Allyson Blythe, Certified Life Coach & LCSW
7430 US Highway 42 #217
Florence, KY 41042
(859) 341-7773 **Fax (859) 341-0376**
www.allysonblythe.com **allysonblythe@live.com**

Client Registration

General Information:

Name:

Address:

City: State: Zip:

Phone: Work:

Email Address:

Date of Birth: Social Security Number:

Marital Status: Gender:

Is it ok to forward office information to you through this email, including upcoming events? ◯ Yes ◯ No

Who can I thank for referring you?

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General Consent for Treatment and Payment

1. Consent to Treatment:

   I understand that treatment is a cooperative effort that involves open and honest communication between myself and my therapist. Because difficult feelings and issues may need to be experienced and addressed, I understand there are certain risks associated with psychotherapy that include, but are not limited to: worsening of mood, behavior, and/or functioning. I acknowledge that the benefits of treatment may not be immediately realized and understand that no guarantee or assurance is made as to the results that may be obtained. I hereby consent to treatment.

2. Fee-For-Service:

   I understand that I am fully responsible for payment of services and products provided. Payment is due at the time of service. I understand that I am responsible for payment for all services, missed, or late-cancelled appointments.

3. Release of Information / Assignment of Insurance Benefits:

   I understand that in the course of my treatment, it may be necessary for Allyson Blythe, LCSW to share my mental health information with other specialists, physicians, and/or health care agencies. Mental health information may also be shared with my insurance carrier should I decide to submit claims to my insurance company.

4. Emergency Contacts:

   I acknowledge that the services I receive from Allyson Blythe, LCSW are confidential. I also understand that should Allyson Blythe, LCSW assess that I present a risk to myself or others, or that there is a potential risk to me, Allyson Blythe, LCSW is under obligation to report such risks. In case of an emergency, I release Allyson Blythe, LCSW to contact:

Name: Number: Relationship:

Name: Number: Relationship:

5. Acknowledgement:

   I certify that I have read and fully understand this Consent for Treatment and Payment form and acknowledge that the following items were provided to me:
   Notice of Privacy Practices & Financial Policy and Fee Schedule

Patient Signature / Personal Representative Date

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Important Policy Information:

I am dedicated to providing the best possible care for you and want to ensure that you understand the following policies. By signing below, you agree to the following:

- to present your credit card and a photo ID at the time of your first visit.
- to notify the office of changes in any of my basic information (address, phone number, etc).
- **payment is collected at the time of service.** I understand that cash or check are accepted for all services. Credit cards, including HSA accounts, are also accepted.
- **to cancel any appointment with at least 24 hours advance notice. There will be an automatic full-fee charge for missed or late cancelled appointments. Email is the best way to convey basic information and appointment changes.**
- to pay for all services rendered, including collection fees and attorney fees up to and including court costs in the event of default.
- to pay any return check fees at the cost of $35.00 each.
- fees and treatment options have been discussed and agreed upon. It is your right to pursue in-network services or to make changes to your treatment as you see fit.
- **to allow email messages to be sent as a form of communication. Email and text messages are not appropriate for emergencies.** Data transmitted over the internet is not secure and is at risk of being read by unauthorized third parties. Liability for this communication cannot be held by me and cannot be held responsible for safeguarding such information once it is delivered to me. You can revoke this authorization at any time in writing.

Printed Name of Client Signature of Client (or Guardian)

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Credit Card Authorization

Client Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Email Address: _____

Name as it appears on card: _____

Credit Card Type: Visa _____ Master Card _____

Discover _____ Other: _____

Credit Card Number: _____

Expiration Date: _____ Security Code : _____

Cardholder Zip Code: _____

I hereby authorize Allyson Blythe, LLC to charge my credit card according to the terms below:

- **Fee for scheduled appointments**
- **A $5.00 charge is added to all credit card payments. Cash, check, and Venmo are additional forms of payment that do not incur this fee.**
- **In case of a Late Cancelation (less than 24 hours) or No-Show, I understand that my card will automatically be charged the full session amount.**
- **This form is valid and kept on file until your case is closed or until you terminate this agreement in writing.**
- **I agree to accept further information about upcoming events via email.**

_____ _____

Client Signature Date