CLAUDIA BRASFIELD, PH.D.

MORNINGSIDE PSYCHOLOGICAL SERVICES, LLC

(404) 358-1685 ● claudia.brasfield@gmail.com

Dear Potential Client,

First, let me thank you for choosing my professional services. I will do my best to provide you with a useful and meaningful therapeutic experience. To make our first meeting more efficient, I am providing you with the following documents for you to read and fill out ahead of time.

(1) There is an **AGREEMENT AND INFORMED CONSENT FOR TREATMENT**, which outlines my policies and the therapy agreement. If you agree to these terms, please sign and date the document. If you would like a copy for your records, please print two copies.

(2) There is a **NOTICE OF PRIVACY PRACTICES**, which explains my practices and the federal regulations regarding the use and disclosure of your health information. After reviewing this document, please sign and date the **CONSENT TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.**

(3) There is the **NEW CLIENT INFORMATION SHEET**, which will help me to better understand you and make our first few sessions more productive.

(4) Finally, there is the **Aetna Insurance Enrollment Form**, which asks for the required information in order for me to file insurance claims on your behalf.

Please complete these documents and bring them to your first appointment. If you have any questions about these documents, please feel free to contact me by phone or e-mail. We can also discuss any questions you might have during our first meeting.

Paperwork aside, it is common for new clients to feel nervous about starting therapy and I understand how stressful it can be. Fortunately, most people begin to feel more comfortable with the process in just a few sessions. In the meantime, it might be helpful for both of us if you would take some time to think about what you want from therapy. You might even make some notes about your goals and what is most important to you, so that we can discuss these together during our first few sessions.

I look forward to meeting with you! If I can provide any additional information, please call me at (404) 358-1685.

Sincerely,

Claudia Brasfield, Ph.D.

AGREEMENT AND INFORMED CONSENT FOR TREATMENT

This document is designed to inform you about what you can expect from your therapist, policies regarding confidentiality and emergencies, and several other details regarding your treatment. We will spend some time reviewing this agreement and I will answer any questions that you may have. Please know that your relationship with your therapist is a collaborative one, and I welcome any questions, comments, or suggestions regarding your course of therapy at any time. Your signature on this agreement indicates your consent for treatment and your understanding of the policies contained in the agreement.

Psychological Services

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. In addition, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees on what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Appointments

The cumulative number of appointments scheduled during a course of treatment will vary with the nature, duration, intensity, and frequency of the concerns that brought you to psychotherapy. Appointments for psychotherapy are generally between 45 and 50 minutes long and are generally scheduled once per week. Although, there may be times in which our work together would benefit from an appointment that lasted longer than the standard time or was scheduled more frequently than once per week.

Cancellation Policy

In the event that you are unable to keep an appointment, you must notify me at least **24 hours** in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions.

Professional Fees and Payment

My fee for psychotherapy is $150 per appointment. Fees for appointments of non-standard times are prorated based on the rate listed above. You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

My practice is fee-for-service. I do work directly with Aetna insurance company and will file claims on your behalf with Aetna. For any other insurance companies it is your responsibility to make payment for services and to work with your insurance company to obtain reimbursement.

Contacting Me

I am often not immediately available by telephone. If you need to reach me, please contact me at 404-358-1685. If I do not answer, you may leave a confidential message for me on voicemail. I monitor my messages on a regular basis and am generally able to return calls within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist/psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Minors

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

Confidentiality and Limits

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if she / he determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child is being abused, I must file a report with the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____ _____ _____

Client Name (please print) **Signature of Client** **Date**

NOTICE OF PRIVACY PRACTICES

This notice describes how protected health information about you may be used and disclosed and how you can get access to this information. Please review it carefully. We understand that privacy is an important concern for all those who come to this office. It is also complicated because of federal and state laws and our professional ethics code. Because the rules are complicated, some parts of this Notice are quite detailed. You may have to read them several times to understand them.

Contents of this Notice

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B. What is "protected health information" (PHI)?

C. Privacy and laws about privacy

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A. Introduction: To Our Clients

The privacy of your psychological and medical information is important to us. Therefore, we are committed to protecting it. This notice will tell you about how we handle information about you. It tells how we use this information here in this office, how we share it with other professionals and organizations, and how you can see it. This information will help you make the best decisions for yourself and your family. We are also required to tell you about this because of the privacy regulations of a federal law, the **Health Insurance Portability and Accountability Act of 1996 (HIPAA).** Because this law and the laws of this state are complicated, we have simplified some parts. If you have any questions about anything in this notice, you are welcome to contact our Privacy Officer.

