

B. KERRY BROWN | LCSW, MSW, CBA

Providing Quality Individual, Couples, & Family Counseling,
Behavior Management Consulting, and Mediation Services

8080 NORTH 56TH STREET • TEMPLE TERRACE, FL 33617

OFFICE 813.988.4788 • FAX 813.987.9716 • PAGER 813.963.8770

www.BKerryBrown.com email: bkerrybrown@juno.com

CLIENT INFORMATION

The following information is required for client records and billing purposes. This information will be placed ONLY in your personal file and our protected computerized billing system. Strict confidentiality will be maintained to the highest ethical and legal standards. **Please complete this form in its entirety.**

Client Name: _____ Email: _____

Sex: _____ Age: _____ Date of Birth: ____/____/____ Marital Status: _____

Street Address: _____ Home Phone: _____

City: _____ State: _____ ZIP: _____ Cell Phone: _____

SS#: _____ - _____ - _____ DL#: _____ Pager: _____

Occupation: _____ Employer: _____

Business Address: _____ Work Phone: _____

City: _____ State: _____ ZIP: _____ Yearly Salary Range:

- | | |
|--|--|
| <input type="checkbox"/> \$0 - \$19,999 | <input type="checkbox"/> \$80,000 - \$99,999 |
| <input type="checkbox"/> \$20,000-\$39,999 | <input type="checkbox"/> \$100,000-\$119,999 |
| <input type="checkbox"/> \$40,000-\$59,999 | <input type="checkbox"/> \$120,000-\$149,999 |
| <input type="checkbox"/> \$60,000-\$79,999 | <input type="checkbox"/> \$150,000 and above |

Person Responsible for Payment: _____ R/ship to Client: _____

Street Address [if different than above]: _____ Home Phone: _____

City: _____ State: _____ ZIP: _____

SS#: _____ - _____ - _____ DL#: _____

Referred By: _____ R/ship to Client: _____

I certify that the information supplied on this form is accurate and correct to the best of my knowledge. I understand that my insurance policy is an agreement between myself and my insurance company, and not with my therapist. I understand that B. Kerry Brown is a "fee for service" provider and does not provide insurance billing. I understand that payment is due at time of service. Upon request, I will be provided a receipt for services rendered with all necessary information to allow me to personally file for reimbursement according to my insurance plan. I further understand and agree that all broken appointments and appointments cancelled with less than 24 hours notice are subject to full charge, at the sole discretion of my therapist. I understand that I am responsible for all outstanding balances. Accounts sixty (60) days or more past due may accrue interest at a rate of 2% per month. Should it become necessary for any balance to be placed for collection, I hereby agree to pay for any/all collection costs, including all attorney's fees and court costs.

Client Signature Today's Date: ____/____/____

B. KERRY BROWN, LCSW, MSW, CBA

*Providing Quality Individual, Couples, & Family Counseling,
Behavior Management Consulting, and Mediation Services*

8080 NORTH 56TH STREET • TEMPLE TERRACE, FL 33617

OFFICE 813.988.4788 • FAX 813.987.9716 • PAGER 813.963.8770

www.BKerryBrown.com email: bkerrybrown@iuno.com

CONSENT FOR TREATMENT

I, _____, GIVE MY CONSENT TO RECEIVE CLINICAL MENTAL HEALTH TREATMENT SERVICES FROM B. KERRY BROWN, LCSW, MSW, CBA.

I UNDERSTAND THAT AN INITIAL ASSESSMENT OF MY TREATMENT NEEDS WILL BE REQUIRED BEFORE A TREATMENT PLAN CAN BE RECOMMENDED. I AGREE TO COOPERATE, IF REQUESTED, IN THE COMPLETION OF A WRITTEN QUESTIONNAIRE TO ASSIST IN THE DEVELOPMENT OF A NEGOTIATED TREATMENT PLAN. I UNDERSTAND THAT I HAVE THE RIGHT TO TERMINATE TREATMENT OR REFUSE TREATMENT AT ANY TIME. I AGREE TO GIVE NOTICE OF SUCH INTENT BEFORE I TERMINATE TREATMENT.

