avalit Client Registration Information

(PLEASE PRINT CLEARLY AND COMPLETE ALL AREAS)

CLIENT: (if client is not the responsible party: also fill out **responsible party information** below)

LAST NAME: _____ FIRST NAME: _____ M.I.: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

TELEPHONE: HOME (____)_____ WORK: (____)_____ CELL: (____)_____

EMAIL: _____

AGE: _____ DATE OF BIRTH: _____ SEX: _____ SOCIAL SECURITY NO. : ____-____-_____

MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED DIVORCED WIDOWED

STUDENT STATUS: (CIRCLE ONE) FULL-TIME PART-TIME NONSTUDENT

EMPLOYMENT STATUS: (CIRCLE ONE) FULL-TIME PART-TIME RETIRED DISABLED UNEMPLOYED

EMPLOYERS NAME: _____

EMPLOYERS ADDRESS: _____ CITY, STATE, ZIP: _____

In Case of an emergency notify: _____

Relationship: _____ Phone: _____

RESPONSIBLE PARTY INFORMATION (Only fill out if client is **NOT** the responsible party)

LAST NAME: _____ FIRST NAME: _____ M.I.: _____

RELATIONSHIP TO CLIENT: (CIRCLE ONE) PARENT LEGAL GUARDIAN SPOUSE OTHER

AGE: _____ DATE OF BIRTH: _____ SEX: _____ SOCIAL SECURITY NO. : ____-____-_____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

TELEPHONE: HOME (____)_____ WORK: (____)_____ CELL: (____)_____

MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED DIVORCED WIDOWED

STUDENT STATUS: (CIRCLE ONE) FULL-TIME PART-TIME NONSTUDENT

EMPLOYMENT STATUS: (CIRCLE ONE) FULL-TIME PART-TIME RETIRED DISABLED UNEMPLOYED

EMPLOYERS NAME: _____

If the client's parents are separated or divorced, or you have legal guardianship and are not the child's biological parent please provide documentation of guardianship to the front desk.

Was this appointment court ordered or recommended by an attorney? Y or N

If yes, what is your attorney's name? _____

Attorney Phone Number: _____ **Case #** _____

Other parties involved: _____

Donaldson Wellness Center
Kerry Donaldson, PhD #39407
508 Grace Street
Waxahachie, Texas 75165
972-923-0730
www.donaldsonwellnesscenter.com

CHILD/ADOLESCENT CLIENT HISTORY

Name: _____ **Date of Birth:**_____ **Age:**_____

Race/Ethnicity: _____ **Sex: M — F — Other:** _____
Referred by: _____
Reason for Referral:_____

_____

_____

Family Members/Others Residing in Home	**Age**	**Relationship to Child**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

How does this child get along with other family members in the home? Alliances? Problems?

_____

_____

_____

How does this child get along with family members/important people residing outside the home?

_____

_____

_____

Parent's/Legal Guardians' Marital Status: Married Divorced Separated (circle one)
Other:_____

Maternal Family Psychiatric History (If so, who?)	**Paternal Family Psychiatric History** (If so, who?)
Depression/Sadness:	Depression/Sadness:
Suicidal Ideation/Attempt:	Suicidal Ideation/Attempt:
Anxiety/Excessive worry:	Anxiety/Excessive worry:
Panic Attacks:	Panic Attacks:
Bipolar Disorder:	Bipolar Disorder:
Obsessive-Compulsive Tendencies:	Obsessive-Compulsive Tendencies:
Schizophrenia:	Schizophrenia:
Attention Problems/ADHD:	Attention Problems/ADHD:

Learning Problems:	Learning Problems:
Alcohol/Drug Use:	Alcohol/Drug Use:
Problems with the Law:	Problems with the Law:
Seizures:	Seizures:

Birth History

Was the pregnancy planned? Y or N (circle one) Was the pregnancy desired? Y or N (circle one)

Complications with the pregnancy: Y or N (circle one)
If Yes, please
explain:_____

Nausea:_____ Vomiting:_____ Swelling:_____ Headaches/Migraines:_____

Diabetes:_____ Other Illnesses:_____ Bed Rest:_____ How long?_____

Tobacco Use:_____ How much?_____ Alcohol use:_____ How much?_____

Prescription Drug Use: _____ What:_____ Illicit Drug
Use:_____What:_____

Length of pregnancy:_____ Was labor induced? Y or N (circle one)
Why?_____
_____

How was the child delivered? (i.e., vaginally, with
forceps)_____
_____

Complications during delivery? Y or N (circle one) If Yes, please
explain:_____
_____

Did this child require admission into the neonatal intensive care unit (NICU)? Y or No (circle one) If yes, please explain:
_____
_____