B. What we mean by your "protected health information" (PHI)

Each time you visit us or any other "healthcare provider" information is collected about you. It may be information about your past, present or future health or conditions, the treatment or other services you received, or payment for healthcare. This information is called **Protected Health Information (PHI).** This information goes into your **record or file**, which is kept at the office. Some examples of the PHI likely to be included in your record at this office are:

* Your history: as a child, in school, at work, marital, personal history.

* Reasons you came for treatment: problems, complaints, symptoms, needs, goals.

* Diagnoses: medical terms for your problems or symptoms.

* Treatment plan: treatments and other services we think will best help you.

* Record of dates of contact and services provided, observations of your progress.

* Records we get from others who treated or evaluated you.

* Psychological test scores, school records, etc.

* Information about medications you took or are taking.

* Billing and payment information.

We use this information for many purposes. For example, we may use it:

* To plan your care or treatment.

* To evaluate your progress.

* To communicate with other professionals who care for you.

* To show that you actually received the services from us for which we billed you.

* For teaching and training other healthcare professionals.

Understanding what PHI is in your record and how it is used can help you to:

* Make sure the information is accurate

* Make better decisions about when and why this PHI is shared, and with whom.

Although your health record is the physical property of the healthcare practitioner or facility that collected it, the PHI belongs to you. You have the right to:

* Ask that it not be used or shared with anyone for some reasons.

* Obtain a paper copy of this notice.

* Inspect and obtain copies of your PHI.

* Ask for changes in your record.

* Obtain an accounting from us of uses and disclosures of your PHI.

* Revoke any authorization you have given to us to release your PHI to others, unless we have already acted upon that authorization.

C. Privacy and the laws

The HIPAA law requires us to keep your PHI private and to give you this notice of our legal duties and our privacy practices which is called the **Notice of Privacy Practices (NPP).** We will obey the rules of this notice as long as it is in effect. If we change the NPP we will post the new Notice in our office where everyone can see. You or anyone else can also get a copy from our Privacy Officer at any time.

D. Use and disclosure of your PHI

As defined in the law, "**use**" refers to sharing your PHI with anyone within this office, while "**disclosure**" refers to sharing your PHI with others outside this office. Except in some special circumstances, when we **use** your PHI here or **disclose** it to others we share only the **minimum necessary PHI** needed for the purpose. The law gives you rights to know about your PHI, how it is used, and to have a say in how it is disclosed.

We **use** and **disclose** your PHI for several reasons. Mainly, we will use and disclose it for routine purposes, called **treatment, payment, and operations (TPO).** After you have read this Notice, you will be asked to sign a separate **Consent form** to allow us to use and disclose your PHI. This Consent form allows us to use your PHI here or disclose your PHI with other people or organizations to provide **treatment** to you, arrange for **payment** for our services, or for other health care **operations.**

For other uses or disclosures, we must tell you about them and have a written **Authorization** form (except for certain situations where the law allows or requires us to make the use or disclosure without your authorization).

We may use and disclose your PHI for the following purposes:

***Treatment:** We use your PHI to provide you with psychological treatment or services. These might include individual, family or group therapy, psychological, educational or vocational testing, treatment planning, or measuring the effects of our services. We may also share or disclose your PHI to others who provide treatment to you, such as your personal physician or the professional who referred you to us. We may consult with other members of this practice for help in making treatment more effective. We may refer you to other professionals or consultants for services we cannot offer such as special testing or treatment, and share information about you with them. We will get back their findings and opinions and those will go into your records here. If you receive treatment in the future from other professionals we can also share your PHI with them. (However, we would first request from you a signed **Authorization to Use and Disclose Protected Health Information**, specifying what information you wish to have disclosed.)

***Payment:** We use and disclose your PHI in order to bill and get paid for services you receive from us. In most cases, you will be responsible for payment. This information may be disclosed to an outside party if that party is responsible for payment (e.g. Children and Youth Services).

***Health Care Operations:** We may use your PHI to see where we can make improvements in the care and services we provide.

***Appointment Reminders:** We may use and disclose PHI to reschedule or remind you of an appointment for treatment or other care. If you want us to call or write to you only at your home or your work or prefer some other way to reach you, we usually can arrange to comply with your wishes.

