Maggie Alexander, PMHNP
(503) 523-9629
3095 SW 118th Ave Beaverton, OR 97005

Intake Information: Adult

Today's date: ______________________________

Name ____ DOB ____________Gender_______ Age_____ Race/Ethnicity________________

Address____City__________________State_______Zip_________________

Telephone home ________________________ work_______________________ cell______________________________

May I leave a message for you at home? ☐Yes ☐No at work? ☐Yes ☐No on cell? ☐Yes ☐No

Emergency Contact ________________________ Relationship __________________________ Phone ___________________

May I email you? If so, email: _____________________________________ How did you hear about me?_____________________________

Marital Status ☐single ☐ married ☐partnered ☐divorced ☐separated ☐widowed ☐other:__________________________

Names of those that you live with and their relationship to you:

Name ___________________________ Relationship _______________________________

Name ___________________________ Relationship _______________________________

Name ___________________________ Relationship _______________________________

Name ___________________________ Relationship _______________________________

Occupation __________________________________ Employer____________________________________Years of Education_____________

Sexual ID: Heterosexual____ Bisexual____ Lesbian____ Gay Male____ Transgendered____ Comment____________________________________

Describe the problem that brought you here: (more space on the last page if you wish to write more)

Please check all of the behaviors and symptoms that you currently consider problematic:

☐Distractibility	☐Change in appetite	☐Suspicion/paranoia
☐Hyperactivity	☐Lack of motivation	☐Racing thoughts
☐Impulsivity	☐Withdrawal from people	☐Excessive energy
☐Boredom	☐Anxiety/worry	☐Wide mood swings
☐Poor memory/confusion	☐Panic attacks	☐Sleep problems
☐Seasonal mood changes	☐Fear away from home	☐Nightmares
☐Sadness/depression	☐Social discomfort	☐Eating problems
☐Loss of pleasure/interest	☐Obsessive thoughts	☐Gambling problems
☐Hopelessness	☐Compulsive behavior	☐Computer addiction
☐Thoughts of death	☐Problems with pornography	☐Aggression/fights
☐Self-harm behaviors	☐Frequent arguments	☐Parenting problems
☐Crying spells	☐Irritability/anger	☐Sexual problems
☐Loneliness	☐Thoughts of hurting others	☐Relationship problems
☐Low self-worth	☐Flashbacks	☐Work/school problems
☐Guilt/shame	☐Hearing voices	☐Alcohol/drug use
☐Fatigue	☐Seeing things	☐Phobias
☐Anorexia	☐Shortness of breath	☐Overspending
☐Bulimia	☐Sweating	☐Chronic pain
☐Weight changes	☐Heart racing	☐Problems focusing

☐Other ____

Are your problems affecting any of the following?

☐Handling everyday tasks	☐Self-esteem	☐Relationships	☐Hygiene
☐Work/School Housing	☐Legal matters	☐Finances	☐Health
☐Recreational activities	☐Sexual activity	☐Other ________________________	

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History of past mental health problems/diagnosis? ☐Yes ☐No

Diagnosis Dates treated or age By whom Comments

_________________ _________________ _________________ ___________________________________

_________________ _________________ _________________ ___________________________________

_________________ _________________ _________________ ___________________________________

Experience with a Therapist? ☐Yes ☐No Helpful? ☐Yes ☐No Comment ____

Experience with a PMHNP? ☐Yes ☐No Helpful? ☐Yes ☐No Comment ____

Experience with a Psychiatrist? ☐Yes ☐No Helpful? ☐Yes ☐No Comment ____

Medications previously taken for mental health issues:

Name Length of use Dosage Usefulness/Side Effects/Concerns?

