

Sage Recovery & Wellness Center  
**FAMILY REGISTRATION FORM**

FINANCIALLY RESPONSIBLE CLIENT INFORMATION				
Legal First & Last Name:		Preferred name:		Middle:
Birth Date:	Age:	Marital Status:	Former Name:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender, Gender Pronoun _____ <input type="checkbox"/> Other, Gender Pronoun _____				
Address:		City:	State:	Zip Code:
Social Security no.:	Home phone no.:	Cell phone no.:		Ethnicity:
Occupation:	Employer:	Employer phone no.:		
Who can we thank for your referral?		Name:		
INSURANCE INFORMATION				
(Please fill in this information and then give your insurance card to the receptionist.)				
<b>If the client is NOT the person responsible for payments, a Release of Information for Financials and Attendance is required.</b>				
Please indicate primary insurance:		Subscriber's Name:		Subscriber's DOB:
Subscriber's S.S. no.:	Group #:		Policy #:	
Patient's relationship to subscriber:				
Name of secondary insurance (if applicable):		Subscriber's name:		Policy no.:
Patient's relationship to subscriber:			Other:	
IN CASE OF EMERGENCY				
<b>Name of local friend or relative:</b>		Relationship to patient:	Cell or Home phone #.:	Work phone #:
I authorize that the above information is true to the best of my knowledge.				
_____ <b>Client Signature</b>			_____ Date	

CLIENT INFORMATION				
<b>Legal First &amp; Last Name:</b>		<b>Preferred name:</b>		Middle:
Date of Birth:	Age:	Marital Status:	Former Name:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender, Gender Pronoun _____ <input type="checkbox"/> Other, Gender Pronoun _____				
Address:		City:	State:	Zip Code:
Home phone no.:		Cell phone no.:	Ethnicity:	
Occupation:		Employer:		
IN CASE OF EMERGENCY				
<b>Name of local friend or relative:</b>		Relationship to patient:	Cell or Home phone #.:	Work phone #:
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Sage Recovery &amp; Wellness Center. I understand that I am financially responsible for any balance. I also authorize Sage Recovery &amp; Wellness Center or the insurance company to release any information required to process my claims.</p>				
_____			_____	
<b>Client Signature</b>			Date	

CLIENT INFORMATION				
<b>Legal First &amp; Last Name:</b>		<b>Preferred name:</b>		Middle:
Date of Birth:	Age:	Marital Status:	Former Name:	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender, Gender Pronoun _____ <input type="checkbox"/> Other, Gender Pronoun _____				
Address:		City:	State:	Zip Code:
Home phone no.:		Cell phone no.:	Ethnicity:	
Occupation:		Employer:		
IN CASE OF EMERGENCY				
<b>Name of local friend or relative:</b>		Relationship to patient:	Cell or Home phone #.:	Work phone #:
<p>I authorize that the above information is true to the best of my knowledge.</p>				
_____			_____	
<b>Client Signature</b>			Date	

**\*\*Please print additional copies of this page to accommodate for the number of family members who plan to participate in therapy.**

# Medication Sheet

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Medication: Include over the counter and herbal	Dose	Frequency/ time of day taken  once daily- 1x, twice daily- 2x, as needed, etc.	Prescribing Physician	<i>Put your initials under week if there are no changes. Put an "x" if you are no longer taking that medication.</i>								
				W k1	W k2	W k3	W k4	W k5	W k6	W k7	Wk 8	
Ex: Wellbutrin	100	2x (or twice daily)/1AM & 1PM	Dr. Weatherby	GR	GR	X	X	X				

\_\_\_\_\_  
Signature of Medical Director, Cole Weatherby, DO

\_\_\_\_\_  
Date

**\*\*All clients planning to participate in family therapy must fill out a separate copy of this page.**

## Physical Health Screen

Please check any of the following symptoms you have experienced in the **past 72 hours**.

