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Client Information/Office Policies

Date:_____

Client Information:

Name:_____
Gender: Male:_____ Female:_____ Date of Birth:_____
Phone: (Hm)_____(Wk)_____(C)_____
Address:_____City:_____
State:_____Zip:_____
May I have permission to mail to this address? Yes_____ No_____
Email:_____Permission to use? Yes_____ No_____
Others living at home: (please list ages and relationships)_____
_____
_____
Employer:_____ Occupation:_____
How long at current job?_____How long in current occupation?_____
Education: (list highest level of education attained)_____
Primary Care Physician:_____Phone:_____
Do I have your permission to consult with your primary care physician to assure continuity of care?
Yes_____ No_____ Signature:_____
List any significant health problems:_____
_____
_____
List any medications you are taking and the dosage:_____
_____
What brought you here today?_____
_____
Have you seen a therapist before? Yes:_____ No:_____
If yes, when and whom?_____
Give a brief description of treatment:_____
_____
How were you referred to this office?_____
Who may we thank for referring you?_____
Emergency Contact:_____Phone:_____
Relationship:_____

Financially Responsible Individual's Information:

Name:_____Relationship to Client:_____
Phone: (if different from above)_____
Address: (if different from above)_____
Insurance Carrier: (if applicable)_____
Social Security Number of the Insured:_____
Group Number:_____Member ID Number:_____
Insurance Phone Number:_____

Informed Consent

Confidentiality Statement:

All information shared in this treatment is confidential and may not be revealed to anyone without your consent, except in circumstances where disclosure is required by law. Circumstances in which disclosure is required by law include: reasonable suspicion of child, dependent or elder abuse or neglect; a client presents a danger to self, to others and/or personal property of others; a client is gravely disabled. All other information requires you to give written consent by signing a "Release of Information" form. You can revoke this permission at any time.

Confidentiality of Email Communication

It is very important to be aware that email and cell phone communication, including text messaging, can be relatively easily accessed by unauthorized people and can therefore compromise the privacy and confidentiality of such communication. Emails are particularly vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Faxes or emails can easily be sent erroneously to the wrong address. Please notify your provider if you decide to avoid or limit in any way the use of any or all of the above mentioned communication devices. Please do not use email, text messaging, or faxes for emergencies.

Conjoint or Family Therapy

In couples or family therapy, or when different family members are seen individually for the same issue, confidentiality and privilege do not apply between the couple or among the family members. Your provider will use his/her clinical judgment when revealing such information. Your provider will not release records to any outside party unless he is authorized to do so by all adult family members who were part of the treatment.

Consultation

Your provider consults regularly with other professionals regarding his/her clients; however, client's name or other identifying information is never mentioned. The client's identity remains completely anonymous, and confidentiality is fully maintained.

Emergencies

If there is an emergency during our work together, or in the future after termination which gives your provider cause to be concerned about your personal safety, the possibility of you injuring yourself or a reasonably identified third party or their property, or to insure you receive proper psychiatric care, your provider will do anything he/she can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose he/she may also contact the person whose name you have provided as Emergency Contact on the Initial Interview Form.

Health Insurance and Confidentiality of Records

Disclosure of confidential information may be required by your health insurance carrier or HMO/PPO/MCO/EAP in order to process the claims. If you instruct your provider, only the minimum necessary information will be communicated to the carrier. Your provider has no control or knowledge over what insurance companies do with the information he/she submits or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy or to future ability to obtain health or life insurance. This risk stems from the fact that mental health information is entered into big insurance companies' computers and may also be reported to a congressionally approved National Medical Data Bank. Accessibility to companies' computers or the to National Medical Data Bank data base is always in question as computers are inherently vulnerable to break-ins and unauthorized access. Medical data has been reported to be sold, stolen or accessed by enforcement agencies, which may put you in a vulnerable position.

Litigation Limitation

Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (the client) nor your attorney, nor anyone else acting on your behalf will call on your provider to testify in court or at any other proceeding, or request disclosure of psychotherapy records, unless specifically stated in writing by the client.

