To New Patients:

This packet includes information about me and forms for you to fill out and bring with you to our first session. It is a lot of reading, but the information is important, so please review it in its entirety. If for some reason you are unable to complete the paperwork before our session, I will have copies in my office and we will use your session time to complete the paper work.

Please complete this paperwork prior to our initial meeting so that we can spend our time together focusing on the personal concerns that you wish to consult me about. I look forward to meeting with you.

Jessica Szymas, MA, LMHC

NAME OF SECTION	PAGE NO
Disclosure Statement about Counselor, Training, Counseling Orientation, General Information, And Counseling Fees	2
HIPAA Notice of Privacy Practices	4
Patient Intake Form – Client 1	7
Patient Intake Form – Client 2	10
Patient Video and Audio Recording Release	13
Patient Authorization to Charge/Debit Credit Card	14

Checklist for completing this paperwork:

- Please print your name in the space provided on this page (page 1).
- Read through the Disclosure Statement on pages 2 through 3. Sign on page 3.
- Read Acknowledgement of Receipt of Notice of Privacy Practices and Financial Agreement on pages 4 through 9. Sign on page 9.
- Complete your Intake Forms on pages 10 through 15.
- Read through and sign the Video and Audio Recording Release on page 16.
- Complete the Credit Card Authorization Form on page 17.
- Initial all pages in lower right hand corner to indicate that you have read and understand the information provided.

Client Name: ______________________________
(please print)

Client Name: ______________________________
(please print)

DISCLOSURE STATEMENT

Counselor Training and Degrees:
I received my Bachelor of Arts in Psychology in 2007 from Cornerstone University in Grand Rapids, Michigan. I graduated with my Master of Arts in Counseling Psychology from The Seattle School of Theology and Psychology in 2012. During my last year of graduate school, I completed an internship at Seattle Therapy Alliance under the supervision of Dr. Susan Hall and Julie Cake. This internship included feminist training and work with adult women around a variety of issues including anxiety and depression, self-harm, sexual abuse, racial identity, and body image. In recent years, I have also received extensive training on sexuality from the Northwest Institute on Intimacy.

Counseling Orientation:
I view psychotherapy as a collaborative process between client(s) and therapist, one that moves the client(s) toward further self-understanding, growth, and healing. I approach your presenting problems from an integrated perspective. This means I take several factors into consideration when assessing the root of the problems: interpersonal dynamics, physiology, psychology, culture, and social situation. If you are struggling with a relational or sexual issue that may have a physiological cause, I will recommend a medical consult in addition to psychotherapy.
Once we have either ruled out or attended to any physiological causes for your presenting problems, we will then consider the variety of other factors that may be contributing to your difficulties. Most often we will look at the nature of your relationships with significant people in your life. I believe that you are made to relate in a satisfying manner and that relationships are both the source of your greatest joys and also of your greatest problems. According to my theoretical orientation, many of the forces and dynamics that have influenced the complexity and intensity of your struggles are rooted in relational patterns. Thus, we will explore how certain aspects of your relational style may interfere with the enjoyment for which you are made.

Fees: The fee for counseling is $115 per 50-minute session and $140 per 75-minute session. Initial sessions are run in the 50-minute session format. Fees are adjusted annually on January 1 and will not increase more than $10 per year. Payments (cash, check, or credit) are to be made at the beginning of each session. Credit Card payments will include a processing fee of up to 3.7% plus $0.15 per transaction and will be the same fees that the credit card company charges me. A $30 fee will be charged for returned checks. Unpaid balances incur the maximum finance charge allowed by law after 30 days. Outstanding balances may be sent to a collection agency.

Missed Appointments: In the event that you are unable to keep an appointment, please notify me via phone or email a minimum of two days (48 hours) in advance. **If you miss your appointment for whatever reason and fail to give me adequate notice, you will be responsible for the full fee for the session.** If you are late, I will still stop at our regular ending time in order to keep my schedule, and you will still be required to pay for the entire session. In the event of a missed appointment, the bill will reflect a late cancellation instead of a clinical session. Most insurance companies will not reimburse for missed appointments. If I have an emergency, I will notify you as soon as possible of my need to reschedule our appointment.

