Summer Joy Haase, MA, LPC / 972.885.0144 / Info@IntricatePeace.com
9330 Lyndon B Johnson FWY. Suite 1250 Dallas, TX 75243

PATIENT INFORMATION & CONSENT TO TREATMENT

PATIENT INFORMATION

If services are for a couple or family, please fill out according to whose first name you want on receipts.

Name: ______________________ Date: ______________________

Home address ______________________ City/State/Zip: ______________________

Email Address: ______________________ Date of birth: ______________________

Phone: Home: ______________________ Mobile: ( ) -

Age: ______________________

Single ☐ Married ☐ Divorced ☐ Separated ☐ Cohabitating ☐ Widowed ☐

Gender: ☐ Male ☐ Female ☐ Other _____

Employed by: ______________________ Occupation: ______________________

Spouse / Partner: ______________________ No. of years together: ______________________

Spouse / Partner's Email: ______________________ Occupation: ______________________

Emergency contact name: ______________________ Contact's #: ( ) -

Relationship to Client: ______________________

Please Indicate Type (s) of Counseling in Which You Are Interested:

Marital ☐ Individual ☐ Family ☐ Group ☐ EMDR ☐ Other ________________

CHILD OR ADOLESCENT

Name of Client:
(If child or adolescent) ______________________ Age: ___ M ☐ F ☐

School name: Grade: __ Date of Birth: _____

Are the parents of the Client divorced? Yes ☐ No ☐ **If yes:** According to the divorce decree, who is allowed to seek treatment on Client's behalf**?** ________________

Only Mother ☐ Only Father ☐ Either Parent ☐ Other: ________________

Please note a copy of the divorce decree declaring guardianship **MUST be on file before the child can be seen**

Summer Joy Haase, MA, LPC / 972.885.0144 / Info@IntricatePeace.com
9330 Lyndon B Johnson FWY. Suite 1250 Dallas, TX 75243

Other persons currently living in your home:

Name	Age	Gender	Relationship

Any children not living in your home:

Name	Age	Gender

Please list siblings or close relatives

Name	Age	Gender

FINANCIALLY RESPONSIBLE PARTY

Name: ______________________ Relationship to client: ______________________
Address: ______________________ Home Phone: (   )   -
City/State/Zip: ______________________ Bus. Phone: (   )   -   ext.
Employed by: ______________________ Email: ______________________

Private Pay: Yes ☐ No ☐
Using Insurance? Yes ☐ No ☐ If yes, are you the primary Insured? Yes ☐ No ☐
Name of Primary Insured: ______________________
Name of Insurance: ______________________ D.O.B of Primary Insured: _____
Company: ______________________

*Please provide a copy of your Insurance card and Driver's License if using insurance.

How did you find me? (Please check one and be specific)

Friend ☐ Psychology Today ☐ Dr. referral ☐ Web site ☐ Internet search ☐
Other: Name of referral source: ______________________

Reason for Referral: ______________________

____

Summer Joy Haase, MA, LPC / 972.885.0144 / Info@IntricatePeace.com
9330 Lyndon B Johnson FWY. Suite 1250 Dallas, TX 75243

MEDICAL INFORMATION

Have you previously received any type of mental health services (counselors, therapist, psychiatric services, etc.) in the past two years?

☐ No
☐ Yes, previous therapist/counselor: ______________________________ Phone : ( ) - ext.

Issues of concern: ____

____

Reason for termination of counseling: ____

Are you currently taking any prescription medication?
☐ No ☐ Yes, Please list

Medication: Prescribed for: Prescribing Physician:

____
____
____

Please list any inpatient treatment you may have received: ____
____
____

Name of primary physician: ______________________ Phone Number: ( ) - ext.
Name of psychiatrist (if applicable): ______________________ Phone Number: ( ) - ext.

Any history of depression, anxiety, substance abuse, mental illness, etc. in the family? Yes ☐ No ☐

If yes, please explain:
____
____
____

In your own words, please describe why you are seeking counseling:
____
____

GENERAL HEALTH AND MENTAL INFORMATION:

1. How would you rate your current physical health? (please choose one)
   Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good ☐

   Please list any specific health problems you are currently experiencing:
   ____
   ____
   ____

Summer Joy Haase, MA, LPC / 972.885.0144 / Info@IntricatePeace.com
9330 Lyndon B Johnson FWY. Suite 1250 Dallas, TX 75243

---

2. How would you rate your current sleep habits?
   Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very Good ☐
   Please list any specific sleep problems you are currently experiencing: ______
   ______
   ______

3. How many times per week do you generally exercise?

   Please list any difficulties you experience with your appetite or eating patterns: ______
   ______
   ______