Your Right to Review Records

Both law and the standards of the profession require that your provider keep appropriate treatment records. As a client, you have the right to review or receive a summary of your records at any time, except in limited legal or emergency circumstances or when your provider assesses that releasing such information might be harmful in any way. In such a case, your provider will provide the records to an appropriate and legitimate mental health professional of your choice. Considering all of the above exclusions, if it is still appropriated, upon your request, your provider will release information to any agency/person you specify unless he/she assesses that releasing such information might be harmful in any way.

Financial Agreement:

Your fee per visit is $_____payable at he time of treatment. We accept cash, check, cashiers check, Visa, MasterCard, or American Express. If you would like us to bill your credit card at the end of each week for all sessions used for that week, please fill out our "Pre-Authorized Healthcare Form."

Financial Policy:

If you have insurance that provides coverage for this provider and this treatment, we would be happy to assist you in processing your claim forms if you provide us with complete insurance information. We do not accept assignment of benefits, unless by individual agreement, and work as an out-of-network provider with most PPO plans. We will gladly check with your insurance company for benefits and eligibility. You are responsible for the full fee regardless of your insurance company's reimbursement policies. Your regular fee will be charged for any additional professional services rendered by your provider at your request, such as phone contacts over 5 minutes, preparation of special forms, insurance reports, court time, consults with other professionals, etc.

Your payment is to be paid in full at the time of each session. Fees are subject to change every six (6) months.

No-show and Cancellation Policy:

Your visit has been reserved for you. 24 hours notice is required for cancellation or you will be charged a late cancellation fee of $____125____.

Telephone and Emergency Procedures:

All calls are rung directly through to your provider's cell phone. This allows your provider to respond to clients' needs is the most timely manner possible during business hours. However, in the event of a life-threatening emergency and your provider cannot be reached, please call 911.

The Process of Therapy/Evaluation

Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Working toward these benefits, however, requires effort on your part. Psychotherapy requires your very active involvement, honesty, and openness in order to change your thoughts, feelings and/or behavior. Your provider will ask for your feedback and views on your therapy, its progress and other aspects of the therapy, and will expect you to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with certain situations. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in your experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc., or experiencing anxiety, depression, insomnia, etc. Your provider may challenge some of your assumptions or perceptions or propose different ways of looking at, thinking about or handling situations that can cause you to feel upset, angry, depressed, challenged or disappointed. Attempting to resolve issues that brought you to therapy in the first place, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing behaviors, employment, substance use, schooling, housing, or relationships. Sometimes another family member may view a decision that is positive for one family member quite negatively. Change can sometimes be easy and swift, but more often it can be slow and even frustrating. There is no guarantee that psychotherapy will yield positive or intended results. During the course of therapy, your provider is likely to draw on various

psychological approaches according, in part, to the problem that is being treated and his/her assessment of what will best benefit you. These approaches may include behavioral, cognitive-behavioral, psychodynamic, existential, family systems, developmental (adult, child, family) or psycho-educational.

Discussion of Treatment Plan

Within a reasonable period of time after the initiation of treatment, your provider will discuss with you his/her working understanding of the problem, treatment plan, therapeutic objectives and his/her view of the possible outcomes of treatment. If you have any unanswered questions about any of the procedures used in the course of your therapy, their possible risks, your provider's expertise in employing them, or about the treatment plan, please ask and you will be answered fully. You also have the right to ask about other treatments for your condition and their risks and benefits. If you could benefit from any treatment that your provider does not provide, he/she has an ethical obligation to assist you in obtaining those treatments.

Termination

You have the right to terminate therapy at any time. In the case that your provider assesses that termination is premature, or in the event that your provider assesses that he/she cannot be clinically beneficial to you, he/she will provide you with names of other qualified professionals whose services you might prefer.

Statement of Understanding:

I have read and understand this information sheet and informed consent.

Client	Date
Provider	Date
Parent or Guardian if minor	Date

I have received and reviewed a copy of the "HIPPA Notice of Privacy Practices".

Client	Date

I authorize the provider to process insurance claims. I understand that this does not guarantee reimbursement and that all uncovered charges or coinsurance are my responsibility.

Client (or parent/guardian	Date