The child has met majority of his/her developmental milestones in a timely manner: _____Yes _____ No

Age child began: Crawling_____ Walking_____ Talking_____

The child's overall development has occurred: _____Slowly _____Normally _____Quickly

Medical History

Heart Problems	Y or No	If Yes, please explain:
Lung Problems	Y or No	If Yes, please explain:
Eye Problems	Y or No	If Yes, please explain:
Ear Infections/Tubes	Y or No	If Yes, please explain:
Speech Problems	Y or No	If Yes, please explain:
Sensory Problems	Y or No	If Yes, please explain:
Broken Bone(s)	Y or No	If Yes, please explain:
Surgery	Y or No	If Yes, please explain:

Allergies	Y or No	If Yes, please explain:
Asthma	Y or No	If Yes, please explain:
Seizures	Y or No	If Yes, please explain:
Head Injury/Concussion/ Unconsciousness	Y or No	If Yes, please explain:
Other:		Please explain:

Are the child's immunizations current? Y or No (circle one) If No, please explain:_____

Please list medications your child is currently prescribed or is using and for **what reason**:

_____

_____

_____

Academic History

What grade is this child in currently?_____ What school?_____

Has this child ever repeated a grade? Y or N (circle one) If Yes, what grade?_____

Has this child ever received special education services? Y or N (circle one) If Yes, for what?_____

Is this child currently experiencing academic problems? Y or N (circle one) If Yes, please explain:_____

Please describe what kind of grades/marks this child is currently receiving in school:_____

Has this child ever received any formal testing through the school? Y or N (circle one) If Yes, please explain:_____

_____

Does this child exhibit behavioral problems at school? Y or N (circle one) If Yes, please explain:_____

_____

Estimated intellectual level: _____ Below Average _____Average _____Above Average

Mental and Emotional History (Y=yes N=no ST=sometimes)

SYMPTOM	Y	N	ST	NOTES
Attention problems				
Hyperactive				
Academic problems				
Fails classes				
Memory problems				
Anger				
Anxiety				
Panic attacks				
Depression/Sad				
Irritable				
Suicidal ideation				

Elevated mood/manic				
Mood swings				
Obsessive- compulsive tendencies				
Aggressive				
Temper tantrums				
Lies				
Steals				
Disrespectful to adults				
Alcohol/substance abuse				
Toileting accidents/bedwetting				
Nightmares/terrors				
Hears things not there				
Difficulty making friends				
Lacks empathy				
Other difficulties				

Do you believe you do an effective job parenting this child? Y or N (circle one) Please explain:_____

_____

Discipline used that is most effective?_____
Least effective?_____

Do adults/caregivers in this child's life agree on how to discipline this child? Y or N (circle one) Is this a problem for you, this child, and/or your family? Y or N (circle one) Please explain:_____

_____

Has this child been abused? Y or N (circle one and all that may apply)

Sexually Verbally Physically Mentally Emotionally Other:_____

If Yes, who was the abuser? _____

Do you believe your child is sexually active? Y or N (circle one) If Yes, please explain:_____

_____

Have there been any significant deaths or losses in the family? Y or N If Yes, please explain:_____

Has this child ever participated in therapy? _____ Psychological testing?_____
With whom?_____ Diagnosis assigned?_____
Was the previous treatment beneficial? Y or N (circle one) Please explain:_____

Strengths and Weaknesses

What do you think are your child's biggest personal strengths?

1. _____

2. _____

3. _____

What do you think are your child's biggest personal weaknesses/limitations?

1. _____

2. _____

3. _____

_____ **Signature**

Donaldson Wellness Center
Kerry Donaldson, PhD #39407
508 Grace Street
Waxahachie, Texas 75165
972-923-0730
www.donaldsonwellnesscenter.com

INFORMED CONSENT TO TREAT CHILDREN
SOME THINGS YOU SHOULD KNOW ABOUT THERAPY

Before we start therapy together there are some things that you should know about the therapy process and about our office. In legal terms, this is called "Informed Consent." This information will help you understand better what to expect, and it will explain some limitations about what you, your child, and the therapist will be doing.

Your Privacy and Confidentiality

Of course, all of our work with your child – our conversations, your child's records, and any information that you give us – are protected by something called legal *privilege*. That means that in most cases the law protects you and your child from having information about you disclosed to anyone without your knowledge and permission. Our office respects your child's privacy, and we intend to honor that *privilege*. However, the law also makes some important exceptions to privacy.