STRICT CONFIDENTIALITY WILL BE MAINTAINED TO THE HIGHEST ETHICAL AND LEGAL STANDARDS. INFORMATION CONCERNING MY PROGRESS DURING TREATMENT WILL BE REVIEWED AND RECORDED PERIODICALLY IN ACCORDANCE WITH THESE STANDARDS. HOWEVER, NO INFORMATION WILL BE RELEASED, EITHER VERBALLY OR IN WRITING, TO ANYONE FOR ANY REASON WITHOUT MY EXPRESSED WRITTEN OR DOCUMENTED VERBAL CONSENT. **THERE ARE TWO LEGAL EXCEPTIONS TO THIS STANDARD OF CONFIDENTIALITY. THE FIRST IS AN ORDER BY A JUDGE TO RELEASE MEDICAL RECORDS OR TESTIFY IN A LEGAL PROCEEDING. THE SECOND IS THE EXISTENCE OF ACTUAL OR SUSPECTED ABUSE OR NEGLECT OF A MINOR CHILD, ELDERLY PERSON, OR DISABLED PERSON. UNDER THESE CIRCUMSTANCES, I UNDERSTAND THERE EXISTS A LEGAL OBLIGATION ON THE PART OF MY THERAPIST TO RELEASE OR REPORT PRIVILEGED INFORMATION.**

I UNDERSTAND THAT FEES FOR SERVICES ARE EXPECTED AT THE TIME THAT SERVICES ARE RENDERED. FEES PER THERAPY HOUR (45-50 MINUTES) MAY BE PAID BY CASH, CHECK, OR CREDIT CARD. IF EXTENUATING CIRCUMSTANCES PREVENT PAYMENT, IT IS MY RESPONSIBILITY TO DISCUSS THIS WITH MY THERAPIST AND NEGOTIATE AN ACCEPTABLE PAYMENT AGREEMENT. I UNDERSTAND THAT MY INSURANCE POLICY IS AN AGREEMENT BETWEEN MYSELF AND MY INSURANCE COMPANY, NOT WITH MY THERAPIST. I UNDERSTAND THAT MY THERAPIST **DOES NOT** PROVIDE INSURANCE BILLING FOR CLIENTS. UPON REQUEST, I WILL BE PROVIDED A RECEIPT FOR SERVICES RENDERED WITH ALL NECESSARY INFORMATION INCLUDED, AND WILL MYSELF BE SOLELY RESPONSIBLE TO FILE FOR REIMBURSEMENT ACCORDING TO MY INSURANCE PLAN.

I ALSO UNDERSTAND AND AGREE THAT ALL MISSED APPOINTMENTS AND APPOINTMENTS CANCELLED WITH LESS THAN 24 HOURS NOTICE ARE SUBJECT TO FULL CHARGE. AN APPOINTMENT CARD WILL BE PROVIDED ME UPON REQUEST, BUT NO OTHER REMINDER WILL BE GIVEN AS IT IS MY RESPONSIBILITY TO KEEP OR RESCHEDULE APPOINTMENTS IN A TIMELY MANNER.

Client Signature

Today's Date: ____/____/____

Parent/Guardian Signature [if patient is a minor]

Today's Date: ____/____/____

B. KERRY BROWN, LCSW, MSW, CBA

*Providing Quality Individual, Couples, & Family Counseling,
Behavior Management Consulting, and Mediation Services*

8080 NORTH 56TH STREET • TEMPLE TERRACE, FL 33617

OFFICE 813.988.4788 • FAX 813.987.9716 • PAGER 813.963.8770

www.BKerryBrown.com email: bkerrybrown@iuno.com

CANCELLATION POLICY

ONE COMPONENT OF THERAPY IS A CONTRACTUAL AGREEMENT BETWEEN THERAPIST AND PATIENT TO PAY FOR THERAPY SERVICES PROVIDED. AN APPOINTMENT IS SET ASIDE FOR ME, AND I UNDERSTAND THAT BREAKING AN APPOINTMENT OR CANCELLING WITHOUT SUFFICIENT NOTICE PREVENTS THE POSSIBILITY OF SCHEDULING A PATIENT ON A WAITING LIST, AND ALSO RESULTS IN A LOSS OF INCOME FOR MY THERAPIST. AS SUCH, I UNDERSTAND AND AGREE THAT ALL BROKEN APPOINTMENTS (NO SHOWS) AND APPOINTMENTS CANCELLED WITH LESS THAN 24 HOURS NOTICE ARE SUBJECT TO FULL CHARGE. AN APPOINTMENT CARD WILL BE PROVIDED TO ME UPON REQUEST, BUT NO OTHER REMINDER WILL BE GIVEN. TO AVOID THE FULL CHARGE OF \$100.00 FOR EACH SCHEDULED THERAPY HOUR MISSED, IT WILL BE MY RESPONSIBILITY TO KEEP OR RESCHEDULE APPOINTMENTS IN A TIMELY MANNER.

Client Signature

____/____/____
DATE