ATTENDANCE LOG

Client Name ______________________________ Client I.D. # ________________

DATE OF SERVICE	SERVICE PROVIDED	DURATION OF SERVICE	STAFF PROVIDER	CON-FIRMED BY:	Y-T-D USED	DATE OF SERVICE	SERVICE PROVIDED	DURATION OF SERVICE	STAFF PROVIDER	CONFIRMED BY:	Y-T-D USED

Patient Intake Form

(PLEASE PRINT CLEARLY AND COMPLETE ALL (PAGES)

PATIENT: _____

LAST NAME_____ FIRST NAME_____ M. I._____

ADDRESS _____ CITY_____ STATE_____ ZIP_____

TELEPHONE: HOME (_____)_____ WORK (_____)_____ CELL (_____)_____

PAGER (_____) _____ EMAIL_____

AGE _____ DATE OF BIRTH_____ SEX _____ SOCIAL SECURITY NO. _____-_____-_____

MARITAL STATUS: (circle) SINGLE Married DIVORCED WIDOWED

STUDENT STATUS: (circle): FULL-TIME PART-TIME NONSTUDENT

EMPLOYMENT STATUS: (circle) : FULL-TIME PART-TIME RETIRED DISABLED UNEMPLOYED

EMPLOYERS NAME _____

EMPLOYERS ADDRESS_____ CITY, STATE, ZIP_____

In Case of an emergency notify_____

Relationship: _____ Telephone: _____

PRIMARY INSURANCE COMPANY: _____

PATIENT'S INSURANCE ID#: _____

INSURANCE PLAN NAME: _____ INSURANCE GROUP NUMBER:_____

PREAUTHORIZATION NUMBER (If applicable): _____

RESPONSIBLE PARTY INFORMATION (Only fill out if responsible party different than above):

LAST NAME_____ FIRST NAME_____ M. I._____

RELATIONSHIP TO PATIENT: ☐ Parent; ☐ Legal Guardian; ☐ ☐ Other _____

AGE _____ DATE OF BIRTH_____ SEX _____ SOCIAL SECURITY NO. _____-_____-_____

ADDRESS _____ CITY_____ STATE_____ ZIP_____

TELEPHONE: HOME (_____)_____ WORK (_____)_____ CELL (_____)_____

POLICYHOLDER'S INSURANCE ID#: _____

INSURANCE PLAN NAME: _____ INSURANCE GROUP NUMBER:_____

MARITAL STATUS: (circle): MARRIED SINGLE DIVORCED WIDOWED

STUDENT STATUS: (circle) : FULL-TIME PART-TIME NONSTUDENT

EMPLOYMENT STATUS: (circle) FULL-TIME PART-TIME RETIRED DISABLED UNEMPLOYED

EMPLOYERS NAME _____

SERVICE FEE AGREEMENT

Client Name _____

SS# _____

☐ **BC/SA** (req. physical prior to 2nd session) ☐ **BC/OPC**
FEP (R# Required)
Messa
ST of MI (81818 & 81819 prior approval req - Magellan)
Managed Care (Ford/Chrysler)
Blue Card (Out of State Plan)

☐ **MEDICAID**
SA (Medicaid, ABW or Block Grant)
COMPCARE (Comm Choice, Molina Great Lakes)
HEALTH PLUS PARTNERS
MCLAREN HEALTH PLAN

☐ **BC/MASTER MEDICAL** (billed by Insight-paid to client – MUST BE PRIVATE PAY AT BC RATES)

TOTAL HEALTH CARE

OTHER _____

☐ **CONN GEN SA** (GM—35 yearly visits at 100%)

☐ **MEDICARE** (PART B - Approved Therapists only)

☐ **CONN GEN OPC** (GM—first 20 visits at 100%; next 15 at 75%) ☐ **PPOM** _____

☐ **HAP** _____ ☐ **VALUE OPTIONS** _____

☐ **HEALTHPLUS** _____ ☐ **OTHER INSURANCE** _____

☐ **PRIVATE PAY** - $_____ per initial intake, $_____ per 45-60 min. individual/family session, $_____ per 1 ½ hour group/didactic session