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Muscle tension      | <input type="checkbox"/> Social isolation | <input type="checkbox"/> Heart Palpitations                |
| <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Sweating         | <input type="checkbox"/> Pain/Tightness in the chest       |
| <input type="checkbox"/> Restlessness        | <input type="checkbox"/> Tremor           | <input type="checkbox"/> Difficulty breathing              |
| <input type="checkbox"/> Irritability        | <input type="checkbox"/> Nausea           | <input type="checkbox"/> Confusion                         |
| <input type="checkbox"/> Insomnia            | <input type="checkbox"/> Vomiting         | <input type="checkbox"/> Delirium tremens (DTs)            |
| <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Diarrhea         | <input type="checkbox"/> Seizures                          |
| <input type="checkbox"/> Poor concentration  | <input type="checkbox"/> Racing heart     | <input type="checkbox"/> Heart attacks                     |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Dizziness        | <input type="checkbox"/> Strokes                           |
|  | <input type="checkbox"/> Fainting         | <input type="checkbox"/> Hallucinations-visual or auditory |
|  |   | <input type="checkbox"/> None                              |

Please check the box indicating any of the following of which you have been diagnosed:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Tuberculosis                   | <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Hypo/Hyperthyroidism        |
| <input type="checkbox"/> HIV/AIDS                       | <input type="checkbox"/> Cancer/Malignancy           | <input type="checkbox"/> Polycystic Ovarian Syndrome |
| <input type="checkbox"/> STD                            | <input type="checkbox"/> Fainting                    | <input type="checkbox"/> Irritable Bowel Syndrome    |
| <input type="checkbox"/> Diabetes                       | <input type="checkbox"/> Blood in vomit or stool     | <input type="checkbox"/> Fibromyalgia                |
| <input type="checkbox"/> Heart disease/attack/condition | <input type="checkbox"/> Menstrual Disorders         | <input type="checkbox"/> Chronic Pain                |
| <input type="checkbox"/> Liver problems                 | <input type="checkbox"/> High/Low BP                 | <input type="checkbox"/> Gastritis                   |
| <input type="checkbox"/> Seizure                        | <input type="checkbox"/> Osteopenia/Osteoporosis     | <input type="checkbox"/> Migraines                   |
| <input type="checkbox"/> Hepatitis B or C               | <input type="checkbox"/> Dental problems, specify: - | <input type="checkbox"/> Other _____                 |
| <input type="checkbox"/> Impaired immune system         | _____  | <input type="checkbox"/> None                        |

Please indicate by checking the box if you have experienced any of the following symptoms or conditions in the **past 24 hours**:

- |  |  |
|--|--|
| <input type="checkbox"/> Fever or chills               | <input type="checkbox"/> Any unexplained weight gain or loss in the last 30 days |
| <input type="checkbox"/> Vomiting or diarrhea          | <input type="checkbox"/> Any diagnosed infectious illness                        |
| <input type="checkbox"/> Non-healing wounds or abscess | <input type="checkbox"/> None  |
| <input type="checkbox"/> Wet and/or bloody cough       |  |

Any known allergies? \_\_\_\_\_

Have you been seen by a physician in the last 12 months?  YES  NO

If applicable: Most recent OBGYN visit: \_\_\_\_\_

Last time had labs/bloodwork done (month/year): \_\_\_\_\_ Results normal? \_\_\_\_\_ If not normal, what abnormalities? \_\_\_\_\_

Have you experienced any physical discomfort or continuous pain?  YES  NO

If so, please explain: \_\_\_\_\_

**For adolescent clients:** Are they up to date with the CDC recommendations for immunizations?  YES  NO

If no, explain: \_\_\_\_\_

**\*\*All clients planning to participate in family therapy must fill out a separate copy of this page.**

For Office Staff use only

- Referred to medical provider  No referral  Needs medical clearance

Print & Signature of Therapist: \_\_\_\_\_ Date: \_\_\_\_\_

The chart below pertains to specific substances you have used in the past and/or present. Please **check ONE** number under the category that best describes your use pattern. Consider only drugs taken without a prescription from your doctor, unless the prescriptions were/are taken at a higher dosage than prescribed.

	Age of first use	Date of most recent use	Never used	Tried but quit	Several times a year	Several times a month	Week-ends only	Several times a week	Daily	Several times a day
Alcohol (beer, wine, liquor)			0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Tobacco (chewing tobacco, dip, snuff, cigarettes, cigars, e-cig)			0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Cannabis (marijuana, weed, THC)			0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Cocaine (coke, blow, crack, rock, freebase)			0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Opioids (heroin, smack, horse, opium, morphine, codeine, hydrocodone, buprenorphine, oxycodone, norco)			0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Benzodiazepines (valium, Xanax, klonopin Ativan, ambien, Prozac)			0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Methamphetamine (Speed, amphetamines, methylphenidate-concerta & Ritalin, crystal)			0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Designer drug (MDMA, Ecstasy, bath salts, K2)			0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Hallucinogen (LSD, PCP, psilocybin, peyote, ACID, shrooms)			0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Barbiturates (Quaalude, downers, ludes, blues)			0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>
Inhalant (glue, gasoline, spray cans, whiteout, rush)			0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>	6 <input type="checkbox"/>	7 <input type="checkbox"/>

**\*\*All clients planning to participate in family therapy must fill out a separate copy of this page.**

## Adolescent Intake Assessment

How would you describe your relationship with your parent(s)/legal guardian?

