



**MONARCH**  
BEHAVIORAL HEALTH, PLLC  
Live at Full Potential

## **ADULT INTAKE PACKET**

Welcome to Monarch Behavioral Health, PLLC. Please fill out and review the following questionnaires and information so that we may best help you. In this packet you will find:

- Intake Background Questionnaire for Individuals over age 18 (fill out and sign)
- MBH Policies
- MBH Privacy Practices Notice
- MBH Receipt of Privacy Practices
- Email Permission Form
- Coordination of Care Authorization Forms
- Payment Authorization Form

35980 Woodward Ave., Suite 100, Bloomfield Hills, MI 48304

Phone: 248-220-3332 | Fax: 248-462-6963 | Email: [office@mbh-mi.com](mailto:office@mbh-mi.com) | Website: [www.mbh-mi.com](http://www.mbh-mi.com)



**MONARCH**  
BEHAVIORAL HEALTH, PLLC

**Intake Background Questionnaire**

**Full Legal Name:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

**Age** \_\_\_\_\_ **Date of Birth** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Monarch Behavioral Health, PLLC has permission to call me at the following numbers:**

**Home Phone#** \_\_\_\_\_ **OK to leave a message: Yes No**

**Work Phone #** \_\_\_\_\_ **OK to leave a message: Yes No**

**Cell Phone #** \_\_\_\_\_ **OK to leave a message: Yes No**

**Other #** \_\_\_\_\_ **OK to leave a message: Yes No**

**Address** \_\_\_\_\_ **City** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Occupation** \_\_\_\_\_ **SS#** \_\_\_\_\_

**Place of Employment** \_\_\_\_\_

**Type of Employment** \_\_\_\_ **Full time** \_\_\_\_ **Part time**

**Highest Grade Completed** \_\_\_\_\_ **Sex** \_\_\_\_ **M** \_\_\_\_ **F**

**Relationship Status (Please circle one)**

**Never Married**    **Married**    **Partnered**    **Separated**    **Divorced**    **Widowed**

**Are you involved in any legal cases at the present time? Yes No**

**If yes, please explain:** \_\_\_\_\_

**List Family Members (Parents/Siblings or Partner/Spouse/Children)**

**Name** \_\_\_\_\_ **Relationship** \_\_\_\_\_ **Age** \_\_\_\_ **Occupation (or grade)** \_\_\_\_\_

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

**Emergency Contact Person:** \_\_\_\_\_ **Relationship to you:** \_\_\_\_\_

**Work or Daytime Phone** \_\_\_\_\_ **Home Phone** \_\_\_\_\_

**Primary Physician** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Please list any current medications (including birth control pills) and /or physical health problems:**

\_\_\_\_\_

**Significant past health problems:** \_\_\_\_\_

**Who referred you to our office?** \_\_\_\_\_



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**POLICIES REGARDING PROFESSIONAL SERVICES**

**CONFIDENTIALITY**

Any information that you provide, as well as counseling and/or evaluation records that are maintained, are kept strictly confidential, with the exception of life threatening situations, cases of suspected child abuse, when release is otherwise required by law, or when you request that the information be released. Testing and evaluation data may be entered into the computer by Monarch Behavioral Health data entry specialist. Should the need arise; your case may be discussed anonymously during case consultation with another licensed psychologist while keeping identifying information strictly confidential.

**PAYMENT OF FEES** It is customary to pay for professional services when they are rendered, preferably by Credit Card with automatic payment form, cash or check made payable to Monarch Behavioral Health.

**CHARGES**

Charges for professional services are as follows:

- Initial Clinical Interview (Therapy, first session): \$250.00
  - Individual and Family Therapy (per 45 minute session): \$175
  - Group Therapy Services (per meeting): \$55.00
  - Full Psycho-Educational Assessment\*\* \$2700.00-\$4,625.00 (Based on age of child at time of testing)
  - School Visit (per hour, additional travel fees may apply): \$250.00
  - Legal fees (per hour): \$250.00
  - Record Review (Academic, Clinical, etc., per hour): \$50.00 per 5 minute increment
  - Telephone/Email Communication, per 15 minutes: \$50.00
- \*\*Evaluation Price quoted at Intake is valid for 90 Days.

**INSURANCE** Many insurance plans cover all or part of the costs of psychological services. If you expect to file for reimbursement from your insurance company, a statement of services will be uploaded to your Patient Portal. Submission of forms or receipts to the insurance company is, in all cases, the client's responsibility.