4. Are you currently experiencing overwhelming sadness, grief, or depression?
   ☐ No
   ☐ Yes, - for approximately how long? ______

5. Are currently experiencing anxiety, panic attacks, or have any phobias?
   ☐ No
   ☐ Yes, - when did you begin experiencing this? ______

6. Are you currently experiencing any chronic pain?
   ☐ No
   ☐ Yes, - please describe: ______

7. Regarding alcohol, I: ☐ Never drink ☐ Consume drinks per week
   ☐ Drink on social occasions ☐ Recovered alcoholic Sober If yes, for how long? ______

8. Regarding drugs, I: ☐ Have never used drugs. ☐ Currently use ______
   ☐ Used to use ______, though quit ______ (approximate date).

9. Are you currently in a romantic relationship? ☐ Yes ☐ No
   If yes, for how long? ______

10. My Spiritual/Religious preference: ______

11. What significant life changes or stressful events have you experienced recently?
    ______
    ______

PSYCHOSOCIAL STRESSORS

Please indicate any issues that you (the Client) are having difficulty with:

☐ Hopelessness ☐ Hyperactivity ☐ Difficulty relaxing
☐ Fatigue ☐ Sadness ☐ Inferiority Feelings
☐ Helplessness ☐ Panic Attacks ☐ Job Stress

Summer Joy Haase, MA, LPC / 972.885.0144 / Info@IntricatePeace.com
9330 Lyndon B Johnson FWY. Suite 1250 Dallas, TX 75243

- ☐ Grief/Loss
- ☐ Racing heart
- ☐ Worthlessness
- ☐ Stress
- ☐ Divorce/Separation
- ☐ Lack of enjoyment of life
- ☐ Parenting issues
- ☐ Emotional abuse
- ☐ Poor Appetite
- ☐ Depression
- ☐ Weight Issue
- ☐ Self-control issues
- ☐ Anger/frustration
- ☐ Marital issues
- ☐ Isolation/withdrawal
- ☐ Eating disorder
- ☐ Thoughts of hurting self
- ☐ Thoughts of hurting others
- ☐ Nightmares
- ☐ Anxiety
- ☐ Loss of employment
- ☐ Phobias
- ☐ Obsessive thoughts/behaviors
- ☐ Excessive worry

Have you ever considered or attempted suicide? Yes ☐ No ☐

If yes, please explain: ______________________________

____

ADDITIONAL INFORMATION:

Are you currently employed? Yes ☐ No ☐

If yes, what is your current employment situation? ______________________________

Do you enjoy your work? Is there anything stressful about your current work? ______________________________

____

____

What do you consider to be some of your strengths? ______________________________

____

What do you consider to be some of your weaknesses? ______________________________

____

What would you like to accomplish out of your time in counseling? ______________________________

____

____

Consent to Treatment

Please read carefully the following information concerning my professional services and business policies and discuss with me any questions you may have. I will also go over this consent verbally. Your signature at the end of this document indicates you have read and understand this information, thus providing an agreement for proceeding with treatment.

Qualifications:

Summer Joy Haase, MA, LPC, is a Licensed Professional Counselor.

Summer Joy Haase, MA, LPC, maintains Intricate Peace Counseling, a private practice, at 9330 Lyndon B Johnson, Suite 1250, Dallas, TX 75243 providing a variety of mental health services. Summer Haase subleases space from Stanford Couples Counseling, PLLC and is not in a partnership or any other form of business entity with the PLLC or with any of the other mental health providers practicing at this location.

Orientation: I am trained in a variety of approaches to therapy, including cognitive-behavioral, family systems and family of origin approaches, EMDR (Eye Movement Desensitization and Reprocessing), and solution-oriented, short-term therapy. I employ a variety of techniques to assist you in clarifying your goals for change and taking steps in the desired direction. My overall goal in therapy is to assist you in being as healthy as possible physically, mentally, emotionally, relationally, and spiritually. I believe all people are created with a need for purpose and meaning, a need for significant connection with others, and a capacity for growth. Thus, I am committed to providing quality psychological care to assist you in achieving these goals.

Nature of Psychological Services: The purpose of psychological treatment may include relieving distress; decreasing symptoms of a mental or emotional disorder; improving one's mood, self-esteem, or overall wellbeing; working through trauma or loss; working to improve significant relationships; or learning better coping skills for life's challenges. As such, psychotherapy is not an exact science and it is not like a visit to a medical doctor, but rather requires your active participation in identifying problems and goals and working to make changes. As your therapist, I will work to create a safe setting in which you feel respected and accepted in order for you to openly discuss issues which may be at times personal and uncomfortable. I will be sensitive to the pacing and timing of these discussions to maximize a therapeutic result.