_______________________ _________________ ______________________ ____

_______________________ _________________ ______________________ ____

_______________________ _________________ ______________________ ____

_______________________ _________________ ______________________ ____

_______________________ _________________ ______________________ ____

Previous hospitalization for mental health problems? ☐Yes ☐No Please explain circumstance: ____

____

Please note presence of family history of mental health problems:

Issue	Relationship to you	Age of Diagnosis?	Treatment?
☐Depression			
☐Anxiety			
☐ADHD/ADD			
☐Bipolar (manic/depressive)			
☐Post-traumatic stress disorder			
☐Schizophrenia			
☐Alcohol abuse			
☐Other substance abuse			
☐Suicide/or attempted			
☐Other			

Date of Last physical ___/___/______ List medical concerns: ____

Name of Primary Care Provider ____ Phone__________________________

Address____Fax ____________________________

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Allergies? ☐Yes ☐No If Yes, list: ____

Suicide Attempt or Thoughts? ☐Yes ☐No If Yes, when ________________ where ____________________ **got help?** ☐Yes ☐No

History of Abuse (physical____, sexual____, emotional____)? Comment ______________________________________

Diet on a typical day____

____

Exercise in a typical week____

Current prescription medication/ Over the counter meds/ Herbal remedies / Nutritional Supplements:

Name	Dosage/Frequency	Purpose	Provider's Name

Presence of personal or family medical problems (Check if Yes):

	Personal History	Current You	Family History	Relationship to you?	Comment
Thyroid Disease					
Anemia					
Liver Disease					
Kidney Disease					
Heart Disease					
Diabetes					
Asthma					
Stomach Intestinal					
Problems					
Cancer					
Epilepsy					
Pain					
High Cholesterol					
High Blood Pressure					
Head trauma					
Alcohol					
Drugs					
Cigarette					
Caffeine					
Other:					

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Height: ________ **Weight:**________ Weight Range in past 3 years: ________ to ________ Ideal Weight: ________

Sleep: Ave # of hrs/night _________ Go to bed @____________ Get up @___________ # of wakings _____________

Sleep aides/meds ____

Nightmares ☐Yes ☐No Comment ____

____

All Electronics: Ave # of hrs/day _____ Favorite kinds____

Friends: Ave # of hrs/week _____ Favorite things you like to do with them ____

Hobbies you've done in the past year: ____

More details about what brought you in to see me today:

____

____

____

What are you most hoping to accomplish by coming to see me?

____

____

____

Other Questions or Comments?

____

____

____

____ ___________________________

Client Signature **Date**

Maggie Alexander, PMHNP
(503) 523-9629
3095 SW 118th Ave Beaverton, OR 97005

Notice of Privacy Practices and Professional Disclosure Statement
Receipt and Acknowledgment of Notice

Client Name: ____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Maggie Alexander, PMHNP's Notice of Privacy Practices and Professional Disclosure Statement. I understand that if I have any questions regarding the Notice or my privacy rights I can contact Maggie Alexander, PMHNP.

____

Signature of Client **Date**

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: ________________________________ Relationship to Client: ________________________________

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

This form will be retained in your medical record

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POLICY STATEMENT

Confidentiality
Communication between client and provider/therapist is confidential, even if the client is a minor, and may be shared only for the purpose of consultation without the client or parent/guardian present. You will be informed in the event that any information is released without your express consent. Information may be released without written permission only: 1) if a court order is received, 2) when there is reasonable cause to believe that child/elder abuse or neglect has occurred, 3) when there is reasonable cause to believe that there is clear and imminent danger to self and/or others, 4) when a medical emergency exists, and 5) when required for insurance billing. **A release of information must be signed before any information can be provided to or requested from other individuals or agencies.**

Client Responsibilities
- Become actively involved in the treatment goals and share periodic reviews with your provider to assure each other of productivity and that we are working toward desired outcomes. If the client is a minor, the parent(s)/guardian(s) of the child agree to actively participate in the healing of the family by establishing family treatment goals
- Assume control of all payments to the provider at the time of the appointment
- Notify the provider no less than 48 hours in advance of any cancellations.
- Failure to comply with the cancellation policy will result in a missed appointment fee. Insurance companies do not typically reimburse patients for these costs and the client will be directly held responsible for these costs.