In most cases parents enjoy full access to the information shared between your child and his or her therapist, and a similar right of access to the child's treatment record. That access is available to both parents regardless of the nature of the parents' relationship with one another or with the child. On the other hand, therapy with children is most effective when the child's relationship and communications with the therapist are allowed to remain substantially private. Your child's therapist will provide information to both parents, as needed and as requested and in a manner that will protect the privacy of the relationship and the child's welfare. Parents are encouraged to respect their child's privacy regarding the therapy to the greatest extent possible. Parents should not press children for information about the therapy outside the therapy office and outside the therapist's presence. Your child's therapist will regularly, and as appropriate, spends time discussing your child's progress with you. At your request, or when your child's therapist believes it is warranted, you may schedule an appointment to discuss specific treatment issues. Your child's therapist takes very seriously her responsibility to communicate with you and to protect your child's privacy.

If we believe there is a risk your child might harm himself, herself, or someone else, we may be called upon to contact the authorities to give them the opportunity to protect your child. If your child is being, or has been abused we are required to notify the authorities. If you become involved in any legal dispute about custody, possession, or parental rights and obligations, we may be compelled to provide information to the lawyers and/or to the court. That concern is especially important to understand if you and your child's other parent find yourselves in divorce litigation. Similarly, you and your child would lose the protection of privacy if you sue us or if you file a complaint against us with a state licensing board.

The financial part of our relationship also imposes some confidentiality limits. If you are using insurance or any third-party payer, our office must share certain information with them, including (but not necessarily limited to) diagnosis and the times of your visits. If there is a managed care company involved, they may require us to provide additional information, such as symptoms and progress. You should also understand that insurance and managed care information is often stored in national computer databases. By your signature, below, you authorize our office to provide information to your insurance and managed care companies to the extent necessary to enable them to pay for our services. Finally, if we find ourselves in a dispute with you over billing, our office reserves the right to employ a collection service and to provide them with any information necessary to clarify and to collect an outstanding balance.

Side effects of therapy and other potential unpleasantness

You should know that therapy is not always easy. Your child may have to discuss personal information. He or she may find those conversations difficult and embarrassing and might be very anxious during and after such conversations. As your child learns more about himself or herself, he or she might encounter increased conflict with friends, classmates, and family members. It is possible that your child might become somewhat depressed. Therapy is intended to alleviate those problems, but sometimes at first, as the process gets below the surface of some things, your child may feel things more acutely than in the past. We may also ask you and your child to do some things that might, at first, make both of you feel uncomfortable or awkward. Sometimes therapy requires trying new and unfamiliar ways of doing things. Your child will always be free to move at his or her own pace, however. We will work with your child to make changes, but we cannot promise anything about the results we will obtain. The outcome we achieve will depend on many factors.

Our office specializes in the treatment of specific issues and clients. If we believe that your child's problem requires knowledge that we do not have, we may refer you for a consultation with someone with training or experience different from our own. We will discuss any such referral with you before we act. At the very beginning we will create a treatment plan with you. That is, we will look at what you and your child would like to change, what we will

do to change it, how we will know we are succeeding, and we will estimate how long it will take to achieve your goals. Periodically, we will review that plan with you to see if it needs to be updated.

The Internet and Electronic Communication

You may, at your discretion, use email to communicate with your child's therapist. If you choose to communicate via email, remember that email communications are not private. Email is, by its nature, subject to pass through a variety of email servers and thus subject to interception by unknown parties. Email communication with our office should be limited to administrative and logistical matters; your therapist will NOT use email to discuss important personal and therapy matters. If you wish to communicate via email, please provide your preferred email address:

By my signature, below, I understand and I accept the limited privacy of email communications, and I authorize your office to communicate with me at the following email address:

Email: _____

Policy Regarding Inclusion of Both Parents

The rules that govern our practice require that, in the event that there is or has been a court order that directs your parental rights and obligations, our office must have a copy of that (final) order for our file. The law requires us to have a copy of the order before therapy can begin. We are obligated to abide by the court's order.

Further, it is a well-established standard of practice that children benefit most when both parents are involved in their child's therapy. Our office policy and the best standards of require that both parents be contacted and that both parents be included in the therapy. Unless a court order specifically restricts the other parent from receiving information, our office will contact the other parent within a week of your child's first contact with our office. If you have an objection or if you have reservations about our calling your child's other parent, please discuss your concerns with your child's therapist.

You should also be aware that as soon as your child attains his or her eighteenth birthday, the right to privacy and to control of the therapy effort passes to your child. Before your child reaches that age, you should discuss these considerations with your child's therapist.

