2021 Cashman Center MINOR Client Update

Client Information

Client Name: ____ Gender: _______ Date of Birth: __________

Address: ____ City: ___________ State: ______ Zip: ____________

Parent/Guardian ________________________________ Relationship ________________ Phone _______________

Address _______________________________________ Email address: ___________________________________

Parent/Guardian ________________________________ Relationship ________________ Phone _______________

Address _______________________________________ Email address: ___________________________________

Insurance Information

Insurance Company: ____ Phone Number: ___________________

ID # ___________________________________Group # ____________________ Policy # ___________________

Effective Date: ________________________________ Co-pay/ deductible: ______________________________

Policy Holder Information

Name: ____ Date of Birth: _______________________

Relation to Client: ______________________________ Employer: ____________________________________

Secondary Insurance

Insurance Company: ____ Phone Number: ___________________

ID # ___________________________________Group # ____________________ Policy # ___________________

Effective Date: ________________________________ Co-pay/ deductible: ______________________________

I assign all benefits from insurance or other third-party coverage to the provider of service. I understand that by signing this form, I acknowledge that if my insurance carrier or I-IB/IO/PPO does not cover certain services, I will pay for them in full. I authorize the release of any medical information necessary to process any claim for services provided by provider or its independent contractors. A photocopy of this authorization may be honored.

Client Signature: ____ Date: _____________________

No-Show/ Late Cancellation Policy

This policy has been established to provide the highest level of care to all our clients who receive Cashman Center Integrated Health and Wellness Services. It has been proven that consistent attendance provides the greatest opportunity for success. By providing us notice of a cancellation, we may be able to accommodate other clients with your appointment slot. We would like to remind you of our office's policy regarding missed appointments.

- Clients must call 24-hours prior to their scheduled appointment time, when they knowingly are unable to make their appointment. Cancellations within 24-hours of your appointment will be considered a late cancellation. We do understand that emergencies arise and that it may not be possible to give such a notice. Any potential exceptions to the No-Show/Late Cancellation policy will be determined by your provider.

- Clients should plan to arrive on time for scheduled appointments. We will allow a 5-minute grace period for 30minute appointments and a 10-minute grace period for 60-minute and 90-minute appointments. Beyond the grace period listed, your provider reserves the right to cancel your appointment and charge a late fee, Fees for No-Shows or Late Cancellations are as follows:
  - Psychiatric Care
    - Missed Intake Appointment: $200
    - Missed Follow-up appointment: $80
  - Psychotherapy
    - Doctorate Level providers missed Intake or Follow-up appointment: $85
    - Masters level providers missed Intake or Follow-up appointments: $80
  - Psychological Testing
    - Missed Testing Interview or Administration appointment: $100 per hour blocked in provider's schedule.
  - Nutrition Counseling
    - Missed Intake or Follow-up appointment: $80
  - Acupuncture
    - Missed Intake or Follow-up appointment: $80
  - Other Health and Wellness services
    - Missed Intake or Follow-up appointments: $80

- Continuation of Services
  - Cashman Center reserves the right to discontinue services after **THREE** No-Show/or Late Cancellations. Because we are an integrated care team, a No-Show and/or Late Cancellation for an appointment with any of our clinicians will be included in determination of ongoing care.
  - Medicare and Medicaid plans prohibit us from charging you for No-Show and Late Cancellations, and Cashman Center will abide by those prohibitions. Therefore, clients with Medicare or Medicaid insurance policies will be discharged from treatment and all future appointments will be cancelled after **TWO** No-Show and/or Late Cancellations.
  - If extenuating circumstances have contributed to missed appointments, all clients have the right to appeal the discontinuation of services by writing a letter explaining such circumstances.

Thank you for providing our office and our clients with this courtesy. Signing below indicates you understand and agree to the terms of this policy.

____ ____________________

Signature of Client Date

____ ____________________

Signature of Provider Date

Client Receipt of Information

I have read, understand, and agree to abide by the policies given to me in the Client Registration and Treatment Contract Handbook. I understand all center information provided to me within these documents; should I have concerns about any policies, I will discuss with my treatment provider. The information I received includes.

- Client registration
- Crisis Coverage
- Notice of Health Information and Privacy Practices
- Responsibilities of Cashman Center
- Bill of Rights
- Client responsibilities
- Cashman Center is an integrative care clinic, which means consultation occurs across providers on the same case to facilitate care. Providers will disclose the minimal necessary information to protect client privacy.

____ ________________________

Signature of Client Date

____ _________________________

Parent Signature of minor client Date

Please return forms to Cashman Center.

Email to: cashmanforms@therapysecure.com

(please note, private information may not be secure by email)

Fax: 952-224-8991

Or mail to: 2970 Judicial Road Suite 100, Burnsville, MN 55337