

**Tender Hearts Child Therapy Center**  
**1353 N. Mount Auburn Road Suite C**  
**Cape Girardeau, MO 63701**  
**573-803-1402**

**Patient Name** \_\_\_\_\_ Male or Female  
(Last) (First) (Middle)

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Medical Diagnosis \_\_\_\_\_ Medications \_\_\_\_\_

**Mother's Name** \_\_\_\_\_ **Birth Date** \_\_\_\_\_

Mother's Home Phone # \_\_\_\_\_ Mother's Cell Phone # \_\_\_\_\_

Mother's Employer \_\_\_\_\_ Employer's Phone # \_\_\_\_\_

**Father's Name** \_\_\_\_\_ **Birth Date** \_\_\_\_\_

Father's Address (if different from mother) \_\_\_\_\_

Father's Home Phone # \_\_\_\_\_ Father's Cell Phone # \_\_\_\_\_

Father's Employer \_\_\_\_\_ Employer's Phone # \_\_\_\_\_

**Legal Guardian's Name and Address** (if different from above) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone Number \_\_\_\_\_

Insured's Name & Date of Birth \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_

**Insurance** \_\_\_\_\_ **Insurance ID #** \_\_\_\_\_

May we contact you by ... (check all that apply)

Sending mail to your home  leaving a message with someone else

leaving a message on answering machine  calling your home  calling your work

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**Informed Consent for Treatment**

I give consent for evaluation and treatment to be provided for myself/my child by  
(name of therapist) \_\_\_\_\_.

- I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment.
- The risks, benefits, side effects and alternatives of treatment as well as the consequences of noncompliance with treatment have been discussed with me and I have had the opportunity to ask questions.
- I understand that I need to provide accurate information about myself to my clinician so that I will receive effective treatment. I also agree to play an active role in my treatment process.
- I understand that I may terminate treatment at any time.
- I understand that what is discussed in therapy is confidential unless and until I (the client or parent) give consent to its release, with two exceptions. The therapist will need, and is compelled by law, to report to an appropriate other person(s) if:
  1. The therapist believes that I am in danger of hurting myself or someone else, and
  2. If there is reasonable suspicion that a child has been abused or neglected.

My signature below shows that I understand and agree with all of the above statements. I have had the opportunity to ask questions about the treatment process. If the client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign this consent.

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Patient (if applicable)

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

**PRIVACY NOTICE**

I have received the Tender Hearts Child Therapy Center Notice of Privacy Practices. My signature acknowledges I have received the Notice.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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Financial Information

REGULAR THERAPY SERVICES: Our therapy sessions are \$135.00 per hour. An hour of therapy is considered 45-50 minutes, with the remaining time used for the therapist to complete related paperwork, collateral phone calls, etc., that may be necessary for the benefit of treatment. We honor negotiated rates with multiple insurance companies. We also offer a Sliding Fee Scale for clients without insurance benefits. Payment or fee arrangements must be worked out before the end of the first meeting with the therapist.

INSURANCE INFORMATION / THIRD PARTY PAYMENT: We are licensed mental health providers so many insurance plans will help pay for therapy. We are considered Specialists by most insurance companies. You may obtain benefit information from the customer service number on your insurance card or from your agent.

**Your insurance co-pay must be made at each visit.** There is a possibility that your health insurance plan will not cover outpatient mental health services. In either case, **the financial responsibility for services is yours as a client/parent.** Please note: Occasionally contact with collateral professionals, e.g., school counselors or teachers, may be needed and most insurance companies do not cover these expenses. This will require us to bill you directly.

TENDER HEARTS CHILD THERAPY CENTER CANCELLATION POLICY:

We require that 24-hour notice be given if it is necessary to cancel or change an appointment. At the discretion of the therapist, the following charges may be applied: First late cancellation or failure to show— \$0 charge; 2nd late cancellation or failure to show —\$70 charge; 3rd or more cancellations or failure to show - \$135 will be charged each time. I also understand that my insurance will not cover cancellation charges.

PATIENT/PARENT/GUARDIAN AGREEMENT:

Tender Hearts Child Therapy Center has notified me that there is the possibility that outpatient mental health services may not be a covered benefit by my health insurance. **If my insurance is not in effect today or a service is not a covered benefit, I agree to be financially responsible for the charges that occur today and any subsequent charges that may occur.**

I give this office permission to release any information to my insurance company during treatment of me or my family, which is necessary to obtain authorizations or support any insurance claims on this account and secure timely payments due to the assignee or myself.

ASSIGNMENT OF BENEFITS:

I hereby assign medical benefits, including those from government-sponsored and other health plans to Tender Hearts Child Therapy Center. A photocopy of this assignment is to be considered as good as the original. I agree to the above statements and attach my signature below.

\_\_\_\_\_  
Client's (or parent/guardian's signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name

**PLEASE MAKE SURE WE HAVE A COPY OF YOUR INSURANCE CARD**

Insurance Company \_\_\_\_\_

Cardholder name \_\_\_\_\_ Employer/Group Name \_\_\_\_\_

Effective Date of coverage \_\_\_\_\_ Family Coverage Yes / No

Co-Pay per visit \$ \_\_\_\_\_ Deductible \$ \_\_\_\_\_ per person \_\_\_\_\_ per family \_\_\_\_\_

Is physician referral required? Yes / No

Is authorization required? Yes / No If yes, authorization #? \_\_\_\_\_ # of visits? \_\_\_\_\_