Termination of Treatment: When you wish to terminate treatment, please give a minimum of one week's notice. You may terminate treatment at any time without moral, legal, or financial obligation beyond payment of services already rendered. It is expected that we will discuss the prospect of termination so that both parties will be clear about any details that need attention as part of the termination process. If you fail to schedule a future appointment, cancel a scheduled appointment, or fail to keep a scheduled appointment and do not contact me within 30 days of the date of last recorded contact, it will be understood that you have terminated treatment. I shall have no further obligation to you once treatment has been terminated.

Testifying in Court: If you become involved in any legal proceedings that require my participation, you will be expected to pay for all of my professional time. This includes any preparation and transportation time, even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $185 per hour for preparation and travel, for attendance (waiting and participation) at any legal proceeding. Having said this, I am not a certified child custody evaluator and will be unable to you legally if this is your purpose in pursuing treatment with me.

__________, _________ (Client Initials)

Choosing a Counselor: You have the right to choose a counselor who best suits your needs and purposes. You may seek a second opinion from another mental health practitioner or may terminate therapy at any time.

State Mandated Disclosure: I have broad discretion to release any information that I deem relevant in situations where I believe my client or others to be at risk of physical harm, physical or sexual abuse, molestation, or severe neglect.

Consultations: I regularly consult with other professionals regarding patients with whom I am working. This allows me to gain other perspectives and ideas about how to better help you reach your goals. These consultations are conducted in such a way that confidentiality is maintained.

State Registration: Therapists practicing psychotherapy for a fee must be registered or certified with the Department of Health for the protection of the public health and safety. Registration of an individual with the department does not include recognition of any practice standards, nor does it necessarily imply the effectiveness of any treatment. The purpose of the Counselor Credentialing Act (Chapter 18.19 RCW) is (a) to provide protection for public health and safety, and (b) to empower the citizens of the citizens of the State of Washington by providing a complaint process against those counselors who commit acts of unprofessional conduct.

Unprofessional Conduct: The brochure titled "Counseling or Hypnotherapy Patients" lists ways in which counselors may work in an unprofessional manner. If you suspect that my conduct has been unprofessional in any way, please contact the Department of Health at the following address and phone number:

Department of Health, Counselor Programs
PO Box 47869
Olympia, WA 98504-7869
(360)664-9098

Contacting Me By Phone: You may leave me a voice message at (425)243-4218. I check my messages periodically and will typically return your call within 48 hours. Please limit your phone conversation needs to appointment scheduling and emergencies.

Emergencies: If you are in an emergency situation and cannot reach me, please call one of the following numbers for help:

General Emergencies	911
Crisis Clinic	(800) 244-5767 or (206) 461-3222

I have read and understand the information present in this form.

Date:________________ ________________________________
Client Signature

Date:________________ ________________________________
Client Signature

Date:________________ ________________________________
Jessica Szymas, MA, LMHC

__________, _________ (Client Initials)

HIPAA COMPLIANCE
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

As part of my professional practice, I maintain personal information about you and your health. State and federal law protects such information by limiting its uses and disclosures. "Protected health information" ("PHI") is information about you, including demographic information, that may identify you or be used to identify you, and that relates to your past, present or future physical or mental health or condition, the provision of health care services, or the past, present or future payment for the provision of health care.

Your Rights Regarding Your PHI: The following are your rights regarding PHI I maintain about you:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in certain limited circumstances, to inspect and copy your PHI that I maintain. I may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request a copy of the required accounting of disclosures that I make of your PHI.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that I communicate with you in a certain way or at a certain location. I will accommodate reasonable requests and will not ask why you are making the request.
- **Right to a Copy of this Notice.** You have the right to a paper copy of this notice.
- **Right of Complaint.** You have the right to file a complaint in writing with me or with the Secretary of Health and Human Services if you believe I have violated your privacy rights. ***I will not retaliate against you for filing a complaint.***

__________, _________ (Client Initials)

My Uses and Disclosures of PHI for Treatment, Payment and Health Care Operations

Treatment. I may use your PHI for the purpose of providing you with health care treatment. To coordinate and manage your care, I may disclose your PHI to others of your current providers, and to the extent you have not raised an objection in writing, to your prior providers, or to other persons, including family members, involved in your care.