Fees and Policies Regarding Litigation Services

Ordinarily, our office does not conduct evaluations in court- or litigation-related matters, nor do we customarily offer testimony in depositions or in court hearings. We believe that your interactions with your therapist should remain private, and the success of your work depends, in some part, on protecting you and your information from disclosure. Our office will do all that we can to avoid offering information or testimony about your child and his or her contact with our office in the context of litigation, although the courts or lawyer may be able to require our participation and disclosure. In the event we are required to respond to litigation-related request there are some additional, specific considerations.

If our office, or your therapist, does become involved as a witness in litigation related to your child's treatment, you will be required to pay, in advance, your child's therapist's litigation fees and for the cost of any appearance in court or for a deposition. By your signature below, you agree to the following payment terms:

1. For any deposition or court appearance regarding your child's therapy, whether commanded by you and your lawyer, or by an adversarial lawyer or party, you agree to pay your therapist $750 per half-day or $1500.00 per whole day for court appearances.
2. You agree to pay at least two additional hours for your therapist to review documents and to prepare for her appearance.
3. You agree to deposit with our office an advance retainer in the amount of $2,000. That amount will cover six hours' appearance and two hours' preparation. The retainer is fully refundable until five days before any scheduled appearance. Half of the retainer will be refunded if the appearance is cancelled within five days and more than forty-eight hours in advance of the scheduled appearance. With less than forty-eight hours' notice, any retainer balance is non-refundable.
4. Payment of these fees is due in advance as a retainer, due and payable at least ten days prior to any appearance. Our office will not schedule a deposition or court appearance until the retainer has been paid to our office.
5. In addition to the contracted fees for your child's therapist's time and appearance, if our office believes it is necessary to retain an attorney to represent your therapist's interests, you agree, by your signature, below, to reimburse our office for your therapist's attorney fees, up to a maximum of one thousand five hundred dollars ($1,500).

Agreement for Private Psychological Testing and Evaluation Services

If you are seeking services from our office for a psychological evaluation or for psychological testing rather than, or in addition to counseling/psychotherapy services, you should be aware of the following considerations.

I understand that the assessment services may include face-to-face interviewing and administration of tests, questionnaires, checklists, and other assessment methods. They may also include the psychologist's time required for the reading of records, consultations with other psychologists and professionals, scoring of tests, interpreting the results, constructing a report about the results and findings, and other activities to support these services. If you have questions or concerns about this assessment, the psychologist will answer your questions, although some answers may be deferred until after completion of the testing and interview.

Referral Source:

_____

I understand that the purpose of this evaluation is to provide information regarding the following question(s):

_____

I request that a report of the findings of this assessment will be sent to

Name:_____
Address:_____
Phone:_____
Fax:_____

Signature of Patient or Authorized Representative:_____

Printed Name:_____

I understand that the office of The Donaldson Wellness Center will perform the following services:

1. Psychological testing, assessment, or evaluation and will
2. Release the findings, conclusions, and recommendations to:

_____

I understand that if a diagnosis is assigned, the diagnosis is not made based on the results of any single assessment instrument alone. Rather a diagnosis is made while considering all test results, the clinical interview, historical information obtained, review of collateral documents, and observations made during the assessment.

I agree to cooperate and to participate as diligently I can by supplying full and accurate answers and making a sincere effort to do my best on all of the tests and interviews. I understand that I may refuse to answer any question or terminate the evaluation whenever I wish. I understand that the evaluator is required to notify authorities if the evaluator believes or suspects that a child is abused, or if the evaluator has reason to believe that I may harm others or myself. I have discussed the issues above with the psychologist who has answered any questions I have raised. I assert that I am fully competent to give informed and willing consent to this assessment.

I, the psychologist/therapist, have discussed the issues above with the client (and/or his or her parent or guardian) and answered any questions raised. My observations of this person's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

_____Date ___/___/___

Signature of psychologist/therapist

By my signature, below, I affirm to your office that I am the parent of _____, and that I have the legal right to consent to my child's treatment at your office.

By your signature below you consent to the treatment offered to your child by our office, you agree to pay for the services your child receives as indicated and at the time of service, and if you are using a third party (e.g. insurance) payer, you agree that our office may provide any information to your insurance carrier and managed care company necessary to consider, process, and approve payment for our services. Further, you agree that all charges for services are reasonable, and that finally, all fees are your responsibility, and that in the event your insurance carrier refuses payment, you agree to pay all amounts due. Your therapist may refuse to schedule an appointment until you have paid any outstanding balance you have with our office. If you are unable to pay for your child's services in the future, you understand and agree that your therapist will be unable to continue to work with you or your child. In that event, your therapist will provide you with a referral to another provider or providers more readily able to work within your budget.

