Amrita Singh, M.S., LMFT
Adult, Child, and Adolescent Psychotherapy

12280 Saratoga Sunnyvale Road, Suite 104, Saratoga, CA 95070

THERAPY SERVICES:
OFFICE POLICIES AND GENERAL INFORMATION AGREEMENT

Confidentiality:

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (parent/guardian) written permission, except where disclosure is required by law. Most of the provisions explaining when the law requires disclosure were described to you in the notice of privacy practices that you received with this form.

When disclosure is required by law:

Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; and where a patient presents a danger to self, to others, to property, or is gravely disabled.

When disclosure may be required:

Although confidential, if a child reports intent to harm themselves or someone else, or reports grave disability, I consider that to be important enough to act upon to ensure safety, which at the least includes alerting the parent/guardian. I consider significant drug or alcohol use as self-harm and may disclose this information to a minor's parents. Disclosure may be required pursuant to a legal proceeding. If you place your child's mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by the therapist. In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. The therapist will use clinical judgment when revealing such information. No release records to any outside party will occur unless so authorized to do so by all adult family members who were part of the treatment.

Emergencies:

If there is an emergency during our work together, where the therapist becomes concerned about your child's personal safety, the possibility of your child injuring someone else, or about your child receiving proper psychiatric care, the therapist will do whatever she can within the limits of the law to prevent your child from injuring him or herself or others and to ensure that

your child receive the proper medical care. For this purpose, she may also contact the police, hospital, or the person whose name you have provided on the biographical sheet.

Health Insurance and Confidentiality of Records:

Disclosure of confidential information may be required by your health insurance carrier in order to process the claims. Only the minimum necessary information will be communicated to the carrier. Psychotherapy notes will not be disclosed to your insurance carrier. The therapist has no control or knowledge over what insurance companies do with the information you submit or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance. The risk stems from the fact that mental health information is entered into insurance companies' computers and soon will also be reported to the Congress-approved National Medical Data Bank.

Litigation Limitation:

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters that may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.), neither parent/guardian nor your attorney, nor anyone else acting on your behalf will call on Ms. Singh to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested.

Consultation:

Ms. Singh consults regularly with other professionals regarding her patients; however, the patient's name or other identifying information is never mentioned. The patient's identity remains completely anonymous, and confidentiality is fully maintained.

Contacting Therapist and Emergencies:

If you need to contact the therapist between sessions, please leave a message on her voicemail (408) 384-9638, and your call will be returned as soon as possible. The therapist checks her messages a few times a day, and less frequently on weekends and holidays. If an emergency situation arises, please indicate it clearly in your message. If you need to talk to someone right away, you can call the therapist at (408) 384-9638, the Police (911) or 24-hour Suicide and Crisis Service at (855) 278-4204.

Media Use Agreement:

There is an agreement that needs to be made between client and the therapist regarding text messaging and email messaging. These tools are vital and necessary in order to enable and

facilitate timely communication between you and Ms. Singh. However, there are some limitations with these forms of communication.

They are as follows:

- Subject to availability, the therapist will respond to text and email messages during my normal business hours between 8:00 am to 6:00 pm Monday-Thursday and 8:00 am to 5:00 pm Friday.
- If you are in a crisis, please do NOT use text or email messages. Please use the Suicide and Crisis Service at (855) 278-4204, dial 911 or go to your local emergency room, depending on your situation.
- Emails and texts should be limited to information appropriate to send in this form of communication. Examples are limited treatment information or for scheduling purposes only. It is NOT recommended that you send any identifying client information, i.e. only use client initials and a brief summary of information needing to be imparted. You may be charged for a session if these message exchanges become lengthy.

PLEASE NOTE: This office **does not** provide a 24-hour crisis service.

Payments and insurance reimbursement:

First intake session is 60 minutes. Subsequent sessions consist of a 50 minute hour. In order to be effective, therapy needs to take place on a regular basis. The best results occur when appointments are consistently scheduled and the client maintains regular attendance.

The therapist fee is $270 for the **first intake session.** Fee is $230 per 50 minute session for subsequent individual sessions. Fee is $270 per 50 minute subsequent session for couples therapy, and $270 per 50 minute subsequent session for family therapy.
Checks, Cash, and Credit cards are accepted. Payment for professional services is

- ❏ due in full at the time services are provided.

