CLIENT INTAKE SHEET for:
SYLVA CLINICAL ASSOCIATES, P.A.

Today's Date:_____

CLIENT: _____ Sex: ____M ____F
(Last Name) (First Name) (Initial) (Preferred Name)

____Single ____Married ____Widowed ____Separated ____Divorced (If Married), Spouse's Name:_____

Home Phone:_____ Cell:_____ Age:_____ Date of Birth:_____

Mailing Address:_____ City_____ State_____ Zip_____

Employer: _____ Business Phone:_____

Occupation:_____

Name of Who Is Responsible for Payment _____ Relationship to Client_____

Address:_____ City_____ State_____ Zip_____

Phone Number:_____ SS#:_____ Date of Birth:_____

Employer:_____ Employer's Phone Number:_____

Primary Insurance Name: _____

Policy Number:_____

Group Number:_____

Company Insured Through:_____

Policy Holder's Name:_____

Policy Holder's SS#:_____
DOB:_____

Secondary Insurance Name: _____

Policy Number:_____

Group Number:_____

Company Insured Through:_____

Policy Holder's Name:_____

Policy Holder's SS#:_____
DOB:_____

HOW DO YOU PLAN TO PAY TODAY? _____Cash_____Check_____Credit/Debit Card (VISA/Mastercard/Discover)

Who Referred You:_____ **Name of Your Personal Physician:**_____

- I have read Sylva Clinical Associates Financial Policy and agree to be bound by its terms

_____ _____ _____
(Signature of Patient or Responsible Party) (Print Name) (Date)

****** CONTINUED ON BACK******

HIPAA NOTICE OF PRIVACY PRACTICES AND CONSENT FOR TREATMENT

Sylva Clinical Associates, P.A.

I give this clinic/practice my consent to use and disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations such as quality services.

I have been informed that I may review the practice's Notice of Privacy Practices (for a more comprehensive understanding of its uses and disclosures) before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also know that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

I understand the **CHARGE for my INITIAL SESSION is $195.00 and the charge for any subsequent sessions is $160.00, PLUS ADDITIONAL CHARGES for any and all psychological testing, if done, in the amount of $160.00 *PER unit* of testing**. Sylva Clinical Associates, PA, normally accepts assignments of insurance benefits. Sylva Clinical Associates, PA will look to me for full payment of my account, and I will be responsible for payment of all charges. Different co-payments are required by various group coverage plans. My co-payment is based on the insurance policy selected by me. I am responsible for and shall pay my co-pay portion of the charges for services at the time the services are provided to me. **It is recommended that I determine my co-payment or any prior authorizations required by my insurance plan for mental health benefits, before my first visit, but definitely by my second visit, by calling my benefits office or insurance company.** I have received and reviewed a copy of the Financial Policy of Sylva Clinical Associates, PA

"I consent for Sylva Clinical Associates, PA to communicate with me by mail, by phone, or by E-mail at the following address(es) and phone number(s), and I will IMMEDIATELY advise my clinician in the event of any change."

MAILING ADDRESS:_____

TELEPHONE NUMBER (s):_____

E-MAIL ADDRESS:_____

"I voluntarily agree to receive, or for my child to receive, psychological assessment, care, treatment, or services, and authorize Sylva Clinical Associates, PA, to provide such assessment, care, treatment, or services as are considered necessary and advisable."

"I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through Sylva Clinical Associates, PA, at any time."

"By signing this Notice and Consent, I, the undersigned client, acknowledge that I have both read and understand all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me."

SIGNATURE:_____ DATE:_____

Client, Parent, or Legal Guardian

If signed by client representative, please state relationship with the client:_____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: ____ Sex: ☐ Male ☐ Female Date: _____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

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BUSINESS POLICY AND CLIENT AGREEMENT

Welcome to our practice! This agreement contains information about our professional services and business policies. So that misunderstandings regarding our Business Policy and Patient Agreement may be avoided, the following is prepared for you. Please read this carefully. Our CEO or the professional whom you are seeing will be happy to discuss any questions that you may have.

FEES FOR SERVICES:

Our initial visit is $195. Subsequent visits are $160. Most insurances are accepted **with the exception of Medicaid, NC Healthchoice and United Healthcare**. We accept Cash, Check, Visa, Mastercard, American Express & Discover as well as HSA. We do accept self pay.

