Cheng & Associates Family Counseling Inc.
Sherry Cheng, MA, LMFT
949-981-6319

Patient's Name: _____ Date: _____
DOB: _____ SSN: _____
Address: _____
_____
Cell. Phone: _____ Home Phone: _____
Marital Status: ____ Names and Ages of Children: _____
Primary Insurance Company: _____
Name of Insured: _____
DOB of the Insured: _____ Relationship to the Insured: _____
Insurance ID #: _____ Group #: _____

In general, the information you share in sessions is confidential and may not be revealed without your authorization in writing. However, there are some exceptions: You authorize a release of information, you or others present a danger to yourself or others, child/elder abuse/neglect is suspected, you have an overdue in your account, and when I am ordered by a judge to testify in certain legal situations, etc.

When working with a couple or family, I ask all parties to sign releases of information so that relevant information can be shared to provide feedback. When one partner or family member requests to release information, I request all involved parties to sign an authorization.

When you choose to use your insurance, the information regarding your treatment will be released to you insurance company for claims, case management, quality improvement, benefit administration, etc. If you have a copayment/coinsurance, you will be expected to pay **at the beginning of each appointment**. As a courtesy, your insurance benefits will be verified before the first appointment. However, the final payment determination is by your insurance carrier. You are responsible for the portion of the fee that is not reimbursed by your insurance carrier (e.g., deductibles, copayments, miss or cancelled sessions, etc.).

If your check bounces and is returned by the bank for insufficient fund, you are responsible for making payment in full and for any administrative fees (charges from the bank and time spent discussing the issue with the bank) before we continue treatment. If there is an unpaid balance in your account, subsequent appointments will not be scheduled until the unpaid balance is paid in full.

It is extremely important to keep your appointments in order to increase the likelihood of therapeutic gains. If you cancel your appointment, a 24-hour notice is required. **If you miss or cancel your appointment with less than a 24-hour notice, you will be charged $100 prior to scheduling next appointment.**

I do not interject myself into legal matters. Therefore, I do not write reports/letters for legal proceedings. If I am called to testify in front of a judge, you will be responsible to pay for my participation including travel time and parking fee (based on the rate of $250.00 an hour).

**Please initial here that you have read and understood the above office policies: _____**

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Reading and writing reports/letters within my scope of practice will be charged based on the rate of $250.00 an hour. These are charges that insurance carrier do not cover, please consult with your insurance carrier before requesting the services.

When a copy of your record is requested, you will be charged for travel time to obtain the records from the storage and for coping, faxing or mailing the record to the requested party based on $100.00 an hour.

I have a telephone voice mail that I check during work hours on weekdays. However, if you have a life-threatening emergency, please call 911 or go to the nearest hospital for immediate assistance.

**Notice of Privacy Practices:** If you would like a copy of the Notice Of Privacy Practices, please let the practitioner know.

**Consent for Treatment:** By signing below, you are consenting to enter into treatment with Sherry Cheng, MA, LMFT, and that you are authorizing this practitioner to conduct diagnostic procedures, psychological exams, and treatment throughout the course of treatment.
Print Name: _____
Signature: _____ Date: _____

**Credit Card Authorization:** Please complete the following information.

I, _____, authorize Sherry Cheng, MA, LMFT to charge my credit card for any unpaid balances and fees associated with my psychotherapy.

Name as it appears on card: _____

Card Number: _____ Expiration Date: _____

Type of Card (MC, Visa or Discover): _____ Security Code: _____

Signature: _____ Date: _____

**Please initial here that you have read and understood the above office policies: _____**