Some insurance companies will not cover outpatient psychotherapy as these services are considered to be out of network. Therefore, it is your responsibility to contact your insurance company prior to our initial appointment to inquire about reimbursement. Upon request, I will provide you with a statement at the end of the month to submit to your insurance carrier for reimbursement. Your estimated fees and a payment schedule will be disclosed during our initial phone interview. There is a $25 fee for all returned checks. Standard fees may be raised on an ongoing basis. You will be notified in advance prior to any changes in fees if they occur. A credit card will be put on file prior to your first session.

Telephone conversations, site visits, report writing and reading, consultation with other professionals on your or your child's behalf, release of information, reading records, longer sessions, travel time, and so forth, will be charged at the same rate, unless indicated and

agreed otherwise. Please notify the therapist if any problem arises during the course of therapy regarding your ability to make timely payments.
The therapist will provide you with written notice regarding all unpaid fees and allow a reasonable amount of time for payment of those fees. If a mutually agreed upon arrangement cannot be made, and if payment is not received, a collection agency will be notified.

Therapy Process:

In situations involving separation or divorce, authorization for consent for treatment and authorization for the release/exchange of information must be signed by both parents. Ms. Singh will make reasonable efforts to involve both parents in the treatment of the minor patient. Participation in therapy can result in a number of benefits to your and/or your child, including resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Ms. Singh will ask for your feedback and views on you and/or your child's progress in therapy.

During the evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your child experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, and so forth, or experiencing anxiety, depression, insomnia, and so forth. It is possible that the therapist may challenge some of your and/or your child's assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations that can cause your child to feel upset, angry, depressed, challenged, or disappointed. Attempting to resolve issues that brought you and/or your child into therapy in the first place may result in changes that were not originally intended. Therapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, relationships etc. Sometimes a decision that is positive for one family member is viewed quite negatively by another family member. There is no guarantee that therapy will yield positive or intended results.

Treatment plan:

Within a reasonable period of time after the initiation of treatment, the therapist will discuss with you, her working understanding of your and/or your child's problem, treatment plan, therapeutic objectives, and view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your child's therapy, their possible risks, the therapist's expertise in employing them, or about the treatment plan, you are encouraged to ask these questions. You also have the right to ask about other treatments for your child's condition and their risks and benefits. If you could benefit from any treatment that this therapist does not provide, she has an ethical obligation to assist you in obtaining those treatments.

Medications:

This therapist does not prescribe medications. Medications need to be prescribed by a psychiatrist or physician. A referral to a psychiatrist for an evaluation can be made if needed.

Termination:

Ms. Singh accepts patients into treatment in an effort to determine whether he or she can benefit from the services available. If the therapist feels that your child is not able to benefit, or she is not effective in helping your child reach their therapeutic goals, she is obliged to discuss it with you and, if appropriate, withdrawal will be recommended and other plans discussed.

Parents/guardians have the right to terminate therapy at any time. If you choose to do so, Ms. Singh will offer to provide you with names of other qualified professionals whose services your child may benefit from.

Cancellation:

If you are unable to keep an appointment, please be sure to cancel at least 24-hours in advance, or you will be charged the usual fee for that session. Last minute cancellations lead to wasted time slots that could otherwise have been filled for other clients. It is your responsibility to keep track of the appointments you have made.

I/we have read and understand all of the terms and conditions stated above regarding therapy. All my/our questions have been answered fully. I/we understand and agree to the terms and conditions of this agreement.

_____

Date Signature Printed Name

_____

Date Signature Printed Name

- ❑ Copy given to client
- ❑ Copy kept by the therapist

INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)
Name of parent/guardian (if under 18 years):
_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: Male | Female
Marital Status:
Never Married | Domestic Partnership | Married | Separated | Divorced | Widowed

Please list any children/age:
_____

Address:

_____
(Street and Number)
_____
(City) (State) (Zip)

Home Phone: ( ) May I leave a message? Yes | No
Cell/Other Phone: ( ) May I leave a message? Yes | No

E-mail: _____ May I email you? Yes | No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any):_____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
No
Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