Therapy Relationship: Sessions are usually 45-50 minutes on a weekly basis. Less frequent sessions will be scheduled as improvements occur, goals are met, and you near the end of treatment. Feel free to express your preferences for scheduling of sessions, as your needs will likely change over the course of therapy. While psychotherapy often addresses very personal issues, for your work to be therapeutic the relationship between you and I must be a professional relationship rather than a social one. Personal and/or business relationships undermine the effectiveness of therapy. Payment for services rendered is the only remuneration that is expected. Contact with me will be limited to sessions you schedule at my office. I will not accept friend requests on social networking sites. Emergency phone calls after hours will be handled as follows: if it is life-threatening, you will be directed to call 911 or go to your nearest emergency room. Crisis management calls will be brief and aimed at stabilizing the situation for processing at your next scheduled appointment. **Any phone calls lasting more than 10 minutes will be charged per minute at your regular session rate**. For example: if your regular session fee is $100/per a session, a call lasting 15 minutes will be charged $25.00. $100/60 minutes = $1.67. 15 minutes x $1.67 = $25.00. This same pricing structure will be used for email correspondence.

For your protection, I advise emails to be limited to dealing with typical office matters such as scheduling or billing questions. Email is not a secure form of communication and your confidentiality cannot be guaranteed. All other matters should be discussed during your session time.

Effects of Therapy: Psychotherapy can have benefits and risks. Therapy often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. However, I cannot guarantee your specific results. Progress depends on many factors including motivation, effort, and how well you work with me as a team. Additionally, therapy at times involves unpleasant feelings and addressing issues that initially may be difficult, even painful. The changes you make may impact your relationships, your functioning on the job or at home, or your understanding of yourself. Some of these changes may be temporarily distressing.

Whenever possible, I will anticipate these risks and discuss them with you throughout the course of therapy. As your therapist, I am committed to working with you to achieve the best possible results for you.

Patient Rights: Some individuals only need a few sessions to achieve their goals; others may require months or even longer. Your first 1-3 sessions will involve an evaluation of your needs and goals. I will then offer you some initial impressions of what your work will include and make recommendations regarding a treatment plan. Your active involvement in this plan, along with your opinion of what you need and whether you feel comfortable working with me are crucial to your success in therapy. You have the right to discontinue your professional relationship with me at any time, though it is recommended you schedule a termination session for reaching closure. You also have the right to refuse any recommendations I make. If your refusal compromises my ability to render services in an ethical or beneficial manner (e.g. refusal to make a safety contract when feeling suicidal), I may determine to discontinue treatment. In such cases, you will be provided with referrals to another competent mental health professional, if you desire.

My services will be rendered in a professional manner consistent with the legal and ethical standards established by the Texas State Licensing Board for Professional Counselors. If at any time or for any reason you are dissatisfied with my services, please let me know. If you are still unsatisfied, you may report your complaints to the Texas State Board of Examiners of Professional Counselors at 1-800-252-8154.

Referrals: Throughout the course of therapy, I may make recommendations concerning treatment, some of which may involve alternative treatment options I do not provide, e.g. hypnotherapy, medication evaluations, inpatient or intensive outpatient treatment, to name a few. If at any time you or I believe a referral is needed, you will be provided recommendations for other providers or programs to assist you. Alternative treatment options and/or adjuncts to therapy may also be discussed at your request (e.g. support groups, community services). You will be responsible for contacting and evaluating those referrals or alternatives.

Fees and Payment: Please visit with me to obtain the fees that apply for my services. Sessions may be scheduled for more or less than 50 minutes and will be billed in proportion to the hourly rate. Payment is expected at the time services are rendered. You may pay by personal check, cash, or credit card. If payment becomes a hardship for you, please discuss this with me so a suitable payment plan can be arranged for you.

Other services for which additional fees may apply include: telephone calls, clinical consultations with other providers that you give consent for me to speak with; preparation of treatment summaries or treatment plans, letters or documents for employment, disability, or legal purposes; and photocopying and/or mailing of medical records to you, to another provider, attorneys, or insurance companies.

For legal proceedings that require your therapist's response, I bill $300 per hour (includes time spent responding to subpoenas, depositions, time spent waiting to testify, driving time to the court, etc.).