Telephone Messages and Emergency Coverage
You may reach me or leave a voiceN mail for me at 503N 523-9629. I work part time and only return calls on days I am in my office. If I am away for an extended time period, the message will direct you as to who is providing coverage for my patients. In the event of an emergency, call 911 or go to the nearest emergency department. I do not carry a 24N hour pager.
In the event of a crisis, you may contact:
- Emergency (police, fire, ambulance) 911
- Multnomah County Crisis Line 503-988-4888 or 1-800-716-9769
- Washington County Crisis Line 503-291-9111
- Clackamas County Crisis Line 503-655-8401
- Clark County Crisis Line 360-696-9560
- Portland Women's Crisis Line (domestic violence) 503-235-5533
- Rape Crisis Center 503-640-5311
- Poison Control 503-494-8968 or 800-452-7165
- Oregon Council on Alcoholism and Drug Abuse Hotline 800-923-4357
- Cascadia 24-hour Urgent Walk-In Clinic (Located at 2415 SE 43rd Ave – near Division)

Prescription Refills
- Refills of medication usually are written at the time of your scheduled appointment.

- Prescription refills are not emergencies, and must therefore be handled during regular business hours- Mon-Friday, 9 am-5 pm.
- Please contact your pharmacy and have them fax me a refill request at 503 992-6625 allowing 72 hours for refills to be completed on business days.

Payment Agreement

1. It is your responsibility to know if your insurance covers my services. Charges not covered by your insurance are your responsibility. It is also your responsibility to notify me of any changes in insurance coverage.
2. It is customary to pay for professional services when rendered. Payments must be made or services may be discontinued.
3. If you have a balance on your account, you will receive a statement. All accounts are due and payable within thirty days of notification. If payment is not received within 60 days, a late fee will be applied. If a client fails to be responsible for the account, and it is necessary to place a delinquent account into the hands of a collection agency/attorney, the client agrees to pay all court costs affixed by the court.
4. If you have a question regarding the payment of fees, please discuss this with me.
5. If you late cancel (cancel with less than 48 hour notice) or miss an appointment, you will be charged the total appointment fee. Insurance companies typically do not pay these fees and it will be your responsibility to pay these costs. Additionally, insurance companies do not typically pay charges for phone sessions or written documentation. You will be asked to pay for these charges directly.
6. All checks are to be made out to Maggie Alexander, NP.
7. There is a $35 service charge for NSF/Returned checks.

Length of Treatment

Individual therapy typically involves regularly scheduled weekly or bi-weekly sessions.
Medication management sessions are more frequent in the beginning, or after any changes are made, and then typically occur monthly or bi-monthly. Duration of treatment varies depending on the nature of the treatment and individual client needs. When medications are used in psychiatry, please be advised that they are frequently used “off-label” meaning that they are used to control symptoms other than what the FDA originally approved the medication to treat. This is especially true in children. Patients must be seen at minimum every 90 days to be considered active patients with Maggie Alexander, PMHNP. Should you not schedule an appointment for a period of 90 days and make no arrangement in writing with this provider for said time, you will no longer be considered an active client of Maggie Alexander, PMHNP and therefore have terminated treatment. Also, if you “no show”/ “late cancel” for two consecutive appointments or “no show”/ “late cancel” for one appointment and do not reschedule within thirty days, you will be considered to have terminated treatment with Maggie Alexander, PMHNP.

Grievance Procedure

I encourage you to discuss your complaint with me directly to resolve the problem/issue. You may also contact your insurance company. Additionally, I am licensed through the Oregon State Board of Nursing. It also has a process for hearing complaints. You may contact the Oregon State Board of Nursing at: 17938 SW Upper Boones Ferry Road, Portland, OR 97224-7012, or at (971) 673-0685.

Client Endorsement
After reading these, policies please sign below. By signing you express that you understand these policies. You can request a signed copy for your records. I have read this policy statement and understand its provision.