***Treatment Alternatives:** We may use and disclose your PHI to tell you about or recommend possible treatments or alternatives that may be of interest to you.

We may use and disclose your PHI <u>without</u> your consent in the following circumstances, as allowed or required by law:

***Reporting Child Abuse:** If, on the basis of our professional judgment, we suspect the abuse of a child with whom we have come in contact in our professional capacity, we are required by law to report this to the appropriate authorities.

***Reporting Adult and Domestic Abuse:** If we have reasonable cause to believe that an older adult is in need of protective services (due to abuse, neglect, exploitation or abandonment), we may report such to the local agency which provides protective services.

***Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about services we have provided to you, such information is privileged under state law, and will not be released without your authorization or a court order. *This privilege does not apply when you are being evaluated for a third party or when the evaluation is court ordered, such as in custody evaluations.* You will be informed in advance if this is the case.

***Serious Threat to Health or Safety:** If you express a serious threat, or intent to kill or seriously injure yourself or an identified or readily identifiable group of people, and we determine that you are likely to carry out this threat, we must take reasonable measures to prevent harm. Reasonable measures may include disclosing PHI to a person or persons reasonably able to prevent or lessen the threat, including the target or potential victim of the threat.

***Worker's Compensation:** If you file a worker's compensation claim, we will be required to file periodic reports with your employer that shall include history, diagnosis, treatment, and prognosis.

***Law Enforcement:** We may disclose your PHI for law enforcement purposes as required by law or in response to a valid subpoena.

***In an emergency:** If it is an emergency, and we are unable to ask if you disagree, we can share PHI if we believe that it is what you would have wanted and/or if we believe it will help you if we do share it. You will be notified of this disclosure as soon as possible. In the event that you object to this disclosure, we will respect your decision, as long as it is not against the law.

***To prove compliance:** We may be required by government agencies to disclose some information to prove that we are obeying the privacy laws.

E. Uses and disclosures requiring your *Authorization*

If we want to use your information for any purpose besides TPO or those described above, we need your permission on an **Authorization form.** For example, if we receive a request for information from an employer or school (that is not involved in paying for your services), we cannot release your PHI without your authorization. That authorization will include a specific definition of the information to be used or disclosed, to whom the information will be disclosed, the purpose of the disclosure, an expiration date, the right to revoke the authorization, and the right not to authorize the disclosure.

If you do authorize us to use or disclose your PHI, you can revoke (cancel) that permission, in writing, at any time. After that time, we will not further use or disclose your information for the purposes stated in the authorization. Of course, we cannot take back any information already used or disclosed with that authorization.

F. Your Rights

***Confidential Communications:** You have the right to request how and to whom your PHI is shared. For example, you may not want a family member to know that you are being seen here, and may request that correspondence be sent to another billing address that you provide.

***Asking for Restrictions:** You have the right to ask us to restrict disclosures of your PHI. For example, you may place restrictions on the type of information we leave in phone messages, or request that we contact you at home and not at your workplace. We are not required to agree to these restrictions; however, in most cases we will be able to do so. Once we have agreed to restrictions, we are bound to stand by that agreement unless required by law or in the event of an emergency.

***Inspection and Copies:** You have the right to look at or get copies of your PHI, with the exception of psychotherapy notes. You must make this request in writing. In most cases, your request will be fulfilled within 30 days. However, we can deny your access to PHI under certain circumstances. If you have questions about the request and denial process, you can contact the Privacy Officer.

***Requesting Changes:** You have the right to request changes to your PHI if you believe that it is wrong or incomplete for as long as your PHI is kept by us. To request a change, you must do so in writing. We may

deny your request if we believe your PHI is accurate and complete, your request does not involve your PHI, or your request is about PHI that we did not make (for example, information provided by another professional).

***Accounting of Disclosures:** When we disclose your PHI, we keep records of when we disclosed it, to whom we disclosed it, and what was disclosed. You have the right to request an accounting (a list) of these disclosures. This list may not include disclosures made to other professionals for your care, disclosures made for payment, or disclosures which you requested through an authorization form. In order to obtain an accounting of disclosures, you must request it in writing, and your request must state the time period for which you are requesting the accounting. This time period cannot be for more than six years or for information disclosed prior to the date of this Notice. The first accounting you request will be free. However, additional requests within the same 12-month period will carry a $10 charge. We will notify you of the costs involved each time you make a request, and you may decide not to obtain the accounting if you do not want to pay.

