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Introduction

The following documents are for new clients. Before we meet, I would like you to review my practice documents and provide some information about yourself. Please complete and sign the forms and bring them to your first appointment. Please bring your insurance card and driver's license for photocopying.

If you are using insurance, you will need to call your insurance company to verify your benefits for outpatient mental health treatment before your first appointment. Please complete the information below:

Name of company that manages your mental health insurance benefits:

_____

Number of sessions authorized _____

Copayment or coinsurance amount _____

Please bring payment for your copayment at the first visit. I accept cash or check and we can arrange a monthly payment if that is more convenient.

New Patient Information

Patient Name (First, Middle initial, Last) _____

DOB_____ Age _____ Social Security Number_____

Patient Address Street, City, State, ZIP Code_____

Home Phone Number_____ Cell Phone_____

May I call to leave a message? Yes _____No_____

Marital Status: Single_____ Married (_____years) Divorced (_____years) Separated _____(years)

Widowed _____(years) Number of marriages _____

Employment: Employed_____ Student_____ Unemployed_____ Retired _____

Employer or School Name_____

Primary Care Physician Name and Phone_____

By whom were you referred? _____

Primary Insurance Information

Subscriber's Name_____

Insurance Co. Name_____

Member ID No_____ Group No_____

Insurance Plan Name_____

Insurance Claims Address_____

Insurance Telephone Number_____

Secondary or Co-Insurance

Subscriber's Name_____

Insurance Co. Name _____

Group No. _____Member ID No._____

Insurance Plan Name_____

Insurance Claims Address_____

Insurance Telephone Number_____

For office Use only:

Authorization #_____

Copayment: $10 $15 $20 $25 10% 20% other_____

Number of sessions: _____

DSM-IVTR Code: _____

<u>Office Policies and Fee Agreement</u>

Appointments: Appointments are 50 to 53 minutes long, depending on your insurance company's requirements. Your appointment is held exclusively for you. Please arrive on time as your appointment will not be extended if you arrive late.

Should I be late due to unforeseen circumstances I will make up the missed time with you in a manner, we both agree upon. If you are late, I will have to charge the full fee, and you will most likely lose that portion of time from your scheduled session. We can discuss other options should this occur.

Please see the included Cancellation Policy.

Fees: The charge for a therapy session is $235. If I am contracted with your insurance company and bill them, your copayment will be expected at the time of service. The remaining amount will be billed to the insurance company. My billing cycle ends on the last day of the month. Payment of all fees and co-payments is expected at the time of service or no later than the end of the month. A fee of $25 will be charged for a return check for handling purposes.

Emergencies: In the case of an urgent situation, you may leave a message on my voicemail as I check it throughout the day and will return your call as soon as possible. If you cannot reach me in an emergency, please go to the nearest hospital, emergency room or contact the police. You can also contact the 24-hour Multnomah County Crisis Line at 503-988-4888.

HIPPA Requirements: I am required by federal law, (Health Insurance, Portability, and Accountability Act) known as HIPAA, and by state law, to protect the privacy of your personal information, and to give you a notice that describes how clinical information about you may be used and disclosed and how you can get access to this information. Please ask for a copy of the *HIPPA Notice of Policies and Practices*. Should you wish to have a complete copy for your records.

Your signature below indicates that you have read this agreement and agree to all its terms. Your signature also serves as an acknowledgment that you have been offered a copy of the HIPAA Notice of Policies and Practices described above.

_____

Signature of Client Date

_____

Please Print your name