Yes
No
Please list:
_____

_____

Have you ever been prescribed psychiatric medication?
Yes
No
Please list and provide dates:
_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific health problems you are currently experiencing:
_____

2. How would you rate your current sleeping habits? (please circle)
Poor Unsatisfactory Satisfactory Good Very good
Please list any specific sleep problems you are currently experiencing:
_____

3. How many times per week do you generally exercise? _____
What types of exercise to you participate in:
_____

4. Are you currently experiencing overwhelming sadness, grief or depression?
No
Yes
If yes, for approximately how long? _____

5. Are you currently experiencing anxiety, panic attacks or have any phobias?
No
Yes
If yes, when did you begin experiencing this? _____

6. Are you currently experiencing any chronic pain?
No

Yes
If yes, please describe? _____

7. Do you drink alcohol more than once a week? No | Yes

8. What significant life changes or stressful events have you experienced recently:

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).
Please Circle List Family Member

Alcohol/Substance Abuse yes/no
Anxiety yes/no
Depression yes/no
Domestic Violence yes/no
Eating Disorders yes/no
Obesity yes/no
Obsessive Compulsive Behavior yes/no
Schizophrenia yes/no
Suicide Attempts yes/no

ADDITIONAL INFORMATION:
1. Are you currently employed? No | Yes
If yes, what is your current employment situation:
_____

Do you enjoy your work? Is there anything stressful about your current work?
_____
_____

2. Do you consider yourself to be spiritual or religious? No | Yes

3. What do you consider to be some of your strengths?
_____
_____
_____
_____

4. What do you consider to be some of your weaknesses?

_____
_____
_____
_____

5. What would you like to accomplish out of your time in therapy?

_____
_____
_____
_____

HIPAA NOTICE OF PRIVACY PRACTICES

This document describes how medical information about you may be used and disclosed and how you can get access to this information. Please read and review the document carefully.

It is the therapist's legal duty to safeguard your Protected Health Information (PHI). By law, I am required to ensure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this notice about my privacy procedures. This notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this notice.

The therapist reserves the right to change the terms of this notice and privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will change this notice and post a new copy of it in my office. You may also request a copy of this notice from me, or you can view a copy of it in my office.

I can use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization. Others, however, will not. Please read and review the different categories of my uses and disclosures, with some examples.

Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent.

I may use and disclose your PHI without your consent for the following reasons:

- For treatment: I can use your PHI within my practice to provide you with mental health treatment. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care. Example: If a psychiatrist is treating you, I may disclose your PHI in order to coordinate your care.
- For health care operations: I may disclose your PHI to facilitate the efficient and correct operation of my practice. For example: I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.

- To obtain payment for treatment: I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. For example: I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.
- Other disclosures: Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent but you are unable to communicate with me (for example, if you are unconscious or in severe pain) but I think that you would consent to such treatment if you could, I may disclose your PHI.

Certain Other Uses and Disclosures Do Not Require Your Consent

I may use and/or disclose your PHI without your consent or authorization for the following reasons:

- When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or law enforcement. I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel, and/or in an administrative proceeding.
- If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.
- If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.
- If disclosure is compelled by the patient or the patient's representative pursuant to California health and safety codes or to corresponding federal statutes of regulations, such as the privacy rule that requires this notice.
- To avoid harm. I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public (i.e., adverse reaction to meds).
- If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.
- If disclosure is mandated by the California Child Abuse and Neglect Reporting law. For example, if I have a reasonable suspicion of child abuse or neglect.
- If disclosure is mandated by the California Elder/Dependent Adult Abuse Reporting law. For example, if I have a reasonable suspicion of elder abuse or dependent adult abuse.
- If disclosure is compelled or permitted by the fact that you tell me of a serious/ imminent threat of physical violence by you against a reasonably identifiable victim or victims.
- For public health activities. In the event of your death, if a disclosure is permitted or compelled, I may need to give the county coroner information about you.

