# HICKS GROUP: WELLNESS CENTER

## OFFICES OF AUNJULI HICKS, PHD

### New Patient Fee for Service Intake Form

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**Name of Patient**:_____ **DOB**:_____ **SSN#**:_____

**Address**:_____

**Home#**:_____**Work#**:_____**Cell#**_____**Emergency Contact#**_____**Email**:_____

**FAMILY MEMBERS**

| Name | Sex | DOB | Relationship |
|---|---|---|---|
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I_____ agree to self-pay for all my counseling and therapy services provided by
**Print Your Name**

**Hicks Group: Wellness Center and Offices of Aunjuli Hicks, PhD** and will be responsible for all out-of-pocket services. I elect to self-pay for the following reasons:

- Personal reasons
- I do not have a health plan.
- I do have a health plan but it does not cover behavioral health services.
- Hicks Group Wellness Center and/or Aunjuli Hicks, PhD is not contracted with my health plan.

If I do have a health insurance plan that covers behavioral health services, I decline the offer given by **Hicks Group: Wellness Center and Aunjuli Hicks, PhD** to use those benefits. I wish and understand I will therefore be financially responsible for all services provided by the therapist.

I understand that **Hicks Group: Wellness Center and Aunjuli Hicks, PhD** has *a NO SHOW POLICY FEE of $250, CANCELLATION FEE of $50, Return Check Fee of $35* and additional fees for assessments, reports, and letters which I agree am require to pay.

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**Authorization & Release**

I have read and fully understand the Fee for Service Financial Form as outlined above. In event that it is necessary to turn my account over to collections I will also be responsible for any and all costs of collections. I understand that this authorization shall apply to all services provided to me, my dependents, or any other person for which I have assumed responsibility by signing below, from this date forward.

**Patient Signature**_____ **Date:** _____