***Right to a Paper Copy of this Notice:** You have the right to receive a paper copy of this notice, and you may obtain additional copies by contacting the Privacy Officer in writing.

***Right to File a Complaint:** If you have a problem with how your PHI has been handled or if you believe your privacy rights have been violated, you have the right to file a complaint by writing to the Privacy Officer. You may also send a written complaint to the Secretary of the Department of Health and Human Services (address available from the Privacy Officer upon request). You will not be penalized for filing a complaint, and your treatment here will not be affected by your filing a complaint.

***Right to Give Authorization for Other Uses and Disclosures:** We will request your permission in writing (an **Authorization Form**) any time we need to use or disclose your PHI in a way not described in this notice or permitted by law. You may revoke that authorization at any time, by contacting the Privacy Officer in writing. If you revoke your authorization, we will no longer release the information that was permitted by the authorization. However, we cannot take back information that was shared before you revoked the authorization, and we will continue to maintain records of your treatment.

G. If you have questions or problems

If you believe your rights have been violated, or you disagree with a decision made about access to your records, you may contact Claudia Brasfield, Ph.D. at 404-358-1685. We encourage you to speak to us about your healthcare concerns. You may file a written complaint to the Secretary of the US Department of Health and Human Services. This address can be provided to you upon request.

Consent to Use and Disclose your Protected Health Information

This form is an agreement between you, _____, and _____, regarding the use and disclosure of the Protected Health Information (PHI) of _____.

When we examine, diagnose, treat, or refer you (or your child) we collect what the law calls **Protected Health Information (PHI)** about you. This information will be used to decide on what treatment is best for you (or your child), to provide treatment to you (or your child), to share this information with others who provide treatment to you (or your child), to arrange payment for treatment, or for other healthcare operations.

By signing this form you are indicating that you have read our **Notice of Privacy Practices (NPP)** which explains in more detail your rights and how PHI may be used and disclosed for treatment, payment or health care operations. If in the future, we decide to change how we use and disclose PHI, we will change our NPP.

You have the right to request in writing that we not use or share some of your (or your child's) PHI for treatment, payment or health care operation purposes. We will try to respect your wishes, as long as they are not in conflict with the law, but we are not required to agree to these limitations. We promise to inform you as to whether we can agree to any limitations you may request.

After signing this consent, you have the right to revoke it (by written request), and we will comply with your wishes from that time on. However, we cannot take back information we may already have used or disclosed at that point in time.

I, _____, have read the **Notice of Privacy Practices** and understand the uses and disclosures of PHI for treatment, payment and health care operations. I have been given a chance to ask any questions I may have and to discuss any limits I may wish to impose on uses and/or disclosures of my (or my child's) PHI. I hereby consent to the use and disclosure of my (or my child's) PHI as explained in the NPP.

_____ _____

Signature of client or personal representative Date

_____ _____

Printed name of client, parent or personal representative Relationship to client

_____ _____

Signature of witness Date

NEW CLIENT INFORMATION SHEET

IDENTIFYING INFROMATION

Full Name: _____ Name You Prefer: _____

Date of Birth: _____ Age: _____ Gender: M____ F____ Social Security #: _____

Mailing Address: _____

_____

Home Phone: _____ Okay to leave a message? Yes/No

Work Phone: _____ Okay to leave a message? Yes/No

Cell Phone: _____ Okay to leave a message? Yes/No

Email Address: _____

Emergency Contact:_____ Relationship to You:_____

Phone: _____

Ethnicity: _____Birthplace (country/state): _____

Relationship Status:

___ Single ___ Committed Rel. ___ Married ___ Separated ___ Divorced ___ Widowed

Highest Degree Earned: _____ School/College: _____

Occupation: _____ Employer: _____

Please list everyone in your household and their relationship to you:

Name Age Gender Relationship to You

_____

_____

_____

PROBLEM IDENTIFICATION

What problem(s) or difficulties bring you here at this time? _____

_____

_____

When did these problem(s) begin? _____

_____

How would you rate the intensity of the problem(s) from 1-10? (1=minimal 10=extreme) _____