LATE CANCELLATIONS AND MISSED APPOINTMENT POLICY

Scheduled appointments are reserved strictly for you and for no one else. Because of this, we require a **24 Hour Notice to cancel or change your appointment**. Please let us know if you are unable to keep an appointment that you have scheduled, otherwise, you may be charged a late cancellation or a no show fee for the time that was reserved by you for you ($80.00 for individual therapy sessions and $30.00 for group sessions).

SEPARATION/DIVORCE POLICY

For parents who are separated, pending separation, divorced, or engaged in litigation we do require a Special Contract from the parents. In separated or divorced families, **the person who initiates services** with us is held financially responsible. **We do not bill another person** or an estranged spouse unless that individual informs us in writing of his or her willingness to pay for services rendered. Should another party be willing to assume financial responsibility for our services, they may contact our office and ask for our CEO, Chimene Mathis.

PAYMENT POLICY

Payment for all services is due at each session. Services may be interrupted until payment is made. Finance charges are added if you do not make a payment within 30 days. Late charges are computed at one & 1/2% monthly (18% annually) for any balance over 60 days old. Final payment is expected on behalf of the client before reports, including psychological evaluations, are released. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure payment. This may involve hiring a collection agency or going through small claims court, which will require us to disclose your name, address, phone number, and the amount due. If legal action is necessary, the cost will be included in the claim.

HEALTH INSURANCE POLICY

- Insurance claims - As a courtesy, we will file insurance for you under most circumstances as long as you provide us with current information on your insurance plan. Each plan has different benefits for you as well as different financial obligations. Not all insurance policies cover all services. You are ultimately responsible for understanding the details of any particular coverage you may have as well as the payment of all charges you incur.
- Insurance Card- **please provide a copy of your insurance card** prior to each visit.
- Unpaid Insurance Claims - If your insurance company has not responded to us within 60 days of a filed insurance claim, the charges will be sent to you directly and you will be responsible for their payment as well as for payment of any other charges incurred consistent with this financial policy.

Services provided by our office are covered under Mental Health insurance provisions. Since plans are so varied, please check your policy to make sure you understand benefits and limitations. If you belong to a Managed Care Plan or PPO, you must have proper authorization for your visits prior to your first visit with us. Please be aware that not all services are covered by insurance policies (e.g., school visits). In the event that insurance coverage changes, it is the responsibility of the patient to notify Sylva Clinical Associates and to accept financial responsibility for services denied due to the change.

We are providers for Medicare, Crescent, Tricare/Champus/ChampVA, Blue Cross Blue Shield, MedCost, and most other private insurances. Unfortunately we are **not** providers for Medicaid and NC Health Choice or United Healthcare.

CONTINUED ON BACK →

CONFIDENTIALITY POLICY

The associates of Sylva Clinical are a collaborative practice of professionals. To provide you with the best care possible, we consult with one another when clinically advisable. If your therapist is out of town or for some reason unavailable, it is important that the associates in the practice have access to relevant information in order to provide the best possible care for your family. The confidentiality of the work that we conduct together with you as a client is upheld at all times. However, there are certain exceptions to this rule:

1. If the therapist suspects child abuse or if there is reasonable cause to believe that a disabled adult is in need of protective services, then appropriate authorities are contacted.
2. If a therapist believes that you are a clear and imminent danger to yourself or another person, the therapist may notify appropriate others to prevent the occurrence.
3. If there is need for healthcare oversight, the North Carolina Psychology Board has the power, when necessary, to subpoena relevant records from our practice if we are the focus of an inquiry.
4. If there are legal proceedings, patient/therapist communications are privileged except for the following:
   - If your mental status is an issue before the court.
   - If the judge authorizes a court order because he or she feels that communication is necessary to the proper administration of justice.
   - If a government agency is requesting information for health oversight activities, we may be required to provide it for them.
   - If a complaint or lawsuit is lodged against us, we may disclose relevant information regarding that patient in order to defend our practice.
   - If a patient files a worker's compensation claim, we are required by law to provide mental health information to your employer and the North Carolina Industrial Commission.

In working with children and adolescents, there are instances when confidential issues are not clear-cut. In treating a child or adolescent, we need your permission to confidentially handle the information shared with us by your child. **Should legal/custody problems arise, we furnish treatment summaries only**. Unless safety is an issue, we do not disclose actual communications the child or adolescent has made with us without the consent of the child, or both parents and therapist are in agreement, or there is a court order. However, as we go forward in treatment, efforts are made to keep parents informed of important issues as they arise.

PATIENT / THERAPIST COMMUNICATIONS

Phone: If you need to contact us between sessions, the best way to do so is by phone at 828-586-5555 and either ask to speak directly with us or leave a brief message with our office administrator, Brittany Buttery. We make efforts to check our mailboxes on a daily basis, Monday through Thursday.