Payment. I may use your PHI in connection with billing statements I send you and my system for tracking charges and credits to your account. In addition, but with your authorization, I may disclose your PHI to third party payers to obtain information concerning benefit eligibility, coverage, and remaining availability, as well as to submit claims for payment and to disclose PHI for medical necessity and quality assurance reviews.

Health Care Operations. I may use and disclose your PHI for the health care operations of my professional practice in support of the functions of treatment and payment. Such disclosures would be to Business Associates for health care education, or to provide planning, quality assurance, peer review, administrative, legal, or financial services to assist me in my delivery of your health care.

Other Uses and Disclosures That Do Not Require Your Authorization or Opportunity to Object

Required by Law. I may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. Examples are public health reports, abuse and neglect reports, law enforcement reports, and reports to coroners and medical examiners in connection with investigation of deaths. I also must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

Health Oversight. I may disclose your PHI to a health oversight agency for activities authorized by law, such as my professional licensure. Oversight agencies also include government agencies and organizations that audit their provision of financial assistance to me (such as third-party payers).

Threat to Health or Safety. I may disclose your PHI when necessary to minimize an imminent danger to the health or safety of you or any other individual.

Appointment Reminders. I may use your PHI to contact you to remind you of your appointments with me.

Business Associates. I may disclose your PHI to Business Associates that are contracted by me to perform health care operations or payment activities on my behalf which may involve their collection, use or disclosure of your PHI. My contract with them must require them to safeguard the privacy of your PHI.

Compulsory Process. I will disclose your PHI if a court of competent jurisdiction issues an appropriate order. I will also disclose your PHI if (1) you and I have each been notified in writing at least fourteen days in advance of a subpoena or other legal demand, identifying the PHI sought, and the date by which a protective order must be obtained to avoid my compliance, (2) no qualified judicial or administrative protective order has been obtained, (3) I have received satisfactory assurances that you received notice of an opportunity to have limited or quashed the discovery demand, and (4) such time has elapsed.

__________, _________ (Client Initials)

Uses and Disclosures of PHI With Your Written Authorization

I will make other uses and disclosures of your PHI only with your written authorization. You may revoke this authorization in writing at any time, unless I have taken a substantial action in reliance on the authorization such as providing you with health care services for which I must submit subsequent claim(s) for payment.

This Notice

This Notice of Privacy Practices informs you how I may use and disclose your protected health information ("PHI") and your rights regarding your PHI. I am required by law to maintain the privacy of your PHI and to provide you with notice of my legal duties and privacy practices with respect to your PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will make available a revised Notice of Privacy Practices by providing you a copy upon your request, or providing a copy to you at your next appointment.

Contact Information

I am my own Privacy Officer, so, if you have any questions about this Notice of Privacy Practices, please contact me.

My contact information is:

Jessica Szymas, MA, LMHC

444 NE Ravenna Blvd, Suite 309

Seattle, WA 98115

425-243-4218

Complaints

If you believe I have violated your privacy rights, you may file a complaint in writing to me, as my own Privacy Officer, specified on the first page of this Notice. **I will not retaliate against you for filing a complaint.** You may also file a complaint with the Secretary of the Department of Health and Human Services.

The effective date of this Notice is September 1, 2017.

I have read and understand my privacy rights as they have been outlined here.

Client Signature: ________________________________ **Date:** ______________________

Client Signature: ________________________________ **Date:** ______________________

__________, _________ (Client Initials

PATIENT INTAKE FORM—CLIENT #1
PART 1

Date__________________

Last Name	First Name		Date of Birth
Address	City	State	Sex (M/F)

Email Address: ____

CAN I EMAIL YOU FOR: (CIRCLE ALL THAT APPLY) SCHEDULING RESOURCES AVAILABLE GROUPS

I typically will not identify myself as a Mental Health Counselor when I call to protect your privacy. Due to a variety of factors, sometimes people are difficult to reach or never receive messages. Please call me again if you do not hear from me. I am authorized to contact you as listed below:

- ☐ Home phone number ___________________/ Can I leave voice mail at this number? Y/N
- ☐ Cell phone number ___________________/Can I leave voice mail at this number? Y/N
- ☐ Office phone number ___________________/Can I leave voice mail at this number? Y/N
- ☐ Other phone number ___________________/Can I leave voice mail at this number? Y/N
- ☐ Fax Number ___________________

Who I am authorized to communicate with: Name: ______________________ Relationship: _________________

Name: ______________________ Relationship: _________________

How did you hear about me?