The court fee will be billed at the stated amount with a **4-hour minimum** charge. Payment is due and is **non-refundable 48 hours in advance**. Any additional time spent on the day of court/deposition appearance will be billed within 24 hours and is expected to be paid in full within 48 hours of the bill being sent. Out-of-pocket expenses associated with travel shall also be billed to you with the same expectation of payment.
You are responsible for **ANY legal fees** that I incur as related to your case or treatment (including, but not limited to, any legal consultation that is sought regarding your case or treatment). As your therapist, I reserve the right to suspend services if there is an unpaid balance in your account. With regard to litigation, please note that a Licensed Professional Counselor (LPC) is not considered an expert witness in the courts. LPCs are considered a "witness of fact" in the state of Texas. Any testimony given by LPCs in court will be allowed only as a "witness of fact".

Summer Joy Haase, MA, LPC / 972.885.0144 / Info@IntricatePeace.com
9330 Lyndon B Johnson FWY. Suite 1250 Dallas, TX 75243

Payment will be expected from you, regardless of whose attorney subpoenas my involvement. Patient records will not be released without written consent, unless court ordered to do so. Please note: a subpoena does not constitute a court order.

Cancellation Policy: If you are unable to keep a scheduled appointment or need to change an appointment, please notify my office as soon as possible. Appointments not kept or cancelled less than 24 hours in advance will be billed for the time scheduled at your regular session rate.

Records and Confidentiality: All records may legally be disposed of six years after the file is closed.

Trust and openness are essential for effective therapy. Our communications over the course of therapy become part of your **protected health information,** recorded in your patient file, which will remain confidential and stored securely. When law requires disclosure of your records, you will be notified. Most of these provisions were described to you in the **notice of privacy practices** that you received with the intake packet.

Please be aware of the following **Exceptions to Confidentiality:**

1. You provide consent to release your records or to share information regarding your treatment.
2. You are at risk of imminent serious harm to yourself or others.
3. You disclose abuse, neglect, or exploitation of a child, elderly, or disabled person.
4. You disclose sexual misconduct of a physician or therapist.
5. Information is requested by your insurance company pertinent to processing claims for payment.
6. A court order is received to disclose information (e.g. child custody or mental competency cases).
7. You file a complaint with a licensing board or in cases of a malpractice suit; records will be released to the Board and/or legal counsel.

*In the event that you are deemed an imminent danger to yourself or others, your therapist has a professional duty to contact the proper authorities. ***Medical and/or law enforcement officials may be notified with or without your consent.***

Please indicate in the spaces below who you give consent for me to contact in the event of any emergency:

Name:	Phone Number:	Relationship to Patient:
	( ) - ext.	
	( ) - ext.	

Couples/Family Therapy: When seeing couples or families, I will treat as confidential (within the limits cited above) information you disclose that you specifically request not be shared with your partner or family member. However, open communication is encouraged between couples and families, and I may reserve the right to terminate treatment if I judge a secret to be detrimental to the therapeutic process.

You should be aware that some insurance plans do not cover marital and/or family therapy.

Phone Messages, Fax Transmissions, and Email:
HIPPA regulations and our professional Code of Ethics both require that I keep your Protected Health Information private and secure, and indeed I want to do so. I always prefer to have communication via a phone call. Email and texting are very convenient ways to handle administrative issues, but neither is 100% secure. Some of the potential risks you might encounter if we e-mail or text include:

- Mis delivery of email to an incorrectly typed address.
- Email accounts can be "hacked", giving a 3rd party access to email content and addresses.
- Email providers (i.e. Gmail, Comcast, Yahoo) keep a copy of each email on their servers, where it might be accessible to others.
- Our phone might be visible to others who could see a text message.
- If a phone is stolen the security might be breached, making text messages accessible by others.
- Text messages can be accessed online by the account holder. If you are not the primary account holder this may mean a family member can access your messages.

For these reasons, I will not use email or text to discuss clinical issues (i.e. the important things that need be talk about in session.)

If you are not comfortable with these risks, administrative issues will be managed via phone calls.

I ☐ DO ☐ DO NOT

consent to use electronic communication for administrative matters. If given, consent will expire 2 years after our last appointment. This means that I will not initiate contact via email or text, but that I will briefly reply if you do.

Please initial the following that apply:

I authorize messages may be left for me regarding appointments or returned calls… (Initial all that apply)
___ My home answering machine ___ With a family member ____My cell phone ___My work voicemail
___Text messaging ___ Email
___ I acknowledge that medical records, insurance information, or other information concerning my treatment may be sent by fax transmission when a release of information has been authorized.
___ Emails may be checked only during business hours (not on weekends), and thus should not be used for conveying urgent or highly sensitive information. Be aware that information sent via email is not guaranteed to be secure.