What symptoms are you experiencing? _____

_____

Describe your thoughts and feelings regarding your problem(s). _____

_____

What makes the problem(s) better? _____

_____

What makes the problem(s) worse? _____

_____

How does this problem interfere with your daily functioning? _____

_____

How have you tried to cope with this problem(s)? _____

_____

Please circle any of the following areas of concern, either past or present:

Alcohol/Drug Abuse	Hopelessness	Paranoia	Anger Control
Homicidal Thoughts	Parenting Concerns	Anxiety	Hostility
Phobias/Panic	Assertiveness	Isolation	School
Attention/Concentration	Impulse Control Problems	Bereavement/Grief	Self-Defeating
Insomnia	Self-Esteem Issues	Communication	Irritability
Self-Injurious Behaviors	Depression	Identity Issues	Sexual Abuse
Work Problems	Legal Issues	Sexuality	Spirituality
Domestic Violence	Marital /Relationship Problems	Stress	Eating/Food
Medical Concerns	Suicidal Thoughts	Memory	Family

PSYCHIATRIAC HISTORY

Have you been in therapy before? *Yes/No* If yes, with whom? _____

How long did you see the therapist? _____Was the therapy helpful? _____

Reason for ending? _____

Have you ever been psychiatrically hospitalized? *Yes/No* If so, when and how long? _____

Does anyone in your family have any emotional problems? *Yes/No* If so, please explain _____

_____

ABUSE HISTORY

Have you ever been abused physically, sexually, or emotionally? _____

Please elaborate as best as possible _____

_____

MEDICAL HISTORY

Do you have any current medical problems? _____

How does it impact your daily functioning? _____

_____

Name of physician: _____ Date of last visit: _____

Are you currently taking any medications? *Yes/No* If so, please list below:

Medication	Dosage	Reason for Use	Prescribing Physician

Does anyone in your family have any medical problems? _____

_____

FAMILY OF ORIGIN HISTORY

Are your parents married? _____

How is your relationship with your mother? _____

How is your relationship with your father? _____

What are the names/ages of your siblings? _____

_____

How are your relationships with your siblings? _____

SUBSTANCE ABUSE

Do you have any problems with drugs or alcohol? _____

How often do you drink? _____ How much do you drink? _____

How often do you use drugs? _____ How much do you use? _____

How long have you been drinking or using drugs? _____

Do you drink or use drugs by yourself or with others? _____

Have you been in previous substance abuse treatment? _____

If so, when and where? _____

Does anyone in your family have problems with drugs or alcohol? _____

LOSS

Please discuss any personal losses you have had: _____

_____

LEGAL HISTORY

Have you ever been arrested? *Yes/No* If yes, please elaborate (convictions, charges…) _____

_____

OTHER

What are your personal strengths? _____

How would you describe yourself? _____

Are you a religious and/or spiritual person? _____ Please elaborate _____

_____

Who is your social support? _____

What are your goals for treatment? _____

Is there anything else you would like to tell me about yourself? _____

_____

Referred by: _____ May we thank them? *Yes/No*

Morningside Psychological Services, LLC
Dr. Claudia Brasfield, PhD

AETNA INSURANCE REGISTRATION FORM

(Please Print)

Today's date: / /				
CLIENT INFORMATION				
Client's last name: First: Middle:			Sex (M /F):	Marital status (circle one) Single / Mar / Div / Sep / Wid
Birth date: / /	Age:	E-mail (if wish to be contacted this way):		
Home Address:		Mobile phone no.: ( )		Home phone no.: ( )
PO Box:	City:	State:		ZIP Code:
Occupation/Student:	Employer/University Name:			

INSURANCE INFORMATION					
(Please provide your insurance card)					
Name of Primary Insurance Holder:	Address (if different):			Phone no. if different: ( )	
Occupation:	Employer:			Employer phone no.: ( )	
Client's relationship to primary insurance holder:	❑ Self	❑ Spouse	❑ Child	❑ Other	Co-payment: $
Type of Aetna Insurance (Full Name/Description on Card, i.e. Student Health, PPO, etc.)					
Group Number:	Policy Number:				

OFFICE BILLING AND INSURANCE POLICY

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. Claudia Brasfield. I understand that I am financially responsible for any co-payment and unpaid balance. I also authorize Morningside Psychological Services or Aetna insurance company to release any information required to process my claims. It is your responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by your insurance the day and time of your appointment. There will be a $25.00 service charge on all returned checks.

Client signature *Date*