- ☐ Internet
- ☐ Church
- ☐ Referral
- ☐ Other ______________

Has anyone urged you to come here? ________________

Briefly tell me the concerns that have brought you here.

____

____

____

____

Would you be interested in a counseling group? Y/N For what issues/topics? ______________________________

__________, _________ (Client Initials)

PATIENT INTAKE FORM—CLIENT #1
PART 2

Please check any current or past issues that still affect you.

- ☐ Eating disorders
- ☐ Academic issues
- ☐ Childhood abuse (*i.e. physical, sexual, emotional*)
- ☐ Depression
- ☐ Stress/Anxiety
- ☐ Phobias (*type:____)*
- ☐ Sexual Identity Issues
- ☐ Alcohol/Other Drug Use
- ☐ Relationship Concerns
- ☐ Sexual Assault/Rape
  - *Recently (when:____)*
  - *In the past (when:_____)*
- ☐ Death of someone close
  - *Recently (when:_____)*
  - *In the past (when:_____)*
- ☐ Gender Identity Issues
- ☐ Family Issues *(i.e. divorce, alcoholism, domestic violence)*
- ☐ Other:_____________________
- ☐ Pregnancy Issues
- ☐ Spiritual Concerns
- ☐ Suicidal Thoughts
- ☐ Pornography or compulsive sexual behavior
- ☐ Sexual Concerns *(please list:__________________________________)*
- ☐ Relationship Concerns
  - *Family*
  - *Friend*
  - *Parent*
  - *Significant other*
  - *Roommate*
  - *Other:_________*
- ☐ Other

If you currently experience any of the following symptoms, please rate them using the key below.
NEVER=0 SELDOM=1 OFTEN=2 ALWAYS=3

______Difficulty concentrating
______Crying
______Missing classes
______Feeling helpless
______Feeling uptight
______Worrying
______Feeling hopeless
______Feeling afraid
______Lying to others
______Feeling out of control
______Feelings of self-doubt
______Injuring self
______Nervous around others

_____Memory loss or blackout
_____Difficulty sleeping
_____Stealing
_____Anger
_____Eating binges
_____Drinking heavily
_____Other drug use
_____Guilt feelings
_____Withdrawing socially
_____Sexual preoccupation
_____Physical symptoms (i.e. headaches, digestive)
_____List: _____________________________________
_____Suicidal thoughts
_____Other:___________________________________

Please use the scale below to answer the following questions.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

____My current concerns affect my success in life.
____My current concerns affect my ability to interact and connect with others.
____I am optimistic that I will be able to make some positive changes as a result of counseling.

___________, __________ (Client Initials)

PATIENT INTAKE FORM--CLIENT #1
PART 3

Your History

Please list any current medical issues or concerns:

____

____

What medications are you taking? (all, including herbal)

____

____

Are you currently working with a Personal Physician? Y/N Phone Number: ___________________________

Physician's Name __________________________________ What for? ________________________________

Have you been on any medication in the past for mental health issues? (Please list type & dosage)

____

____

Have you previously seen a counselor? Y/N Who/Where? ____

How long ago? ____________________ How long was your treatment?______________________________

For what types of issues?

____

____

Are you currently seeing a counselor? Y/N If Yes, who/Where? ____

How long ago? ____________________ How long was your treatment? ______________________________

For what types of issues?