**MISSED APPOINTMENTS**

Because your appointment times are scheduled and held specifically for you, we ask that cancellations are made with more than 24 hour notice. To ensure delivery of notice to cancel your appointment, please e-mail our office at [office@mbh-mi.com](mailto:office@mbh-mi.com) and call (248) 220-2223. Appointments cancelled less than 24 hours before appointment date and time will be charged as 45 minutes professional time and your clinician will work on details pertaining to your care. To account for emergencies and unavoidable circumstances, each patient/family is allowed one late cancellation per 6 months of service.

**I give consent for myself or my child to be seen professionally by Monarch Behavioral Health, PLLC.**

**Please indicate that you have read the above statements by signing below.**

Client signature: \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_  
Date

Client Name Printed: \_\_\_\_\_

Parent/Guardian/Caregiver signature (If applicable): \_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_  
Date

Parent/Guardian/Caregiver Name Printed: \_\_\_\_\_



## NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU (OR YOUR CHILD, IF YOUR CHILD IS THE PATIENT) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THOROUGHLY**

**If you have any questions about this Notice please contact our Privacy Officer at (248)-220-2223**

This Notice of Privacy Practices describes how Monarch Behavioral Health, PLLC may use and disclose your protected health information to carry out treatment, payment or health care operations, and for other purposes that are permitted or otherwise required by law. It also describes your rights, as the patient, to access and control your protected health information.

“Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

### 1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your psychologist, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your psychologist’s practice.

Following are examples of the types of uses and disclosures of your protected health information that your psychologist’s office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

**Payment:** Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Health Care Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your doctor’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical or doctoral students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party “business associates” that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

**Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object**

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

**Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the applicable law, and will be limited to the relevant requirements of the applicable law. You will be notified, if required by law, of any such uses or disclosures.

**Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

**Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

**Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

**Food and Drug Administration:** We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, *as* required.

**Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

**Law Enforcement:** We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

**Coroners, Funeral Directors, and Organ Donation:** We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

**Research:** We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

**Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

**Workers' Compensation:** We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

**Inmates:** We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

#### **Uses and Disclosures of Protected Health Information Based upon Your Written Authorization**

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

#### **Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object**

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

**Others Involved in Your Health Care or Payment for your Care:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

## **2. YOUR RIGHTS AS THE PATIENT**

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

**You have the right to inspect and copy your protected health information.** This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits –

Access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location.** We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

**You may have the right to have your physician amend your protected health information.** This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.** This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

**You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice electronically.

**Psychologist's Duties: -**

- Monarch Behavioral Health, PLLC is required by law to maintain the privacy and security of your Protected Health Information and to provide you with a notice of my legal duties and privacy practices with respect to your Protected Health Information.
- Monarch Behavioral Health, PLLC reserves the right to change the privacy policies and practices described herein.
- If Monarch Behavioral Health, PLLC makes significant revisions to its policies and procedures which might affect the privacy of your Protected Health Information, we will provide you with a copy of the revisions. If you are still in treatment with Monarch Behavioral Health, PLLC, you will be provided with a copy of the revisions in a manner permitted by law, which includes hand delivery at your next appointment. Updated notices of Monarch Behavioral Health, PLLC' privacy policies will always be available for review upon request at our office.

**Effective date, restrictions and Changes to Privacy Policy:**

- Restriction: In the case of a minor child, the child's legal guardian has the right to inspect or obtain a copy (or both) of the Protected Health Information in our mental health and billing records which were used to make decisions about the child for as long as the Protected Health Information is maintained in the record(s). However, in order to protect the child's right to confidentiality, psychotherapy notes, including, but not limited to, statements made by a child during therapy sessions will NOT be released, unless required by law or deemed, in the professional judgment of a licensed psychologist at Monarch Behavioral Health, PLLC, to be in the best interest of the child.
- Restriction: In most cases, Monarch Behavioral Health, PLLC is prohibited by law from disclosing raw psychological test data and test materials to anyone other than a licensed psychologist qualified to interpret such data.

**3. COMPLAINTS**

If you believe that your privacy rights have been violated by us, you may contact us or the Secretary of the Department of Health and Human Services to file an official complaint. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer at (248)220-2223 for further information about the complaint process.

This notice was published and becomes effective on 9/15/17.



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**RECEIPT OF NOTICE OF PRIVACY PRACTICES**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Given to Patient on: \_\_\_\_/\_\_\_\_/\_\_\_\_

Version/Effective Date: 9/15/17

\_\_\_\_\_  
Signature of Patient or Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Relationship of Personal Representative to the Patient:





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## ELECTRONIC CORRESPONDENCE AGREEMENT

Patient: \_\_\_\_\_

Parent/Guardian Name(s): \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Additional E-Mail Addresses: \_\_\_\_\_

Permission to communicate via e-mail: **Yes No**

Permission to email clinical documentation containing confidential personal patient information as an attachment to an email in PDF format: **Yes No**

Permission to email information about upcoming events and workshops, associated with Monarch Behavioral Health, PLLC, your name and e-mail address are kept private and will not be seen by anyone other than office staff: **Yes No**

Monarch Behavioral Health, PLLC will **NOT** be able to respond to clinical issues via email. Due to the nature of patient confidentiality, issues are best addressed during session, in person. However, at times, it may be more convenient to schedule appointments with the office manager via email at: [office@mbh-mi.com](mailto:office@mbh-mi.com). Issues regarding a change in schedule, please also leave a message on our voicemail at (248) 220-2223.