E-mail: We prefer to use emails primarily for inquires about office procedures, billing practices or administrative matters. We have a general office mailbox but please do not use this to email content related to your therapy sessions, as it is not completely secure or confidential. If you do choose to communicate by email, be aware that all emails are retained in the logs of internet service providers. Any emails that you send to us should contain non-urgent matter, as the timeliness of email review cannot be guaranteed. If you are experiencing an emergency, you should go to your local hospital emergency room.

Friending and Text Messages: We do not accept friend or contact requests from current or former clients on any social networking site (Facebook). As a general rule, we do not accept text messages, Twitter, or any other form of social media. We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when you speak with the office staff or your therapist. If we should have to contact you after hours or on weekends using our personal cell phones, we ask that you respect our privacy and direct any future calls to our business phone numbers. YOUR SIGNATURE THAT YOU HAVE READ and AGREE TO THIS POLICY & AGREEMENT: _____

PROFESSIONAL DISCLOSURE STATEMENT

KATIE DEWHURST, MA, LCMHCA
SYLVA CLINICAL PSYCHOLOGY
70 Westcare Dr., Suite 402
Sylva, NC 28779
828-586-5555
Katiedewhurst@gmail.com

I am pleased to have the opportunity to serve you! This disclosure statement provides information about my qualifications and how I view the therapeutic process. This information will be helpful in making an informed decision regarding my services.

QUALIFICATIONS AND RESTRICTED LICENSURE

I graduated from Richmont Graduate University in 2015 with a Masters in Professional Counseling and have been seeing clients consistently since October of 2015. As a Licensed Clinical Mental Health Counselor Associate in North Carolina, license number A11891, I hold a provisional license and receive regular supervision. As I work towards full licensure, I am being supervised by Dr. Mitchell Durham, PhD, who may be reached at 828-424-3773.

COUNSELING BACKGROUND

My areas of competence for mental health counseling include but are not limited to multicultural issues, anxiety, depression, major depression disorder, adjustment disorder, obsessive compulsive disorder and marital distress. Clientele served are adolescents, starting at age 14, couples, families, and adults. My treatment methods include cognitive behavioral therapy, person centered therapy, and motivational interviewing.

FEES, OFFICE PROCEDURES, AND LENGTH OF THERAPY.

Therapy sessions are normally 45-55 minutes, and depending on the nature of the presenting problem, sessions are usually one time per week. It is difficult to predict how many sessions will be needed. I will be better able to discuss the probable number of sessions after we have completed the first two interview/intake sessions. Appointments are typically set at the close of each session. Appointments may be scheduled, rescheduled, or cancelled by telephone from Monday through Thursday during office hours (8:30-4:30). Failure to give notice for any appointment not cancelled 24 hours in advance may result in a charge for the time reserved for you. Please ask about any questions you have concerning fees, payment requirements, and missed appointments.

USE OF DIAGNOSIS

Some health insurance companies will reimburse clients for counseling services and some will not. In addition, most will require that a diagnosis of a mental-health condition and indicate that you must have an "illness" before they will agree to reimburse you. Some conditions for which people seek counseling do not qualify for reimbursement. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before we submit the diagnosis to the health insurance company. Any diagnosis made will become part of your permanent insurance records.

POTENTIAL COUNSELING RISKS

Recognizing that therapy addresses difficult issues, you must commit to the possibly painful process of change. This change should be beneficial to you and your family; however, there are some risks. As a result of counseling, you may realize that you have additional issues that may not have surfaced prior to the onset of the counseling relationship. Some clients experience intense feelings such as anger, fear, guilt, anxiety, or other negative feelings. These feelings are normal to the counseling process, but are likewise unpleasant. Sometimes individuals in marital or family therapy find that spouses or family members are not willing to change. Other risks include emergence of traumatic memories, or considering major life decisions. Finally, even with our best efforts, there is a risk that therapy may not work out well for you. I will attempt to inform you of potential risks specific to our work.

PHYSICAL HEALTH.
In order to better serve your needs, I strongly recommend that you have a complete physical examination if you have not had one within the past year to rule out any medical complication that may be contributing to your mental health needs. Also, please provide a list of any medications that you may be taking as well as any medical conditions.

