2024 Cashman Center Client Update

Client Information

Client Name: _____ Gender: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____Type: Cell/Home/Work Alternate number: _____ Type: Cell/Home/Work

Email address: _____

Emergency Contact: _____ Relationship: _____Phone Number: _____

Insurance Information

Insurance Company: _____ Phone Number: _____

ID # _____Group # _____ Policy # _____

Effective Date: _____ Co-pay/ deductible: _____

Policy Holder Information

Insured Person: _____ Date of Birth: _____

Relation to Client: _____ Employer: _____

Secondary Insurance

Insurance Company: _____ Phone Number: _____

ID # _____Group # _____ Policy # _____

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: _____

Cashman Center
Therapies for Mind & Body

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 start at $80.00.

- 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 _____

Cashman Center
Therapies for Mind & Body

Credit Card Authorization

Cashman Center requires you to provide your credit/debit card information on file with us so we can charge any co-pays, co-insurance, deductible amounts, and professional service charges such as late cancelation or missed appointment charges. It is the client's responsibility to keep cards accurate and up to date. We store financial information and other protected health information in an encrypted, HIPAA compliant site.

Payment is required at the time of service. We provide regular statements for your account balance via mail. You may pay your balance in session with your therapist, online via our website, or by check or cash. If balance accrues and no payment is received within 45 days of service, we reserve the right to seek payment by any means, including using the credit/debit information we have on file, retaining a collection agency, etc. Cashman Center allows you to work out payment plan with us that includes a reasonable period for resolving the balance. If the client's balance remains unpaid, we reserve the right to suspend services until the balance is paid in part or in full.

Client Name _____ Client Number_____

Card type _____ Visa _____ Master Card _____ Discover _____ AmEx _____ Other _____

Name on card _____

Credit card number_____

Expiration Date _____ Security code _____ Billing Zip code _____

Is this card linked to Health Savings Account (HSA) or Flexible Spending Account) (FSA)? _____

Your signature below indicates that you have read and understood our credit/debit card and delinquent account policy. You are authorizing Cashman Center to charge the above credit card. You are aware that your information will be saved on file for a future transaction on your account.

Signature _____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 _____

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