New Hope Counseling
1071 Worcester Rd., Suite 43
Framingham, MA 01701

Name(please print):_____

Address:_____City/State/Zip_____

Date of Appointment: _____ Date of Birth:_____

Contact Phone Number : _____

Emergency Contact Number: _____

Insurance Card #:_____

Authorization Number (If Applicable) _____

Reason for coming in for treatment: _____
_____
_____
_____
_____
_____
_____

By signing below, you hereby allow New Hope Counseling, Inc. and James Valeri, LMHC to contact your insurance company regarding treatment, payment for services rendered and authorization for payment of services rendered. Additionally, you do not hold James Valeri, LMHC or New Hope Counseling responsible for any unfavorable outcomes as a result of choices made during and after therapy sessions. I also have read New Hope Counseling's HIPPA Privacy Policy at:
www.NewHopeCounselingOnline.com

Signature _____

Printed Name _____

Witness: _____

New Hope Counseling, Inc.
1071 Worcester Rd. Suite 43
Framingham, MA 01701

Permission To Treat

By signing below, you give New Hope Counseling, Inc. and Jim Valeri, LMHC permission to communicate with your insurance company about your treatment. Also, this is a consent form for the insurance company's claim processing (lines 12 & 13 on the HCFA 1500).

CLIENT'S SIGNATURE_____

DATE_____

Permission To Share

By signing below, you give New Hope Counseling Permission to share information about your counseling sessions to persons mentioned below. If you do not desire to share information with anyone specific, signing is not necessary.

Person:_____

Person:_____

Signature:_____ Date:_____

New Hope Counseling, Inc.
1071 Worcester Rd., Suite 43
Framingham, MA 01701

LATE CANCELLATION POLICY

It is important to New Hope Counseling that we have as much advanced notice as possible. A fee of $50.00 will be charged for cancellations of less than 24 hours.

Insurance companies cannot be billed for missed appointments so that responsibility is solely the client's.

Additionally, you authorize New Hope Counseling to communicate with your insurance policy and give New Hope Counseling permission to medically treat you.

CLIENT NAME (print) _____

CLIENT'S SIGNATURE_____

DATE_____

New Hope Counseling
Credit Card Form

Card Number:_____

Expiration Date: _____ CSV (3 digit code on back:_____

Cardholder's Name:_____

Billing Address: _____

City, State and Zip Code: _____

Email Address (for receipt):_____

By signing below, you agree to allow New Hope Counseling, Inc. to bill your credit card for co-payments, late cancellation fees ($50, for less than 24 hours advance notice of appointment cancellation), and unpaid counseling sessions incurred by you, the client. Clients may choose to pay cash or check for these payments, but this form must be filled out to prevent the possibility of unpaid services.

In the unlikely event that your insurance company refuses to pay for services rendered, New Hope Cousneling will work with you, and will make arrangements with you regarding payment for services rendered. New Hope Counseling will do everything in its power to obtain payment from your insurance company, and will abide by its agreement with you and their policy. In the event that you can not or will not be reached, you authorize New Hope Counseling to charge your credit card at the rate of $120 per session rendered to you, the client. An invoice of sessions rendered and charged will also be sent to your address in this unlikely event.

Client Signature: _____ Date:_____

Clinician Signature: _____ Date:_____

Please be sure to check with your insurance company regarding policy coverage.