____

____

Have you ever been hospitalized for physical or mental health issues? Y/N (Briefly describe)

____

____

Have you had any previous suicide attempts? Y/N When___________ (Briefly describe)

____

____

___________, __________ (Client Initials)

PATIENT INTAKE FORM—CLIENT #2
PART 1

Date__________________

Last Name	First Name		Date of Birth
Address	City	State	Sex (M/F)

Email Address: ____

CAN I EMAIL YOU FOR: (CIRCLE ALL THAT APPLY) SCHEDULING RESOURCES AVAILABLE GROUPS

I typically will not identify myself as a Mental Health Counselor when I call to protect your privacy. Due to a variety of factors, sometimes people are difficult to reach or never receive messages. Please call me again if you do not hear from me. I am authorized to contact you as listed below:

- ☐ Home phone number __________________/ Can I leave voice mail at this number? Y/N
- ☐ Cell phone number __________________/Can I leave voice mail at this number? Y/N
- ☐ Office phone number __________________/Can I leave voice mail at this number? Y/N
- ☐ Other phone number __________________/Can I leave voice mail at this number? Y/N
- ☐ Fax Number __________________

Who I am authorized to communicate with: Name: _____________________ Relationship: ________________

Name: _____________________ Relationship: ________________

How did you hear about me?

- ☐ Internet
- ☐ Church
- ☐ Referral
- ☐ Other _____________

Has anyone urged you to come here? ________________

Briefly tell me the concerns that have brought you here.

____

____

____

____

Would you be interested in a counseling group? Y/N For what issues/topics? ____________________________

__________, _________ (Client Initials)

PATIENT INTAKE FORM—CLIENT #2
PART 2

Please check any current or past issues that still affect you.

- ☐ Eating disorders
- ☐ Academic issues
- ☐ Childhood abuse (*i.e. physical, sexual, emotional*)
- ☐ Depression
- ☐ Stress/Anxiety
- ☐ Phobias (*type:____)*
- ☐ Sexual Identity Issues
- ☐ Alcohol/Other Drug Use
- ☐ Relationship Concerns
- ☐ Sexual Assault/Rape
    - *Recently (when:____)*
    - *In the past (when:_____)*
- ☐ Death of someone close
    - *Recently (when:_____)*
    - *In the past (when:_____)*
- ☐ Gender Identity Issues
- ☐ Family Issues *(i.e. divorce, alcoholism, domestic violence)*
- ☐ Other:_____________________
- ☐ Pregnancy Issues
- ☐ Spiritual Concerns
- ☐ Suicidal Thoughts
- ☐ Pornography or compulsive sexual behavior
- ☐ Sexual Concerns *(please list:__________________________________)*
- ☐ Relationship Concerns
    - *Family*
    - *Friend*
    - *Parent*
    - *Significant other*
    - *Roommate*
    - *Other:_________*
- ☐ Other

If you currently experience any of the following symptoms, please rate them using the key below.
NEVER=0 SELDOM=1 OFTEN=2 ALWAYS=3

______Difficulty concentrating
______Crying
______Missing classes
______Feeling helpless
______Feeling uptight
______Worrying
______Feeling hopeless
______Feeling afraid
______Lying to others
______Feeling out of control
______Feelings of self-doubt
______Injuring self
______Nervous around others

_____Memory loss or blackout
_____Difficulty sleeping
_____Stealing
_____Anger
_____Eating binges
_____Drinking heavily
_____Other drug use
_____Guilt feelings
_____Withdrawing socially
_____Sexual preoccupation
_____Physical symptoms (i.e. headaches, digestive)
_____List: ____________________________________
_____Suicidal thoughts
_____Other:___________________________________

Please use the scale below to answer the following questions.

1	2	3	4	5
Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree

____My current concerns affect my success in life.
____My current concerns affect my ability to interact and connect with others.
____I am optimistic that I will be able to make some positive changes as a result of counseling.

___________, _________ (Client Initials)

PATIENT INTAKE FORM—CLIENT #2
PART 3

Your History

Please list any current medical issues or concerns:

____

____

What medications are you taking? (all, including herbal)

____

____

Are you currently working with a Personal Physician? Y/N Phone Number: ___________________________

Physician's Name _________________________________ What for? ________________________________

Have you been on any medication in the past for mental health issues? (Please list type & dosage)

____

____

Have you previously seen a counselor? Y/N Who/Where? ____

How long ago? ____________________ How long was your treatment?______________________________

For what types of issues?

____

____

Are you currently seeing a counselor? Y/N If Yes, who/Where? ____

How long ago? ____________________ How long was your treatment? _______________________________

For what types of issues?