CLIENT RESPONSIBILITIES.
Your commitment to the counseling process indicates that you agree to make a good faith effort at personal growth and to engage in the counseling process as an important priority at this time in your life. You agree to complete assignments given or discuss any reasons for resistance. Clients coming from another therapist must first terminate with that therapist. Clients must make their own decisions regarding such things as whether to marry, separate, divorce, reconcile, how to set up custody and visitation, life decisions such as leaving a job, selling a home, faith related decisions, etc. Given that, I will help you think through the possibilities and consequences of decisions, but my Code of Ethics does not allow me to advise you to make a specific decision. You are expected to keep appointments. Missing two appointments without advanced notice may lead to termination of the counseling relationship. If you are seeking therapy with me in conjunction with another ongoing professional mental health relationship, you must first consult and inform the first therapist before I can begin work with you. You must notify me before beginning therapy with any other mental health professional.

PRIVILEGED COMMUNICATIONS AND CONFIDENTIALITY.
All of our sessions will remain strictly and absolutely confidential except for the following circumstances in accordance with state law: (1) The client signs a written release of information indicating informed consent to such release; (2) The client expresses a clear and imminent intent to do serious harm to himself/herself or someone else; (3) there is evidence or reasonable suspicion of abuse/neglect against a minor child, elder person (65 or older), or disabled adult; or (4) a court order is received directing the disclosure of information. Verbal authorization will not be sufficient except in emergency situations.

When working with a family or couple, information shared by individuals in sessions where other family members are not present must be held in confidence, (except for the mandated exceptions already noted) unless all individuals involved sign written waivers. Clients may refuse to sign such a waiver but should be advised that maintaining confidentiality for individual sessions during couple or family therapy could impede or even prevent a positive outcome to therapy. All information shared in group therapy should be held in confidence by other group members.

EMERGENCY SITUATIONS.
Since I provide outpatient services only, I cannot guarantee
around-the-clock availability. After hours, you may leave voice mail at 828-586-5555, and I will return your call as soon as possible. If you should experience an emotional or behavioral crisis, and I cannot be reached immediately by telephone, you can contact a local medical or psychiatric hospital, or call 911 or 1-800-273-TALK (8255).

PLEASE ASK QUESTIONS.
You may have questions about me, my qualifications, the therapy process, assessments, fees, or something that has not been addressed in the previous paragraphs. It is your right to have a complete explanation for any of your questions at any time. My goal is to create a nurturing relationship with all clients, and I certainly want to know if you feel as though I am not meeting your needs or expectations.

COMPLAINTS
Although clients are encouraged to discuss any concerns with me, you may file a complaint against me with the North Carolina Board of Licensed Professional Counselors should you feel I am in violation of any of these codes of ethics. I abide by the ACA Code of Ethics (http://www.counseling.org/Resources/aca-code-of-ethics.pdf).

North Carolina Board of Licensed Professional Counselors
PO Box 77819
Greensboro, NC 27417
telephone: 844-622-3572; fax 336-217-9450
LPCInfo@ncblpc.org.

ACCEPTANCE OF TERMS

We agree to these terms and will abide by these guidelines.

Client Signature: Date: / /

Counselor Signature: Date: / /

Sylva Clinical- *PSYCHOLOGY!*

Breathe in. Breathe out. Relax...

ELIZABETH "BETTY" TULOU, M.A.
General Psychology

KATIE DEWHURST, M.A., LCMHC
Adolescent/Adult/Couples Counseling

SUZANNE STONE, M.A., LCMHCS
Adolescent/Adult Counseling

FAITH COOK, PSYD
Adult Psychology

JAMIE A. THOMAS, LCSW
Adolescent/Adult/Couples Counseling

SHEILA DAVIS, LCMHC
Adolescent/Adult Counseling

LAUREN J MARCH, PSYD, LCAS
Child/Adolescent/Adult Psychology

Informed Consent for Telemedicine Service

PATIENT NAME/DATE OF BIRTH: _____

LOCATION OF PATIENT: _____

PATIENT EMERGENCY CONTACT: _____

EMERGENCY CONTACT NUMBER: _____

THERAPIST NAME: _____

Please initial each bullet

- I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to (clinician's name) _____ providing health care services to me via telemedicine. I understand that I can only receive telemedicine services from my provider if I am within the state of North Carolina and will notify my provider should my location change so that appropriate referrals to clinicians in that area can be made.

- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. I understand that my provider will offer me a secure platform to provide telemedicine and should only attempt to use the platform provided. I also understand that it is my responsibility to ensure that I am in a private, secure, and quiet space. As always, your insurance carriers will have access to your medical records for quality review/audit.