- For health oversight activities. I may be required to provide information to assist the government in the course of an investigation or inspection of a healthcare organization or provider.
- For specific government functions. I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the president of the United States or assisting with intelligence operations.
- For research purposes. In certain circumstances, I may provide PHI in order to conduct medical research.
- For Workers' Compensation purposes. I may provide PHI in order to comply with Workers' Compensation laws.
- Appointment reminders and health-related benefits or services. Examples: I may use PHI to provide appointment reminders. I may use PHI to give you information about alternative treatment options or other health care services or benefits I offer.
- If an arbitrator or arbitration panel compels disclosure, when arbitration is lawfully requested by either party, pursuant to subpoena duces tectum (e.g., a subpoena for mental health records) or any other provision authorizing disclosure in a proceeding before an arbitrator or arbitration panel.
- If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law. Example: When compelled by the U.S. Secretary of HHS to investigate or assess my compliance with HIPAA regulations.
- If disclosure is otherwise specifically required by law.

Certain Uses and Disclosures Require You to Have the Opportunity to Object

I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

Other Uses and Disclosures Require Your Prior Written Authorization

In any other situation not described in Sections IIIA, IIIB, and IIIC above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

<u>The rights you have regarding your PHI</u>

- The Right to See and Get Copies of Your PHI.

In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my

receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed.
If you ask for copies of your PHI, I will charge you not more than $0.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.

- The Right to Request Limits on Uses and Disclosures of Your PHI

You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

- The Right to Choose How I Send Your PHI to You

It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via e-mail instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.

- The Right to Get a List of the Disclosures I Have Made

You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, that is, those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, disclosures to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for 6 years.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous 6 years (the first 6-year period being 2003–2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than 1 request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

- The Right to Amend Your PHI

If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not

part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

- The Right to Get This Notice by Email

You have the right to get this notice by email. You also have the right to request a paper copy of it.

How to complain about my privacy practices

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to file a complaint with the person listed in Section VI below. You may also send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201 or by calling (202) 619-0257. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

Person to contact for information about this notice or to complain about my privacy practices
If you have any questions about this notice or any complaints about my privacy practices, or would like to know how to file a complaint with the Secretary of the DHHS, please contact me at: 12280 Saratoga Sunnyvale Road, Suite 104, Saratoga, CA 95070.

Effective date of this notice
This notice is in effect as of January 1, 2020.
The therapist may provide privacy protection beyond these Federal requirements as outlined by the California Board of Behavioral Sciences. However, your notification of the above is required by Federal law.

Notice of Policy Practices
I hereby acknowledge that I have been given an opportunity to read a copy of this Notice of Privacy Practices.

Patient Name: _____ Date: _____ Signature: _____
(if patient is adult)

Patient Name: _____ Date: _____ Signature: _____
(if patient is adult)

Patient Name (if minor): _____ Date: _____

Signature of parent/guardian: _____
(if patient is minor)

Patient Name: _____ Date: _____

Signature of parent/guardian: _____
(if patient is minor)

*Please note: If you are signing this as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.)

Consent to Treat - Telemedicine

I consent to engage in telemedicine as part of psychotherapy. I understand that telemedicine includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in California or outside of California.

I understand that I have the following rights with respect to telemedicine:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telemedicine based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services), I will be referred to a psychotherapist who can provide such services in my area. I understand that there are potential risks and benefits associated

with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse.

(4) I understand that I may benefit from telemedicine, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with California law.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

Client: _____ Date: _____

Parent/Guardian (if minor) _____ Date: _____

Good Faith Estimate

You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost. Under the law, healthcare providers need to give patients who don’t have insurance or who are not using insurance an estimate of the bill for medical items and services

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment and hospital fees.

- Make sure your healthcare provider gives you a Good Faith Estimate in writing at least one business day before your medical service or item. You can also ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.

- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.

- Make sure to save a copy or picture of your Good Faith Estimate.

Credit Card Authorization Form

I _____ give my permission for Amrita Singh, LMFT, to charge the following credit card for services rendered as agreed upon in the consent for treatment. In addition, I understand that if I do not cancel within 24 hours of my session appointment, a full session charge will be processed on the card below.

_____ _____

Signature of Card Holder Date

Visa Mastercard American Express Discover (Select One)

CARD NUMBER: _____

SECURITY NUMBER (CVV): _____ EXPIRATION DATE: _____

NAME ON CREDIT CARD: _____

BILLING ADDRESS: _____

PHONE NUMBER: _____