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

Winter Park, Florida 32789
407.478.5125/office
407. 386.8900/fax
Email: drvwa@aol.com
Website: www.vwhiteassociates.org
Business 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

Winter Park, Florida 32789
407.478.5125/office
407. 386.8900/fax
Email: drvwa@aol.com
Website: www.vwhiteassociates.org
Business 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

Winter Park, Florida 32789
407.478.5125/office
407. 386.8900/fax
Email: drvwa@aol.com
Website: www.vwhiteassociates.org
Business 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.
2. Telehealth/Virtual Appointments are available.
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: _____