- I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

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70 Westcare Drive, Suite 402
Sylva, North Carolina 28779
Other Offices in Asheville & Franklin
Telephone: (828)586-5555 Fax: (828)586-5527
sylvaclinical.com
sylvaclinical@yahoo.com

CHIMENE MATHIS, B.S.
Chief Executive Officer

BRITTANY BUTTERY, B.S.
Practice Administrator

- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Sylva Clinical Psychology (my clinician at this office) at 828-586-5555. As long as this consent is in force (has not been revoked) (clinician's name) _____ may provide healthcare services to me via telemedicine without the need for me to sign another consent form.

- I understand that sometimes the transmission of electronic services can be unexpectedly interrupted beyond either part's control (e.g., due to loss of internet connection, poor connection, computer failure). Should this occur, I agree to hold my provider harmless during delays of communication or loss of information due to a technology failure.

- I understand that there are certain limitations to telemedicine and that the benefits may not be the same as face-to-face meetings. I understand that there is no guarantee for how I will be impacted by our work together. Should my therapist believe that I would be better served by another form of psychotherapy (e.g., face-to-face services), I will be referred to someone who can provide that service. I understand that should there be some type of emergency, I can call 9-1-1 and/or go to the nearest emergency room for immediate and acute care. I will work with my therapist to create a safety plan as well.

_____ _____

Signature of Patient (or person authorized to sign for patient) *Date*

_____

If authorized signer, relationship to patient

I have been offered a copy of this consent (patient's initials): _____

Sylva Clinical Psychology Financial Policy

Thank you for choosing out practice! We believe that establishing a written financial policy is mutually beneficial for all parties. It is our goal to avoid any miscommunication or concerns regarding financial matters in order to focus our energies on providing psychological services to our patients. Our practice manager Chimene Mathis, will be happy to assist you with any questions or concerns you may have regarding our financial policy. You may contact her at (828)342-2862. Our financial policy is as follows:

1. **Payment-** payment is expected at the time of service. This includes co-pays, co-insurance, and deductibles.

2. **Insurance-**
   a. **INSURANCE CARD-** please provide a copy of your insurance card prior to each visit.
   b. **INSURANCE CLAIMS-** we will file insurance for you under most circumstance as long as you provide us with current information on your insurance plan. Each plan has different benefits for you as well as different financial obligations. Not all insurance policies cover all services. You are ultimately responsible for understanding the details of any particular coverage you may have as well as the payment of all charges.
   c. **UNPAID INSURANCE CLAIMS-** if your insurance company has not responded to us within 60 days of a filed insurance claim, the charges will be sent to you directly and you will be responsible for their payment as well as for payment of any other charges incurred consistent with this financial policy.

3. **Minor Children Patients-**
   a. **MUST BE ACCOMPANIED-** A parent or legal guardian must accompany patients who are minors.
   b. **CHARGES-** Payments, including co-pays, co-insurance, and deductibles for services rendered to minor children are the responsibility of the parent who seeks treatment for the child are due at the time or service.
   c. **MINOR CHILDREN OF DIVORCED PARENTS-** Charges are due at the time of service from the parent who seeks treatment for the child regardless of any court-ordered responsibility for medical costs.
   d. **FINANCIAL RESPONSIBILITY OF BOTH PARENTS-** The stated terms of the Financial Policy shall not modify the duty of both parents to provide for the welfare of their minor children. We expressly reserve the right to hold either or both parents responsible for any and all reasonable and necessary mental health expenses.

4. **Restricted Service-** it is expected that old balances on your account are to be paid in full prior to receiving additional routine services. Please contact Sylva Clinical's Practice Manager, Chimene Mathis, at (828)342-2862 if you are unable to pay old balances.

5. **Missed Appointment Charge-** if you fail to keep a scheduled appointment and do not give our office at least one business day's advance notice of cancellation, you may be charged a $25 no-show fee.

6. **Additional Service Charge-** A service charge of $25 will be added for each of the following:
   a. Returned Checks
   b. Re-filing of insurance due to incomplete or incorrect information given at the time of appointment

7. **Interest-** in the amount of 1.5% monthly (18% annually) may be applied to accounts with an outstanding balance after 60 days (governed by state law).

8. **Collection Costs, Court Costs and Attorney Fees-**
   a. Accounts may be turned over to a third party for collection if past due 60 days or more.
   b. Should your account become delinquent and be referred to a third party for collection you will be responsible for all collection costs, court costs, and reasonable attorneys' fees as defined by N.C. GEN. STAT. &6-21.2.