****

Phone: (833) ETC-LIFE

Email: info@empowermentmail.com

9720 Capital Ct, Suite 303

Manassas, VA 20110

**Child / Adolescent Client Intake Packet**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_ Date of first appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian (1) Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian (2) Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe Guardianship/Custody Agreement (A legal guardian must be present at the intake assessment)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please take your time in providing the following information. The questions are designed to help me begin to understand your child so that our time together can be as productive as possible.

**All information provided is confidential**.

**Referred by:**

\_\_Medical Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_My Website: https://empowerment-therapy-center.com/ PsychologyToday

\_\_Friend/Family: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Has the patient previously received any type of mental health services?** \_\_Yes \_\_No

If yes, which of the following?:

\_\_Psychotherapy \_\_Medication \_\_Outpatient \_\_Hospitalizations \_\_Inpatient Hospitalization

**If yes, please provide:**

Name of provider or facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Briefly, what brings your child in today?**

**When did the problem first start?** Within the last: \_\_30 days \_\_6--12 months \_\_2 years \_\_During adolescence \_\_During childhood

**What areas of your child’s life have been affected because of this problem?**

**Is your child currently experiencing overwhelming sadness, grief or depression?** \_\_Yes \_\_No

If yes, for approximately how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Any Suicidal Thoughts?**\_\_ Current? \_\_Past? – How long ago?\_\_\_\_\_\_\_\_ Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is your child currently experiencing anxiety, panic attacks or have any phobias?** \_\_Yes \_\_No

If yes, when did your child begin experiencing this? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Any History of self-harm?** \_\_Current? \_\_Past? – How long ago?\_\_\_\_\_\_\_ Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*Any thoughts about harming others?** \_\_Current? \_\_Past? – How long ago? \_\_\_\_\_\_\_\_ Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please describe any major losses or traumas your child has experienced:**

**What significant life changes or stressful events has your child experienced recently?**

**What would you like to see accomplished during your child’s time in therapy?**

**Family History**

Where was the patient born? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where did the patient grow up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_City \_\_Suburbs \_\_Country

Please list the patient’s **parents, step-parents,** **siblings, and any other significant family members**.

Please use additional space on the back if needed.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name** | **Age** | **Relationship** | **Where do they live now?** | **If deceased, age and cause of death** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Who has the patient lived with throughout their childhood?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother's occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Father's occupation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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).**

|  |  |  |
| --- | --- | --- |
| **Condition** | **Please Circle** | **List Family Member** |
| Alcohol/ Substance Abuse | Yes / No |  |
| Anxiety | Yes / No |  |
| Depression | Yes / No |  |
| Domestic Violence | Yes / No |  |
| Sexual Abuse | Yes / No |  |
| Eating Disorders | Yes / No |  |
| Obesity | Yes / No |  |
| Obsessive Compulsive Disorder | Yes / No |  |
| Schizophrenia | Yes / No |  |
| Suicide Attempts | Yes / No |  |
| Other diagnosed mental health condition? | Yes / No: Which was?: |  |

**Guardians’ Marital Status:**

Primary Guardian #1 (PG#1) / Primary Guardian#2 (PG#2)

PG#1 / PG#2

\_\_ \_\_ Never Married

\_\_ \_\_ Domestic Partner

\_\_ \_\_ Married

\*\*If married, how long have you been married, and what is your partner’s name:

(PG#1)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (PG#2)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ \_\_ Separated

\_\_ \_\_ Divorced -- For how long? \_\_\_\_\_\_\_\_\_

\_\_ \_\_ Widowed: Please provide your partners name and year deceased: (PG#1 or PG#2?-Circle) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Parent(s) currently in a romantic relationship?

\_\_ \_\_ Yes -- How long? (PG#1)\_\_\_\_\_\_\_ (PG#2)\_\_\_\_\_\_\_

\_\_ \_\_ No

What is the patient’s Gender?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred pronoun(s)?\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the patient’s Sexual Orientation?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any issues related to gender or sexual orientation that might be relevant to treatment?

**Physical Health**

Please list any medications, herbs, or supplements. Be sure to include the condition, as some medications are prescribed for off-label use. Continue on the back if needed, or provide a separate list. If your child has a complicated medical profile, please supply supporting documentation to be able to facilitate a comprehensive understanding of your child’s health.

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication/Supplement** | **Dosage** | **Condition** | **Date Began/Stopped** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Prescribing provider(s) and contact information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone, email, or Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How would you rate the patient’s current physical health?**

\_\_Poor \_\_Unsatisfactory \_\_Satisfactory \_\_Good \_\_Very Good

**Please list any specific and significant health problems the patient is currently experiencing:**

**How would the patient rate their current sleeping habits?**

\_\_Poor \_\_Unsatisfactory \_\_Satisfactory \_\_Good \_\_Very Good

**If the patient is having problems, in which phase of sleep are they experiencing issues?**

\_\_Falling asleep \_\_Staying asleep \_\_Awakening early \_\_Sleep apnea

**Please list any other specific sleep problems the patient is currently experiencing:**

How many times per week does the patient generally exercise? \_\_\_\_\_\_\_\_\_\_\_\_ What types of exercise does the patient participate in?:

Is the patient currently experiencing any chronic pain? \_\_No \_\_Yes If yes, please describe:

**Substance Use/ Abuse**

**Please describe current use of alcohol, cigarettes, and/or recreational drugs:**

**Please describe previous use of alcohol, cigarettes, and/or recreational drugs:**

**Additional Information**

**Describe the patient’s strengths and limitations related to education:**

**Is there an IEP/504 Plan?** \_\_Yes \_\_No

**Describe the patient’s social relationships:**

**What does the patient enjoy doing in their free time? What do they do to relax?**

**Is the patient spiritual or religious? If yes, please describe their faith or belief:**

**What are some of the patient’s strengths?**

**What are some of the patient’s weaknesses?**

**Any additional Information that might help your child’s clinician better understand your child’s unique circumstances:**

**Reviewed by (Therapist/Supervisor):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

 Print Signed Date

\*See biopsychosocial assessment for additional notes\*

****

Phone: (833) ETC-LIFE

Email: info@empowermentmail.com

9720 Capital Ct, Suite 303

Manassas, VA 20110

**Patient Acknowledgement**

**Receipt of Patient Agreement**

**Please sign, print your name, and date this acknowledgement form.**

By signing below, I hereby acknowledge that I have been provided with the *Empowerment Therapy Center’s* (ETC’s) ***Patient Agreement***. The *Patient Agreement* is available at any time on the ETC website located at:

<http://empowerment-therapy-center.com>

I may also obtain a copy from my ETC therapist upon request, or by ETC, or may access a copy for review in the ETC waiting room. The Patient Agreement includes explanations of the following:

**Consent for Treatment**

**Notice of Privacy Practices**

**Financial Policy**

**General Office Policies**

“I (Guardian, if patient is a minor)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_have read in full, have been provided adequate opportunity to clarify any questions, understand, and agree to the Empowerment Therapy Center’s **Patient Agreement**. I also understand that the Patient Agreement may be modified without notice. I will discuss these policies with my (or the child’s) therapist, and I understand that I may ask questions about them at any time in the future. I consent to accept these policies as a condition of receiving mental health services.”

Patient/ (or guardian if minor) Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Guardian (if minor) Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_Patient DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_

****

Phone: (833) ETC-LIFE

Email: info@empowermentmail.com

9720 Capital Ct, Suite 303

Manassas, VA 20110

**RELEASE OF MEDICAL INFORMATION**

Date of Release\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Primary Care Physician),

We are currently working with your patient, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (DOB:\_\_\_\_\_\_\_\_\_\_\_) in outpatient mental health counseling. Many insurance carriers require that health information on clients must be obtained. In order to fulfill this requirement, we must request that you either mail or fax the client’s latest physical health information.

Our mailing address is: Empowerment Therapy Center, etc, PLLC

 9720 Capital Ct, Suite 303

 Manassas, VA 20110

Our fax number is: 833-382-5433

Thank you for your prompt attention and your cooperation in this matter. Below you will find the signatures of the client/ guardian indicating agreement with this release.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client/Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Staff Witnessing Date

Date Sent to PCP: \_\_\_\_\_\_\_\_\_\_\_\_\_

*Clinician: Please complete this form and either fax or mail a copy of this form to the above-mentioned doctor. Scan this completed form with the date sent in the client’s chart.*

****

Phone: (833) ETC-LIFE

Email: info@empowermentmail.com

9720 Capital Ct, Suite 303

Manassas, VA 20110

**GENERAL RELEASE OF INFORMATION**

CLIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_ Date of Release: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby give my written permission for *Empowerment Therapy Center, etc* to exchange the following verbal or written information as indicated with: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name or Entity).

Extent or nature of use/disclosure is limited to: (Check or list all that apply)

\_\_ Discharge Summary \_\_ History & Physical \_\_ Psychiatric Evaluation \_\_ Progress notes

\_\_ Medical Records \_\_ Lab Work \_\_ Consultations \_\_ Treatment Plan

\_\_ School Records \_\_ Psychological Evaluation \_\_ Case Coordination \_\_ Medication

 Management

\_\_ Diagnostic Information \_\_ Treatment Recommendations

\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date and/or condition when release will expire: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If not specified, the release will expire one year from the date signed or 30 days from discharge, if this occurs before one year.

\*As the person signing this authorization, I understand that I am giving my permission to the above named provider to use, disclose, and/or request confidential health care records until the termination of this authorization. I understand this will include information added after the authorization origination date and up until the authorization termination date. I may refuse to sign the authorization. Treatment, payment, healthcare operations, or eligibility are not conditional upon giving authorization. The original, or a copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. I also understand that I have the right to revoke this authorization at any time, but not retroactive to information already released in accordance with the authorization and that my revocation is not effective until delivered in writing to the person who is in possession of my records. The authorization is automatically revoked upon termination of service.

The person who receives the records to which this authorization pertains may not redisclose them to anyone else without my separate written authorization unless such recipient is a provider who makes a disclosure permitted by law. A general authorization for the release of medical or other information is not sufficient authorization. The exact nature of information requested and purpose for which information is sought must be specified. State and/or federal law protect the disclosed confidential information. Federal regulation (42 CFR Part 2), restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Client Signature (parent signature if client is a minor) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_

Staff Witnessing Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_

****

Phone: (833) ETC-LIFE

Email: info@empowermentmail.com

9720 Capital Ct, Suite 303

Manassas, VA 20110

**CONFIDENTIAL**

**CREDIT CARD INFORMATION FORM**

Name of Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Card Holder (as it appears on card):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

VISA\_\_ MASTERCARD\_\_ DISCOVER\_\_ AMEX\_\_ (HSA cards are fine)

Credit Card #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp Date:\_\_\_\_\_\_\_\_\_\_\_\_ CCV:\_\_\_\_\_\_\_

Zip code associated with this card (billing zip):\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize *Empowerment Therapy Center,* to charge this card for:**

**\_\_ copayment(s)/ co-insurance(s) due, or**

**\_\_for a one-time payment in the amount of: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**