PRINTED CLIENT*: ____

SIGNED: ____

DATE: ______________________________________

*IF CLIENT 14 years or older, must be signed by client

PRINTED NAME of PARENT / GUARDIAN: ____

SIGNED: ____

DATE: ______________________________________

INFORMED CONSENT FOR EVALUATION AND TREATMENT

1. You have the RIGHT TO BE INFORMED REGARDING The terms UNDER WHICH TREATMENT OR EVALUATION WILL BE PROVIDED. Policies related to charged; billing third party payers, appointments, emergencies, and coverage for when your provider is unavailable, and other matters will be explained or provided to you. It is your responsibility as a client to stay informed.
2. You have the RIGHT TO CHOOSE THE BEST TREATMENT AND PROVIDER. There are a variety of professionals offering counseling, psychotherapy, psychiatric evaluation. There are also a number of different approaches to working with human issues. It is your right and responsibility to choose the treatment and provider that best matches your needs. You also have a right to a detailed explanation or any treatment or procedure your provider may choose to use including the risks involved and the side effects if any. If you believe you are not receiving the treatment you require, then raise this concern with your provider and she will work with you to revise your treatment plan or to refer you to other professionals who may be able to meet your needs.
3. You have the RIGHT TO KNOW THE QUALIFICATIONS AND TRAINING of your provider. You may request a provider information sheet from your provider. If you have concerns, complaints, or believe a breach of professional conduct has occurred, you may contact the provider directly. If the difficulty is not resolved, you have the right to make a formal complaint to the Oregon State Board of Nursing.
4. You have the RIGHT TO REFUSE TREATMENT OR TO STOP TREATMENT at any time and for any reason. In the case where a minor is the patient/client, then parent(s) or legal guardian has the right to refuse or stop treatment for the minor. You also have the right to refuse or stop evaluations. Your provider also has the right to refuse or terminate treatment, in which case you will be provided with alternatives. If you have concerns regarding your treatment or wish to discontinue, you are encouraged to discuss this with your provider.
5. You have the RIGHT TO CONFIDENTIALITY. This means that what you tell your provider and what is contained in your clinical file will not be repeated or released by the provider to anyone else without your expressed permission (i.e. by a signed release of information). You have the right to see and have access to the contents of your file. You have the right to discuss your own therapy or evaluation with anyone you choose, including another provider.
6. For minors 14-17 years old, psychiatric mental health nurse practitioners may provide treatment to a fourteen year-old without consent of his/her parent. Oregon law requires your provider to have your parents involved in treatment before the end of treatment unless there are clear clinical indications to the contrary, which must be documented in your clinical chart. Maggie Alexander, PMHNP does not need to involve your parents in treatment if you have been sexually abused by your parent or if you are emancipated. It is the policy of Maggie Alexander, PMHNP to notify the parents on or before the third session. By signing this informed consent document you:

a. Authorize Maggie Alexander, PMHNP to contact your parents and to give them a summary of your treatment.
b. Authorize your provider to use her best clinical judgment on when to inform you parents of important issues related to your treatment.
c. Authorize Maggie Alexander, PMHNP to release your treatment records to your parents upon their request. It is the policy of Maggie Alexander, PMHNP to require both you and your parents to sign any release of information to anyone other than your parents.

There are, however, some limits and exceptions to complete confidentiality:

a. CHILD OR ELDER ABUSE: Generally, providers are required by law to report any known or suspected cases of child or elder abuse to the Children's Services Division or other appropriate state agency.
b. VIOLENCE: If a provider learns that someone is about to kill or to do harm to someone else, she will do her best to warn the intended victim.
c. SUICIDE: If a provider earns that a client intends to harm her/himself, the provider will breach confidentiality to the extent necessary for the client's protection.
d. NON-CUSTODIAL PARENTS: By law, non-custodial parents can gain access to their children's records pertaining to treatment or evaluation.
e. SUPERVISION: Your provider may present your case in clinical staffing and also periodically review and discuss your treatment.

CONSULTATION: Occasionally, it is in your best interest for your provider to consult other providers regarding your treatment (e.g. medication issues, family issues, obtaining another's expert opinion, covering emergency phone calls, etc.). This will be carried out with the utmost consideration for your privacy.
INSURANCE: Insurance companies or their designated management company may require information about your diagnosis, treatment history, prognosis, treatment, or other relevant information in order to authorize services or process claims. A release of information will be obtained for this if you are utilizing an insurance company.

I have read and understand my rights and responsibilities as outlined in Maggie Alexander, PMHNP informed consent for evaluation and treatment form. Furthermore, by signing this form, I consent to receive mental health services to be provided by Maggie Alexander, PMHNP.

PRINTED NAME: ___________________________________ DATE:_______________________

SIGNED*: ____ *If client 14 years or older must be signed by client.

