PATIENT INFORMATION

Patient Name_____Date_____

Age: _____ D.O.B. _____ email: _____

Address _____Home Phone _____

City _____State _____Zip Code _____Work Phone _____Cell Phone_____

Marital Status _____Education completed (or, if patient is a child: school & grade:)_____

Spouse _____ Parent(s) [if patient is a minor] _____

Ages and names of Children (or of siblings of child) _____

Place of employment_____

Reason for Referral (symptoms) _____

When did this problem begin? _____Is it work related (Workman's Comp)?_____

Who referred you? _____Primary Care Physician (PCP)_____

I authorize exchange of information with my Primary Care Physician:_____ PCP ph#_____

Signature

Please list any other medical problems the patient may have: _____

Please list any medications the patient is currently taking: _____
(Attach list if more space needed)

In case of a medical emergency who should be contacted? Name_____ Ph# _____

Has patient ever been in counseling or psychotherapy before? If yes, please explain briefly: _____

_____

RESPONSIBLE PARTY: Name _____ Relationship to patient:_____

_____

Address for billing (if different from patient)_____

PRIMARY INSURANCE COVERAGE_____
Policy Holder _____

SECONDARY INSURANCE COVERAGE_____
Policy Holder _____

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*I REQUEST THAT PAYMENT OF **AUTHORIZED** INSURANCE BENEFITS or MEDICARE BE MADE ON MY BEHALF TO MY PROVIDER FOR ANY SERVICES FURNISHED TO ME BY THAT PROVIDER. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.*

Signature _____ Date_____

I HAVE READ AND UNDERSTAND THE HIPAA PRIVACY GUIDELINES. _____
Signature

I ACCEPT THE PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT _____
Signature

IF WE NEED TO CALL YOU AT HOME OR AT WORK, MAY WE LEAVE A MESSAGE? _____yes _____no
If NO, how may we reach you?

FEE SCHEDULE

Psychologists: **Drs. Bradley, Gaskill, Ibsen, Lecci, Matt, and Peters:**

1) Initial Interview	$ 150.00 per 50 minute session
2) Psychotherapy	130.00 per 45-50 minute session
	70.00 per 25 minute session
3) Phone	* 40.00 per extended phone consult
4) Group	50.00 per 75 minutes

*(insurance will not cover phone consults)

Psychological Associate: **Karen Selz:**

1) Initial Interview	$ 110.00 per 50 minute session
2) Psychotherapy	95.00 per 50 minute session
	50.00 per 25 minute session
3) Phone	*30.00 per extended phone consult

Psychological Testing Fees: $150.00 per 50 minutes of contact time and generating report(s)
MMPI / MMPI-A: $75.00 (administration and scoring by technician)

Fee for a missed appointment will be the full amount for the service scheduled. Fees for other procedures are supplied as needed by the therapist. Consideration will be made for appointments missed due to medical emergencies and natural disasters. You are expected to pay the required co-pay if it is known or the full fee for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, your therapist has the option of using legal means to secure the payment, e.g., through a collection agency or small claims court. If this is necessary, it will require disclosure of some otherwise confidential information, in most cases name, nature of services provided, and the amount due, and any additional costs of pursuing the claim.

Please sign your name below so that we may know that you have read the above information and understand its contents as well as your responsibilities. By signing, you agree that you understand the policies and the fees established by your provider, that you agree to pay all charges, and that your questions have been answered to your satisfaction. Thank you.

Signed:_____ Date _____
(Patient's Signature)

Signed:_____ Date _____
(Parent/Legal Guardian)

Signed:_____ Date _____
(Witness)

IF THE PATIENT IS A MINOR: My signature below as parent or legal guardian grants permission for _____ to offer professional evaluation and treatment to
(provider's name)
_____ for whom I am legally responsible.
(patient's name)

Signed: _____ Date_____

Witness: _____ Date_____

Parent(s): Please initial here if you grant permission for this office to verify to school personnel that your child has or has had an appointment should they call for verification: _____