vwhiteassociates.org

Facebook: V. White & Associates, Inc.

CONSENT FOR MENTAL HEALTH SERVICES

I, _____ authorize Veronica Y. White, Ph.D., and/or V. White & Associates, Inc. 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



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

Website: www.vwhiteassociates.org

Facebook: V. White & Associates, Inc.

PAYMENT RELEASE AUTHORIZATION

Kindly accept an electronic or 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., and/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, Ph.D., and/or V. White & Associates, Inc. for charges not covered by this assignment.

SIGNATURE

DATE



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

Website: www.vwhiteassociates.org

Facebook: V. White & Associates, Inc.

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? _____ Email: _____

IMMEDIATE FAMILY

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

What is the nature of your problem?

Previous Counseling/Psychotherapy (With Whom, Location 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: _____

APPOINTMENT INFORMATION:

1. Appointments will be scheduled as needed, upon request and upon verification of payment method and verification of insurance benefits.
2. Tele-Health/Virtual Appointments are available and preferred during a health crisis.
3. An electronic appointment reminder will be provided via text message approximately three days prior to your scheduled session.

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. All payments, including co-pays, are due at time of service. **Clients are responsible for payment.**
- 4. We accept electronic payments, cash, checks or money orders. Please make checks payable to: V. White & Associates, Inc.
- 5. **Returned checks or uncollected third party payments are subject to usual and customary charges.**
- 6. There will be a **\$50.00 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 said report. **Requests for medical records are subject to usual and customary fees. There is a fee of \$175.00 (minimum) that must be paid at the 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: _____