### CONFIDENTIALITY NOTICE

Electronic messages are confidential, intended only for the named recipient(s) and may contain information that is privileged or exempt from disclosure under applicable law.

If you choose to respond to electronic email, you cannot assume anything that you communicate electronically is confidential or will not be read unwittingly, mistakenly or purposefully by another party.

Although reasonable measures are taken to protect electronic communication, there are no guarantees that your communication will be private. If you are concerned that another party may ultimately read what you have written, don't write it or send it via e-mail.

\_\_\_\_\_  
Signature of Patient or Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship of Personal Representative to the Patient: \_\_\_\_\_



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## Permission to Exchange Information to Better Coordinate Care (Authorization for Use and Disclosure of Protected Health Information)

*\*Please note that we are required to have this form on file for you, indicating whether you refuse or authorize coordination of care. Please complete and sign. You may change or update this at any time.*

### Communication with other healthcare providers, institutions and service providers

*We encourage you to allow us to coordinate your care with all of your healthcare providers and other service providers. Let us know if you have any concerns.*

Type of provider (or institution/school) (e.g., other therapists, PCP, OB/GYN, school, etc.):

Provider's name (or institution/school name):

Address:

Phone:

Fax:

Please select one of the following:

I authorize the use and/or disclosure of my health information as described in this authorization with this provider/institution. I also authorize sending a Coordination of Care Letter to this provider. This letter may include impressions and/or preliminary diagnoses from evaluation, as well as recommendations for treatment and/or follow-up care.

I do NOT wish any of my health information to be exchanged with the above provider/institution.

*This authorization will have a duration of consent for the duration of active treatment or until notified that consent is revoked. This authorization gives permission to exchange information by phone, fax, photocopies, or secured email (with confidentiality statements and reasonable precautions in place). Information to be released includes any or all progress notes, evaluations, treatment plans, and chart notes from Monarch Behavioral Health, PLLC., or other providers that have become part of the treatment record. Information will pertain to any and all Dates of Service. Indicate information you do not want exchanged (if any) on the bottom of this form. The purpose of the requested information to be exchanged is for enhancing effective and coordinated care unless indicated otherwise by noting it at the bottom of the form. I understand that the information in the health record may relate to alcohol or drug abuse and my description of my HIV (human immunodeficiency) status. Unless I have indicated otherwise on this sheet, I specifically authorize the release of this information. I understand that I have the right to revoke or cancel this authorization at any time. I understand that to revoke this authorization, I must contact Monarch Behavioral Health, PLLC and put my revocation/cancellation in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I also understand that if I authorize Monarch Behavioral Health, PLLC to disclose information, the recipient of the information might disclose it to others, and that any information disclosed by Monarch Behavioral Health, PLLC may no longer be protected by the federal rule on the privacy of medical records.*

Signature of Patient or Authorized Representative: \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

Printed Name of Patient: \_\_\_\_\_

Printed name of Authorized Representative (if not patient): \_\_\_\_\_



MONARCH  
BEHAVIORAL HEALTH, PLLC

### Credit Card Payment Authorization Form

*Please fill in all areas completely and sign and date the bottom.*

Type of card (check one): \_\_\_\_\_ MasterCard \_\_\_\_\_ VISA

Is this a Debit Card? \_\_\_ Y \_\_\_ N

Is this an HSA/FSA or Flexible Spending Account card? \_\_\_ Y \_\_\_ N

Name of Patient: \_\_\_\_\_

Name on the card (if different from patient): \_\_\_\_\_

Billing address of cardholder:

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

Credit card number: \_\_\_\_\_ CVV: \_\_\_\_\_

Expiration date: \_\_\_\_\_

I, \_\_\_\_\_, authorize Monarch Behavioral Health, PLLC. to charge the credit card indicated above. I understand that unless I notify my clinician otherwise, my current account balance will be charged to this credit card after each session.

***Patient's Signature***

\_\_\_\_\_

\_\_\_\_\_

(Date)

***Credit Card Holder's Signature (\*\* if different than Patient)***

\_\_\_\_\_

\_\_\_\_\_

(Date)