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, ______________________________ (parent/guardian) of__________________________ 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 <u>outpatient</u> 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: ____________