_____ Date_____

Parent Signature

_____

Parent Printed name

_____ _____

Patient's Printed name Patient's Date of Birth

Consent for Telepsychology and Teleneuropsychological/ Telepsychological Assessment

This Informed Consent for Telepsychology contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully, and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Benefits and Risks of Telepsychology

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

Risks to confidentiality. Because telepsychology sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end I will take reasonable steps to ensure your privacy. But it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone or other device. You should participate in therapy only while in a room or area where other people are not present and cannot overhear the conversation.

Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies.

Crisis management and intervention. Usually, I will not engage in telepsychology with clients who are currently in a crisis situation requiring high levels of support and intervention. Before engaging in telepsychology, we will develop an emergency response plan to address potential crisis situations that may arise during the course of our telepsychology work.

Efficacy. Most research shows that telepsychology is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Electronic Communications

We will decide together which kind of telepsychology service to use. You may have to have certain computer or cell phone systems to use telepsychology services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in telepsychology. For communication between sessions, I

use email, TSecure portal, and text messaging with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with my office should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any clinical information by email or text and prefer that you do not either. Also, I do not regularly check my email or texts, nor do I respond immediately, so these methods should not be used if there is an emergency.

If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call.

Confidentiality

I have a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our telepsychology. However, the nature of electronic communications technologies is such that I cannot guarantee that our communications will be kept confidential or that other people may not gain access to our communications. I will try to use updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps to ensure the security of our communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device you use for telepsychology).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Informed Consent [use whatever title you have for your informed consent document] still apply in telepsychology. Please let me know if you have any questions about exceptions to confidentiality.

Appropriateness of Telepsychology

From time to time, we may schedule in-person sessions to "check-in" with one another. I will let you know if I decide that telepsychology is no longer the most appropriate form of treatment for you. We will discuss options of engaging in in-person counseling or referrals to another professional in your location who can provide appropriate services.

Emergencies and Technology

Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. To address some of these difficulties, we will create an emergency plan before engaging in telepsychology services. I will ask you to identify an emergency contact person who is near your location and who I will contact in the event of a crisis or emergency to assist in addressing the situation. I will ask that you sign a separate authorization form allowing me to contact your emergency contact person as needed during such a crisis or emergency.

If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, [include any local hotlines or other resources], or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive communication back within a reasonable amount of time, then call me on the phone number I provided you (972.975.2007) or email us.

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

Fees

The same fee rates will apply for telepsychology as apply for in-person psychotherapy. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be solely responsible for the entire fee of the session. Please contact your insurance company prior to our engaging in telepsychology sessions in order to determine whether these sessions will be covered.

Records

The telepsychology sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

Informed Consent

This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement.

Your signature below indicates agreement with its terms and conditions.

Signature

Date

No show/Late Cancellation Policy

This policy has been established to help us serve you better.

It is necessary for us to make appointments in order to see our clients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another client.

A "no-show" is missing a scheduled appointment. A "late-cancellation" is canceling an appointment without calling us to cancel within 24 hours of an office appointment or 72 hours in advance of psychological testing.

We understand that situations such as medical emergencies occasionally arise. These situations will be considered on a case-by-case basis.

A charge of $75 will be assessed for each no show or late cancellation office visit appointment if less than 24 hours' notice is given.

A charge of $250 will be assessed for each no show or late cancellation psychological testing appointment if less than 72 hours' notice is given.

Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

For your convenience, you can cancel or reschedule an appointment 24/7 by leaving a voicemail or emailing donaldsonwellness@gmail.com. This policy is in effect to ensure that all of our clients have the opportunity to be seen in a timely manner.

_____ Date_____

Patient Acknowledgement (Please sign)

CREDIT CARD AUTHORIZATION FORM

Our office requires that a credit card be kept on file for payment of any co-payment, co-insurance, deductible, or charge that may not be covered by your health insurance. This form will be kept confidential and only authorized staff has access to the information.

PATIENT'S NAME: _____

NAME, AS IT APPEARS ON CREDIT CARD:

_____

BILLING ADDRESS: _____

_____

EMAIL ADDRESS: _____

AMEX/DISC/MC/VISA CARD #_____

EXPIRATION DATE_____/_____ CVV CODE: _____

PLEASE PROVIDE THE CARDHOLDER'S DRIVER'S LICENSE

I acknowledge and authorize The Donaldson Wellness Center to charge the above credit card account for any co-payment, co-insurance, deductible and/or charges not covered by my health insurance provider. I acknowledge that my card will be charged in the event payment is not received. I agree to receive billing statements, invoices and receipts to my email. If I am an uninsured patient, I authorize payment at time of service. I agree to update any information regarding this credit card account as applicable.

_____ _____

Cardholder Signature Date

Email _____