Do you have any concerns/issues in your current environment and living situation?  YES  NO

If so, explain:

Have you experienced or are currently experiencing other addictive behaviors like food, pornography, shopping, sex, and/or internet addiction?  YES  NO

If so, please explain:

Have you ever used alcohol, illegal drugs, or prescription drugs that were not prescribed to you or in higher doses than were prescribed?  YES  NO

In your opinion, what has prompted your family to seek counseling together?

What would you like to get out of your time here?

Do you have any needs or special requirements for treatment?

Client Printed Name: \_\_\_\_\_

Signature of Client: \_\_\_\_\_ Date: \_\_\_\_\_

For Office Staff use only

Referred for nutrition assessment

No referral

Print & Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Questionnaire for Parent/Guardian/Support Person

*\*If a family member under the age of 18 will be participating in family therapy, please answer the following questions. If not, please skip to the top of page 14.*

Is your child subject to a custody court order?  YES  NO

If yes, does the signing parent/guardian have the legal right to EXCLUSIVELY consent to psychological and psychiatric care of the child?  YES  NO

Is legal right to do so subject to the agreement of the other parent (who is not present)?  YES  NO

**\*\*\*If yes, written documentation is required from the other parent/legal guardian authorizing the child to consent to an assessment and treatment.**

Do you have any concerns in the following areas for your child? If so, please explain briefly.

Medical issues?  YES  NO

Emotional issues?  YES  NO

Cognitive issues?  YES  NO

Educational issues?  YES  NO

Nutritional issues?  YES  NO

Social development issues?  YES  NO

Motor development issues?  YES  NO

Delays in developmental functioning?  YES  NO

Sensorimotor issues?  YES  NO

Visual, speech, hearing, and/or language issues?  YES  NO

Oral health or hygiene?  YES  NO

Are there any important family factors that we need to take into consideration?  YES  NO

If so, explain:

Are you concerned that your child is using alcohol and/or illicit drugs?  YES  NO

Has your child ever threatened self-harm?  YES  NO

If yes, when was the last time?

Has your child experienced any past trauma?  YES  NO

If so, explain:

**PAST TREATMENT**

Has your child been diagnosed with a mental health or substance abuse diagnosis? YES NO  
If so, what?

Has it changed over time? YES NO

Have they received previous **outpatient** treatment for mental health and/or substance use (including counseling/psychotherapy and Intensive Outpatient Treatment)? YES NO  
Where and when?

Have they received previous **inpatient** treatment for mental health and/or substance use (including Residential Treatment Center, detox, and Inpatient Psychiatrist hospitalization)? YES NO  
Where and when?

Did they successfully complete previous treatment? YES NO  
If no, explain:

What benefits do you think they received from treatment?

Have they ever been treated for an eating disorder? YES NO  
When and where?

Are you working with any other agencies? YES NO

**FAMILY HOUSEHOLD ASSESSMENT**

Is your child adopted: Yes No  
If so, from what country?:

If adopted, does child know of adoption? Yes No

What age was your child at the time of the adoption?



## Adult Intake Assessment

Does anyone in the family or household have substance abuse or other addictive issues, in the past, present or in recovery?  YES  NO

List their relation to the child and type of addiction:

Anyone in your family diagnosed with a mental health diagnosis?  YES  NO

List their relation to child and type of diagnosis:

Has anyone in the family experienced other addictive behaviors like food, pornography, shopping, sex, and/or internet addiction?  YES  NO

If so, please explain:

Does anyone in the family have any medical issues we should be aware of?  YES  NO

If so, please explain:

Does anyone in the family or household have any legal issues, past or present, that we should be aware of?  YES  NO

If so, please explain:

Has anyone in the family or any individuals living in the household ever been involved with CPS, APS (Adult Protective Services), or APD (Austin Police Department)?  YES  NO

If so, please explain:

Is there anything else about the family or household that we should take into consideration for treatment (cultural or religious beliefs or practices, etc)?  YES  NO

If so, please explain:

Do you have a Psychiatric Advance Directive?  YES  NO

If so, please provide a copy.

