

Kim Flyr, LCPC  
Tula Wisdom  
240.356.3528

### New Patient Information

Client's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
If client is a minor, parent's names: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer's/School's Name: \_\_\_\_\_  
How you were referred to this office: \_\_\_\_\_  
Email: \_\_\_\_\_

### Cancellation Policy

As late-cancellations and "no-shows" are inevitable, it is important that I have a reasonable policy regarding financial responsibility for abruptly cancelled sessions. There will be no charge for cancellations made more than 24 hours prior to an appointment. **If I am notified in less than 24 hours, you will be billed the full fee for the missed visit.** This will be applied even when there is a "good reason" for cancellation. Thank you.

### Fees

Fees (\$165/session) are due in full at the time of service. In addition to these standard charges, Kim Flyr maintains the right to charge administrative fees for costs not absorbed in the session fee, such as requests for medical records, phone calls beyond 15 minutes, and/or correspondence prepared for specific issues related to patient care. Any such administrative fees will be presented and explained to said client before charging them. Unpaid balances are subject to a 1.5% monthly interest charge. If collection agency services are required, you are responsible for payment of any associated costs, to include any legal fees.

**I am a "non-participating" provider with your insurance.** You may choose to file claims with your insurer. Your insurance company may or may not reimburse you, according to the rules that govern your individual insurance contract. I will provide you with a receipt which you may attach to a claim. Any reimbursement sent to me on your behalf will be endorsed over to you or credited to your account.

Sign below to authorize the release of any medical information necessary to process your claim and to accept full financial responsibility for all fees and policies above:

\_\_\_\_\_  
Patient (or guardian) signature

\_\_\_\_\_  
Date