Christine Dievendorf Weiss, PLLC

5400 Holiday Terrace 200A
Kalamazoo, MI 49009-2161
269-520-0050

NEW CLIENT INFORMATION

Client Legal Name - First, Last

Client Name

Date of Birth

Phone

E-Mail

SMS COMMUNICATION CONSENT

YES - By checking this box, you agree to receive text messages from Christine Dievendorf Weiss, PLLC for the purpose of scheduling and relevant communications.

☐ YES

Message and data rates may apply. Message Frequency may vary. Text HELP to 2695200050 for assistance. Text STOP to Opt-Out at any time. For Privacy Policy and Terms and Conditions, please refer to https://www.christineweisscounseling.com/_files/ugd/20053b_e2507e1d8aa8499088add3697456404d.pdf

NO - I do not wish to participate in SMS text messaging services.

☐ NO

ABOUT OUR SERVICES

APPOINTMENTS:
Each appointment is approximately 45-60 minutes in duration, most often 60 minutes. Frequency, duration, and goals of therapy will be based on the individual, couple, or family's need and discussed during your first few appointments.

PAYMENTS:
All fees (co-pays, deductibles, document preparation charges, etc.) are due at the time of service, unless other arrangements are documented in writing. A valid payment card can be stored securely in your electronic account and will be charged following each session for the amount equal to your copay, deductible or payment due. You may change your stored payment method at any time, or you may choose to pay by exact cash or check at the time of service.

INSURANCE BILLING:
We will bill your insurance for you; however, it is your responsibility to verify insurance coverage as well as additional fees or amounts owed toward deductible. It is the responsibility of the client to provide full payment for services if insurance denies payment. Any balance not paid after 90 days from the date of service may be subject to collection by a third-party agency.

CANCELLATIONS:
If an appointment needs to be rescheduled or canceled, a 24-hour notice is required. If such notice is not provided, a fee may be added to your account balance. Payment of this fee is due prior to any further services rendered. Insurance companies do not reimburse for missed appointments, and you will be directly responsible for the cancellation/missed appointment fee. See Schedule of Fees below for additional information.

EMERGENCY PROCEDURES:
If you are experiencing a mental health emergency, please contact Gryphon Place by calling (269) 381-HELP (4357). For a mental health emergency involving Kalamazoo County residents under 18 years of age, you may contact the Mobile Crisis Response team at (269) 373-6000. The National Suicide Prevention Lifeline is available at 1-800-273-TALK (8255). You may also contact 911 or go to your local emergency room.

CONFIDENTIALITY: Confidentiality is of the utmost importance in clinical care. All information and documentation regarding your services will be handled and stored in accordance with HIPAA guidelines, current laws and APA ethics codes. You may request in writing that this information be shared with any source you deem necessary.

SCHEDULE OF FEES:
(When billing insurance, actual contracted rates, copays, and deductibles vary by insurance plan):
Initial Appointment (90791) - $270
60 Minute Session (90837) - $230
45 Minute Individual Session (90834) - $200
45 Minute Family/Couples Session (90846/7) - $250

Reduced Self-Pay Rates
(due at time of service):
Initial Appointment - $170
Standard Appointment - $130

Late Cancel (Less than 24 hours notice) - $80
Missed Appointment (No-Show) - $100

LEGAL
Attorney Consult - $100
Participation in Court Date Proceedings (Includes time reserved for preparation, travel, and court time) - $400/hour, 3 hour minimum

DOCUMENT REQUESTS
Medical Records Request - $50
Written Document Preparation - $100

Reasonable correspondence with referring medical providers, schools, or care givers is included in the original schedule of fees. Fees for any services including and beyond the above mentioned can be discussed with your provider.

CONSENTS AND AUTHORIZATIONS

I agree to the following:

- [ ] I authorize insurance benefits to be paid directly to my treatment provider.
- [ ] I consent to the use of electronic accounts and communications (email, telehealth, etc.).
- [ ] I have received a copy of the HIPAA Privacy Notice (provided with intake materials).
- [ ] I authorize the release of any medical information necessary to process my insurance claims.
- [ ] I consent to the exchange of treatment information between CDWPLLC and my primary care physician.
- [ ] I authorize de-identified communication for the purposes of consultation/research.

I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to comply with all of the above policies of this healthcare practice.

Electronic Signature

DATE
mm/dd/yyyy

Use your mouse (or, on a touch device, your finger) to draw your signature in the box above.