THE COUNSELING GROUP
2840 SW 3rd Avenue
Miami, Florida 33129
Phone (305) 857-0050 Fax (305) 854-4948

## INFORMATION UPDATE

To better serve you, we try to maintain our client information as updated as possible. Please complete what has changed since your last visit.

Name of Client:_____Date_____
Name of Parent/Legal Guardian (if minor):_____
_____
Address: _____ City: _____ State: ___ Zip Code:_____
Phone: _____ May we leave a message? Yes_____ No_____
Email Address: _____

## MEDICAL HISTORY

Primary Physician or Specialist:_____
Address: _____ City: _____ State: ___ Zip Code:_____
Phone: _____
List of Significant Health Problems: _____
_____
List any medication you are taking, dosage, and frequency: _____
_____

## INSURANCE INFORMATION

Insurance Carrier: _____ Ins. Phone Number: _____
Member #: _____Group/Plan/Policy/Account#: _____

## FINANCIAL AGREEMENT

All financial obligations are to be met at the time services are rendered. Any past due amount exceeding two sessions will result in an interruption of your treatment. If you have insurance, we will contact your carrier to verify eligibility and benefits. However, verification of benefits does not guarantee payment. **If the insurance company does not provide expected coverage, you will be held responsible for the agreed upon fee.** We accept checks, cash, debit cards, and all major credit cards. Below is the credit card authorization. We will charge a fee of $25.00 for any returned checks. Additional professional services, such as phone contacts, preparation of reports, school visits, court time, and/or consultation with other professionals, etc. rendered by your provider, will be charged on a prorated basis to you.

_____ _____
Signature Date

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## CANCELLATION POLICY

Please be aware that your appointment time has been reserved exclusively for you. Due to the nature of our services, it is important that a twenty-four (24) hour cancellation notice is given. ***If the required advanced notice is not provided, you will be charged for the full agreed upon hourly rate. Insurance companies cannot be billed for missed appointments.***

## CREDIT CARD AUTHORIZATION

I authorize The Counseling Group to keep a copy of my credit card on file and to charge my account as per the above financial agreement and cancellation policy. Credit card and the information submitted will remain confidential.

Type of card: _____ Billing Zip Code: _____

Credit Card # _____Exp. Date _____

Card Holder's Name (if different from client)_____

* I authorize The Counseling Group to speak with the cardholder regarding any financial matters, when indicated.

_____ _____

Signature Date