**Please mark below which stressors you and your family have faced or are currently facing together:**

<input type="checkbox"/> Job loss	<input type="checkbox"/> Death of parent	<input type="checkbox"/> Birth of child/adoption	<input type="checkbox"/> Suicide attempt	<input type="checkbox"/> Extended absence from the home
<input type="checkbox"/> Pregnancy loss	<input type="checkbox"/> Death of sibling	<input type="checkbox"/> Mental health issue	<input type="checkbox"/> Family conflict	<input type="checkbox"/> Military deployment
<input type="checkbox"/> Financial strain	<input type="checkbox"/> Death of child	<input type="checkbox"/> Substance abuse	<input type="checkbox"/> Legal problems	<input type="checkbox"/> Homelessness
<input type="checkbox"/> Marital separation	<input type="checkbox"/> Death of other family member	<input type="checkbox"/> Illness/medical issue	<input type="checkbox"/> Spiritual or religious struggles	<input type="checkbox"/> Career change
<input type="checkbox"/> Relocation	<input type="checkbox"/> Infidelity	<input type="checkbox"/> Other addictions	<input type="checkbox"/> Child-rearing differences	<input type="checkbox"/> Other ( <i>specify</i> )

What else have you done in an attempt to address or resolve the current issue(s)? \_\_\_\_\_

---



---



---

What do you hope to achieve through counseling? \_\_\_\_\_

---



---

Of the stressors you marked, which ones *currently contribute* to any distress in your family? (*If none of the above apply, please indicate what issues you believe are contributing factors to the current distress*)

---



---

Client Name: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Adolescent Release of Information

**Purpose:** The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

**Expiration:** Unless sooner revoked, this authorization expires on the 60 days after my last appointment.

**Revocation:** I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the therapist I am working with at **Sage Recovery & Wellness Center**. I understand that I may revoke this authorization, by requesting in writing, a discontinuation of this document to **7004 Bee Caves Rd, 2-200, Austin, Texas 78746**. I also understand that the written revocation must be signed and dated with a date that is later than the date of this authorization. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

I, \_\_\_\_\_ (parent/guardian), consent to the release of privileged information for \_\_\_\_\_ (client) and waive the privilege of confidentiality afforded for medical and mental health care, alcohol and drug rehabilitation, and authorize Sage Recovery & Wellness Center’s staff to communicate with the individuals listed below to exchange any information for the purpose of clarifying and enhancing my care and treatment.

**Please check one or both of the following:**

**To obtain from**       **To disclose to**

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

*\*Ask the front desk staff for another copy of this form if you would like to or are required to release privileged information to more than one individual.*

**Please check at least one of the following to indicate what information you would like released to the above individual.**

<input type="checkbox"/> Assessment	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Individual Therapy Notes
<input type="checkbox"/> Master Treatment Plan	<input type="checkbox"/> Homework Assignments	<input type="checkbox"/> Financials
<input type="checkbox"/> Treatment Plan Updates	<input type="checkbox"/> Group Notes	<input type="checkbox"/> Labs

Sage Recovery & Wellness Center, and others listed above, are hereby released from all liability arising out of, or in any way incidental to, producing records or providing information according to this authorization.

A duplicate, photocopy or facsimile reproduction of this document may be used in lieu of the original.

**This authorization is subject to revocation in writing by the undersigned.**

**Client Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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



### Release of Information

**Purpose:** The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

**Expiration:** Unless sooner revoked, this authorization expires on the 60 days after my last appointment.

**Revocation:** I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to the therapist I am working with at **Sage Recovery & Wellness Center**. I understand that I may revoke this authorization, by requesting in writing, a discontinuation of this document to **7004 Bee Caves Rd, 2-200, Austin, Texas 78746**. I also understand that the written revocation must be signed and dated with a date that is later than the date of this authorization. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

I, \_\_\_\_\_, consent to the release of privileged information and waive the privilege of confidentiality afforded for medical and mental health care, alcohol and drug rehabilitation, and authorize Sage Recovery & Wellness Center’s staff to communicate with the individuals listed below to exchange any information for the purpose of clarifying and enhancing my care and treatment.

**Please check one or both of the following:**

**To obtain from**  **To disclose to**

Name: \_\_\_\_\_ Relationship to Client: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

*\*Ask the front desk staff for another copy of this form if you would like to or are required to release privileged information to more than one individual.*

**Please check at least one of the following to indicate what information you would like released to the above individual.**

<input type="checkbox"/> Assessment	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Individual Therapy Notes
<input type="checkbox"/> Master Treatment Plan	<input type="checkbox"/> Homework Assignments	<input type="checkbox"/> Financials
<input type="checkbox"/> Treatment Plan Updates	<input type="checkbox"/> Group Notes	<input type="checkbox"/> Labs

Sage Recovery & Wellness Center, and others listed above, are hereby released from all liability arising out of, or in any way incidental to, producing records or providing information according to this authorization.