PRINTED NAME of PARENT / GUARDIAN: ____

RELATIONSHIP TO CLIENT: ____

SIGNED: ____ DATE: _______________________________

3095 SW 118th Ave Beaverton, OR 97005
phone 503N 523-9629
fax 503-992-6625

Maggie Alexander, PMHNP, LLC **Psychiatric Mental Health Nurse Practitioner**

Authorization to Use and Disclose Protected Health Information (PHI) to Insurance

Client Name ____ DOB____/______/______
Street Address: ____
City, State, Zip Code: ____
Telephone Number: ______________________________ Social Security Number:_______________________________

I, the under signed, hereby authorize Maggie Alexander, PMHNP, to send information to billing representatives. I, the undersigned, hereby authorize Maggie Alexander, PMHNP and its billing representatives to send information to:
Insurance Company: ______________________________ Subscriber: ____________________________________
ID Number: ______________________________________ Group/Policy #: _______________________________

Secondary Insurance : No Yes:
Insurance Company: ______________________________ Subscriber:_________________________________
ID Number : _____________________________________ Group/Policy #: _____________________________

I, the undersigned, certify that I have Neither Medicare or Medicaid.

Purpose of Disclosure (please initial):
____ Authorize to bill insurance named above and coordination of billing issues between Maggie Alexander PMHNP its billing representatives

Information to be released is (please initial):

_____ Diagnosis
_____ Psychosocial History
_____ Treatment plan or summary
_____ Psychological Evaluation/Reports
_____ Psychotherapy Notes
_____ Chemical Dependency
_____ HIV or AIDS information
____ Other

Required Statements:
I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under Federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment from Maggie Alexander, PMHNP, unless the health care services are solely for the purpose of providing health information to someone else and the authorization is needed to make the disclosure. If I do not sign this authorization, I understand that Maggie Alexander, PMHNP, will not be able to bill my insurance. I will be required to pay "Cash Pay" based on the fair and customary rate for all mental health treatment at Maggie Alexander, PMHNP.

I may revoke this authorization in writing at any time. If I do so, the information described may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made cannot be undone. If I revoke this authorization, I understand I will enter into the "Cash Pay" arrangement described above as Maggie Alexander, PMHNP, will not be able to bill my insurance.

This written authorization is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance hereon. If not earlier revoked, or by other agreement specified below, this authorization shall expire twelve months from the date signed. Other (specified): ________

I have read this authorization and understand it.

____

Signature of Client Date

____ ________________ ______

Subscriber Signature *Relationship to Client* *Date* *DOB of Client*
*If patient is 14 years or older form must be signed by patient.

Subscriber SSN if subscriber is a minor: ________________________________

3095 SW 118th Ave Beaverton, OR 97005
phone 503 523-9629
fax 503 992-6625

Maggie Alexander, PMHNP, LLC **Psychiatric Mental Health Nurse Practitioner**

3095 SW 118th Ave Beaverton, OR 97005 Telephone: 503 523-9629 9766 Fax: 503 992-6625

6625 **CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO THE PRIMARY CARE PROVIDER**

I,____, hereby authorize Maggie Alexander, PMHNP to receive information from and/or send information to the clinician indicated below. This release pertains to the following types of information: medical history, mental or physical conditions or treatment, including information relating to my mental health diagnosis and/or substance abuse diagnosis and treatment to my primary care provider.

Clinician Name: ____

Clinician Address (Street, City, and Zip): ____

Clinician Phone Number and/or Fax Number: ____

This authorization for release extends to the care and treatment the client received during:

□ All dates of service or

□ Service between_______________________________________and ______________________

This information may be used for the following purpose(s):

□ Evaluation, assessment and/or treatment and/or □ Ongoing coordination of treatment and/or

□ Other: ____

The information to be released is:

□ Diagnoses □ Psychological Evaluations/Reports □ Medical Evaluations

□ Treatment Plan or summary □ Chemical Dependency Information □ Other: ______________________________

This written consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance hereon. If not earlier revoked, or by other agreement specified below, this consent shall expire:

One year from date signed or □ Upon termination of treatment or □ Other:_____________________________

____ ______________________

Signature of client, parent, or legal guardian Date signed

____ ______________________

Witness Date signed

FOR Maggie Alexander, PMHNP TO COMPLETE:

Primary Care Provider: ____

The purpose of this letter is to notify you that your patient____, (DOB:_____________)

has begun mental health services with me. I believe it is important to coordinate mental health medical services with the medical care, which you are providing. I will contact you as needed to discuss any concerns or questions that I have regarding our client's mental health issues. Please send any information that you deem important to the mental health services being provided or call. Thank you. DSM-V Diagnosis:

Axis I:____

Axis II:____

Known Current Psychotropic Medications: □ None ____

____

Medical Condition/s: ____

Treatment (Therapy) Modalities: □ Individual □ Family □ Couples □ Group □ Other:

Estimated Length of Treatment: □ 3 months □ 6 months □ 9 months □ Other:

Please help monitor these risks: □ None □ Suicidal Ideation □ Homicidal Ideation □ Poor self-care

Coordination of Care Issues: ____

____

____ _________________________

Maggie Alexander PMHNP **Date**

Maggie Alexander, PMHNP, LLC   Psychiatric Mental Health Nurse Practitioner

3095 SW 118th Ave Beaverton, OR 97005 • Telephone: 503 523 -9629 • Fax 503 992- 6625

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Client Name ____DOB ______/_____/_____
Street Address: ____
City, State, Zip Code: __________________________/________________/_________________
Telephone Number: __________________________

I authorize Maggie Alexander, PMHNP, LLC

Check appropriate spaces and initial and give complete name and address:

___**To give health records to:**
___**To receive health records from:**
___**To verbally exchange health information with:**

Name: ____
Street Address: ____________________________________
City, State, and Zip Code: ___________________________
Telephone: ____
Fax Number: _______________________________________

For the purpose of continuing care or: ____
___ **All information in chart**
___**Specific information to be released:**____,
if such information exists:

____Mental health related information
____Drug/alcohol diagnosis, treatment or referral information
___HIV/AIDS related records
___Genetic testing information

As indicated below, the authorization for release extends to the care and treatment the client received during:

____ All dates of service
_____ Service between ______________ and _______________

Required Statements:
This authorization will expire in one (1) year or upon (insert date or event) ______________________________________

I may revoke this authorization in writing by presenting my written revocation to Maggie Alexander, PMHNP, LLC.

The revocation will not apply to information that has already been released in response to this authorization. I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used and/or disclosed under this authorization. Maggie Alexander PMHNP, LLC is not responsible for the cost of copies.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing information under federal or state law.

Signature of Client*____Date__________________________

Signature of Personal Representative____Date__________________________

Relationship to Client____

*If patient is 14 years or older form must be signed by patient

Maggie Alexander, PMHNP-BC

3095 SW 118th Ave Beaverton, OR 97005 p. 503 523-9629 f. 503 992- 6625

CREDIT CARD AUTHORIZATION FORM

Please complete the following information. This form will be securely stored in your clinical file and may be updated upon request at any time.

I,____on behalf of____, authorize Maggie Alexander, PMHNP to charge my credit card for professional services rendered to myself or my child as follows:

Please Initial Where Appropriate:

______ Recurring charges for services in the amount of $_________
_______Per Visit
_______Per month on the _______ day of each month per our signed payment arrangement plan

______ I understand and agree that my card will be charged the full fee of the scheduled appointment for cancellations with less than 48 hours' notice and for appointments I miss without notice as agreed to in the office policies I signed.

______ I understand and agree that my card will be charged for balances of charges not paid by me or my insurance as outlined in the office policies I signed (all visits, phone calls, letters, emails, and consults).

______ I understand this form is valid until I cancel the authorization in writing. I will not dispute charges ("charge back") for sessions I have received or appointments I missed according to the above policy. I further understand that I am responsible for updating my credit card information in the event that it should change, and that I am responsible for any fees incurred for a declined credit card transaction.

______ I understand and agree that my card may be charged without me being present and that a receipt of payment will be sent to me within 48 hours of charges being placed on my card.

Charges will appear on your credit card statement as Maggie Alexander, NP

Card #: ____ Expiration Date: _______________

Name as Printed on Card: ____

Verification/Security Code (the 3 digit code on back of card by signature line): ____________________________

Billing Address: ____

City____ State ____________________ Zip _________________

EmailAddress:____

Signature____

Printed Name____ Date________________________