____

____

Have you ever been hospitalized for physical or mental health issues? Y/N (Briefly describe)

____

____

Have you had any previous suicide attempts? Y/N When___________ (Briefly describe)

____

____

___________, __________ (Client Initials)

VIDEO AND AUDIO RECORDING RELEASE

As an additional support for your counseling process it is sometimes beneficial to use video feedback as part of our work together. This means that I may ask to video or audio record you during specific dialogues, exercises, or during entire sessions. This will give us the option to play back these recordings in session to help you see patterns of behavior in yourself or your significant other (if applicable). Because it usually takes some time to setup a video camera or audio recorder, I'm requesting that we do the paperwork for this on the front end so that we can devote as much time to working on the issues that bring you into counseling. By viewing the video or listening to the audio recording in session, it allows us to "stop action" and process how you might approach an issue in a more productive way. It also allows you to witness your progress with your counselor and/or your relationship.

In addition to in-session use, I occasionally may use the video footage or audio recording to receive consultation from other health care professionals that I consult with. This may occur during time of treatment or thereafter for purposes of peer review, education and quality assurance. During this process your name will be kept confidential. In addition, all matters discussed with other health care providers will remain completely confidential. The video or audio recording will be used for no other purpose without your written permission and it will be deleted when it is no longer needed for these purposes.

These recordings are the property of Jessica Szymas, MA, LMHC and will remain solely in my possession throughout the course of your counseling and until they are destroyed. Should you wish to review these recordings for any reason, we will arrange a session to do so. When unattended by me, these materials will remain in locked facilities and/or on encrypted computer systems at all times to ensure maximum confidentiality.

I ______________________ hereby grant my/our permission for any audio or video recording that may be deemed pertinent in the counseling of my/ourselves, my/our marriage, or my/our family. The counseling sessions, records, video, and audio recordings are strictly confidential except where I consent to release, where state law requires the reporting of threats, violence, harm or child abuse, and neglect (from evidence or suspicion), and when information is subpoenaed by the courts.

In no way will the refusal to grant consent for this video or audio recording effect my/our getting assistance for myself/ourselves. I understand I may revoke this permission in writing at any time, but until I do so, it shall remain in full force and effect.

Client______________________ ______________________ Date____________________
(signature) (printed name)

Client______________________ ______________________ Date____________________
(signature) (printed name)

Counselor__________________ ______________________ Date____________________
(signature) (printed name)

__________, _________ (Client Initials)

CREDIT CARD PAYMENT AUTHORIZATION FORM

Sign and complete this form to authorize **Jessica Szymas, MA, LMHC** to debit your credit as listed below.

By signing this form you give me permission to debit your account for the amount indicated on or after the indicated date. This is permission for therapeutic treatment fees accrued while in treatment with **Jessica Szymas, MA, LMHC** and does not provide authorization for any additional unrelated debits or credits to your account. Credit cards may be run in the event that you forget to bring cash, check or valid credit card to your session. Credit cards will also be debited in the event that you fail to give adequate notice by phone or email of missing an appointment. No more than two consecutive missed appointments will be billed. A receipt of credit card processing will be sent to the email provided below.

Please complete the information below:

I, ______________________ (full name printed) authorize **Jessica Szymas, MA, LMHC** to charge my credit card account indicated below (your card may also be copied for our records). Fees accrued for missed appointments or failure to provide payment at the time of service will be processed via credit card at a rate of $115.00 per 50-minute session and $140 per 75-minute session and Credit Card payments will include a processing fee of up to 3.7% plus $0.15 per transaction and will be the same fee that the credit card company charges me. This is the exact same fee that I am charged by my credit card processing company.

Billing Address ____________________________ Phone #_______________________________

City, State, Zip ____________________________ Email____

Account Type: ___Visa ___MasterCard ___AMEX ___Discover

Cardholder Name ____
Account Number____
Expiration Date _______________
CVV2 (3 digit number on back of Visa/MC/Discover, 4 digits on front of AMEX)_________

I authorize **Jessica Szymas, MA LMHC** to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, for the amounts indicated above only. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

SIGNATURE_______________________________________ DATE___________________________

__________, _________ (Client Initials)