Transfer of Records: In the case of death or incapacity, I have made provision for another mental health provider to take possession of all patient records. In this event, you may contact Lisa Travis Galliano at gallianolpc@gmail.com for information concerning how to access a copy of your record or how to have your record transferred to another mental health professional of your choosing.

I hereby give my consent for psychological treatment from Summer Joy Haase, MA, LPC signed below. I have read this document carefully and understand the information regarding consent and Intricate Peace Counseling services and policies contained herein. 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 at any time. Any questions I had were discussed and answered to my satisfaction. I agree to comply with the policies stated. I understand that, should I require services when my therapist is on vacation, this consent is transferable to the covering professional as designated by my therapist. I have been furnished a copy of this statement.

Patient Signature:	Date:
Parent/Legal Guardian:	Date:
(If patient is under age 18)	
Therapist:	Date:

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you have access to it.

Protected health information about you is obtained as a record of your contacts or visits for healthcare services with Intricate Peace Counseling. This information is called protected health information. Specifically, "Protected Health Information" is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health care services.

Intricate Peace Counseling is required to follow specific rules on maintaining the confidentiality of your protected health information and how I disclose or share this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how I follow those rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law.

Your Rights Under the Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information.
Please feel free to discuss any questions with me.

You have the right to receive and I am required to provide you with a copy of this Notice of Privacy Practices -
I am required to follow the terms of this notice. I reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, I will provide you with a revised Notice of Privacy Practices if you call my office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

You have the right to authorize other use and disclosure - This means you have the right to authorize or deny any other use or disclosure of protected health information not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to designate a personal representative - This means you may designate a person with the delegated authority to consent to or authorize the use or disclosure of protected health information.

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 that is contained in your patient record unless I determine that such disclosure would be harmful to you.

You have the right to request a restriction of your protected health information - This means you may ask me, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare 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. In certain cases, I may deny your request for a restriction.

You may have the right to amend your protected health information - This means you may request an amendment of your protected health information for as long as I maintain this information. In certain cases, I may deny your request for an amendment.

How I May Use or Disclose Protected Health Information
Following are examples of use and disclosures of your protected health care information that I am 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 my office.

For Treatment – I may 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 a third party that is involved in your care and treatment. For example, I would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. I will also disclose protected health information to other physicians who may be involved in your care and treatment. I may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

For Payment -Your protected health information will be used, as needed, to obtain payment for health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services I 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 Healthcare Operations - I may use or disclose, as needed, your protected health information in order to support the business activities of my practice. This includes, but is not limited to business planning and development, quality assessment and improvement medical review, legal services, and auditing functions. It also includes education, provider credentialing, certification, underwriting, rating, or other insurance related activities.

Additionally, it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets and creating de-identified information.

Other Permitted and Required Uses and Disclosures
I may also 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.

To others Involved in Your Healthcare - Unless you object, I 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, I may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

I 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, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

As Required by Law - I may use or disclose your protected health information to the extent that the law requires the use or disclosure.

For Health Oversight - I may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

In Cases of Abuse or Neglect - I 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, I may disclose your protected health information if I believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency

Summer Joy Haase, MA, LPC / 972.885.0144 / Info@IntricatePeace.com
9330 Lyndon B Johnson FWY. Suite 1250 Dallas, TX 75243

authorized to receive such information. In this case, file disclosure will be made consistent with the requirements of applicable federal and state laws.

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

Required Uses and Disclosures - Under the law, I must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

Complaints - You may complain to me or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by me. You may file a complaint with me by notifying our Privacy Manager of your complaint or by calling 1-800-942-5540.

By signing below, you confirm that you have read the above information regarding your Private Healthcare Information.

____

Signature of client, or in the case of a minor, their legal guardian   Date

____

Printed name of client

Summer Joy Haase, MA, LPC / 972.885.0144 / Info@IntricatePeace.com
9330 Lyndon B Johnson FWY. Suite 1250 Dallas, TX 75243

Credit Card Authorization Form
PLEAS PRINT OUT AND COMPLETE THIS AUTHORIZATION AND RETURN TO US.
All information will remain confidential.

Card Holder Name: ___________________________

Billing Address: ______________________________
____
____

Credit Card Number: _________________________
Expirations Date: _____________________________
Security Code (3 digit code): ___________________

Amount to Charge: $ ___________ (USD) I authorize, Summer Haase with Intricate Peace Counseling to charge the agreed amount listed above to my credit card provided herein. I agree that Summer Haase may charge $ _________ fee for missed appointments without 24-hour notice. I agree that I will pay for this service in accordance with the issuing bank cardholder agreement.

Cardholder - Print Name, Sign and Date Below:

Name:_________________________
Sign: _________________________
Date: _________________________