A duplicate, photocopy or facsimile reproduction of this document may be used in lieu of the original.

**This authorization is subject to revocation in writing by the undersigned.**

**Client Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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



## Assessment Authorization Form

I, \_\_\_\_\_, certify that I understand and agree to the information provided  
in the following documentation:

- Policies and Miscellaneous Fees
- Group Rules
- Client Bills of Rights
- Client Responsibilities

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the client is under the age of 18, the signature of a parent or legal guardian is required, and such person's signature will certify agreement on behalf of the client.

Printed Name of Parent or Guardian: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



## Confidentiality Statement

Sage Recovery & Wellness Center is required to provide you with confidentiality and consent information and to obtain your signature to acknowledge that you have read and understood this form.

Those laws require us to treat all contact with you as confidential; this includes phone calls, appointments, and written communication.

Treatment at Sage Recovery & Wellness Center is a voluntary and joint effort. Sage Recovery & Wellness Center staff members are employees of Sage Recovery & Wellness Center and are not directly affiliated with your insurance carrier.

Please note as part of the center's way of protecting your privacy we do not return calls from caller ID. If you would like a return call please leave a message on our confidential voicemail. Even if the request is initiated by you, we also cannot accept requests to be "connected" or "friends" with clients on social media sites as it could breach legally-protected confidentiality. If you see a Sage Recovery & Wellness Center staff member outside of the center, acknowledgment will be left to you in order to respect your privacy. Please note that email correspondence is not a secure method for communication and choosing to do so could result in an unintentional breach of confidentiality.

- I authorize Sage Recovery & Wellness Center to call the **phone number** provided on the **registration form** and to leave a message referencing any items that assist the center in carrying out treatment provided, such as **appointment reminders, insurance items and any calls pertaining to my clinical care**. I understand it is my choice which phone number I authorize consent for.
- I authorize Sage Recovery & Wellness Center to mail any items that assist the practice in carrying out treatment, payment, and healthcare operations (TPO), such as discharge follow up letters and patient statements, to the **address** provided on the **registration form**.

## Appointments, Payment, and Insurance

**Appointments:** All office visits are by appointment and may be scheduled through the front desk staff or your therapist. Consistency is an important part of the counseling process; therefore the appointment time you schedule is reserved for you and is not available to anyone else. Please arrive on time, as you use up your session time when you arrive late for an appointment. The usual length of an appointment is 50 minutes. **If you are unable to keep a scheduled appointment, you must notify Sage Recovery & Wellness Center at least 24-hours in advance to avoid having to pay for the canceled or missed appointment. Please leave a message on our confidential voicemail during non-business hours.**

**Cancellation Policies:** Since scheduling of an appointment involves the reservation of time specifically for you, **a minimum of 24-hours notice is required for rescheduling or canceling an appointment**. Without 24-hours notice, you will be financially responsible for the full amount of the scheduled session. Most insurance companies do not reimburse for missed sessions. Your compliance in keeping appointments and actively participating in treatment is vital.

**Payment:** Self pay clients, including those not billing any insurance company or third party payer, are expected to pay in full at time of service unless other arrangements have been made. Except in the case of minors or when other arrangements are made, the individual receiving services is financially liable. I understand additional fees are charged for lengthy telephone communications, court attendance and report/letter writing. Insurance does not cover this.

**Insurance:** I understand I may be responsible for the remaining balance if the insurance or third party does not cover the full allotted amount. Sage Recovery & Wellness Center will send me an invoice with the remaining amount, which I am required to pay in full within 30 days after the rendering of services. I understand co-pays are expected at the time of service and that co-pays are non-negotiable. Failure to pay your part may jeopardize your insurance benefits. I understand should I become ineligible for insurance coverage, I agree to notify the center and I will be responsible for 100% of the remaining balance. I understand that a re-billing fee/financial charge complying with Texas State Law may be applied to any overdue balance. In the event of non-payment, I will bear the cost of collection, court costs, and/or legal fees should this be required. If services are conjoint (couples or family therapy), all clients 18 and older need to sign this contract due to confidentiality and your individual rights, regardless of who is the identified financially responsible client.