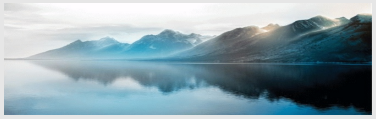

David Hammer, M.A., M.F.T.

Individual and Family Therapy

license # MFC 22942

Print ONLY the names of the participants in counseling:

YOUR NAME:_____ Birthdate:_____

YOUR MATE:_____ Birthdate:_____

CHILD:_____ Birthdate:_____

CHILD:_____ Birthdate:_____

CHILD:_____ Birthdate:_____

CHILD:_____ Birthdate:_____

OTHER HOUSEHOLD MEMBERS:_____

I have filled out will fill out the online forms for scheduling and billing to enable their use.
(circle one)

I consent to work as a team with David Hammer, MA, MFT in counseling and psychotherapy.

I understand that for each :40 session I am responsible for the $110. charge and $130. for 55 min. if not covered by my insurance, to be paid at the time of the session. This includes missed appointments, unless I call and give at least 24 hours notice of cancellation or unless there is major illness. I am also responsible for any interest charges, late payment charges, or returned check charges I accrue. I realize insurance will not pay for
1) a crisis session unless it involves the risk of self harm, 2) sessions outside of the hours of 10 am through 3 pm Mon - Friday as those sessions are not discounted, 3) email counseling, and
4) counseling that focuses on relationships, which they don't consider a "medical necessity".

I a) have insurance coverage and I would like claims information submitted for me, or
b) do not have insurance coverage, or
c) have insurance coverage but choose not to use it, and understand that in doing so I am waiving any right to reimbursement, or
d) have insurance coverage, but understand that my plan indicated your services are not covered. (circle your choice above)

Signature:_____ **Date**:_____

Signature:_____ **Date**:_____

Bring this form to your next session or

fax to David Hammer at: (801) 365 - 7300

or email to: counseling@davidhammer.com

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