* _____ $100.00 No Show/Cancel Fee
Initial

Amount billed to insurance$ 250.00	per initial intake
Amount billed to insurance$ 150.00	per 45-60 minute session
Client's yearly deductible$	
Client's co-pay per 45-60 minute session$	(% or $ per session)
Yearly maximum paid by insurance$	
Client's co-pay after _____ visits per year; per 45-60 minute session	% or $

I am responsible for payment of services should the yearly maximum be reached or should the insurance company not cover the services for any reason. It is my responsibility to notify the agency of any change in my insurance coverage; responsible for incorrect information they may have received from the insurance company.

_____ TREATMENT FOR MINORS: I understand and agree that as parent/guardian of this minor, I am responsible
(Initial Here) for payment of any deductibles, co-payments, or non-reimbursable services. Any agreement with another responsible, either verbal, written or court ordered, is an agreement between that party and myself.

_____ I have read this agreement and have had the opportunity to ask questions which were answered to my
(Initial Here) satisfaction. I understand and agree to the conditions specified herein.

_____ ***PAYMENT IS DUE AND PAYABLE AT THE TIME THE SERVICE IS RENDERED.***
Initial Here

Client Signature _____ Date _____

Witness Signature _____ Date _____

Guardian/Guarantor Signature _____ Date _____

REQUIRED FOR TREATMENT: PLEASE READ

To my Patients:

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

Many of us Psychologists have implemented a similar policy. You will be asked for a valid credit card or debit card number (please provide the card to make a copy) at the time you enter treatment. The information is held securely while your insurance company is billed and pays their portion. After that time, any remaining balance owed by you will be charged to your card on file, and a copy of the charge will be mailed to you upon request. As well, any no show or cancelation fees ($100.00) without the required 48 hour notice will be charged to your card on file (insurance does not pay for these charges), as stated in the agreement for services herein.

This will be an advantage to you, since you will no longer have to write out and mail checks. It will be an advantage to my services since it will greatly decrease the number of invoices needed to be generated. You will also receive an EOB from your insurance with charges you owe such as deductibles and copayments that are your responsibility. This will aid with any misunderstandings between you and your insurance in terms of copayments, deductibles, etc. The combination will benefit everybody in helping keep costs down, along with paying any outstanding fees for services rendered.

This in no way will compromise your ability to dispute any charge or question your insurance company's determination of payment. Thank you for your understanding!

Sincerely Yours,

Dr. Debra Lewis
Licensed Psychologist

I authorize Dr. Lewis to charge any outstanding balances on my account that will include charges such as co-payments, deductibles, missed appointments, and or fees my insurance company does not cover for services rendered.

Visa (____3 letters on back of card) **MasterCard (____3 numbers on back of card)**

Account Number_____ Exp. Date_____

Name on care (please print) _____

Address_____ City_____ Zip_____

Signature_____ Date _____

Have you been in treatment (for mental health issues and/or drug/alcohol) before?
CIRCLE) YES NO (If yes, please complete information below:

REASON FOR	WHEN (dates)?	WITH WHOM AND WHERE?	OUTCOME?

MEDICATIONS: (Please list medications you are presently taking):

MEDICATION	DOSAGE	TIMES PER DAY	FOR TREATMENT OF:

Medical Problems (Please list):

_____

_____

_____

FAMILY PHYSICIAN: _____

TELPHONE #: (____)_____ FAX #: (____)_____

PRESENTING PROBLEM: (WHY ARE YOU CURRENTLY SEEKING PSYCHOLOGICAL SERVICES)?

_____

_____

_____

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_____

Patient Contract Form

When people start counseling they usually have a lot on their minds and do not always remember details about my office policy and the required documentation to get started. Therefore, I am providing my policies in writing. I encourage you to take this time to read these through before your first appointment. Please feel free to bring up any questions you may have concerning my policies.

1. Fees: Fees are $150.00 for the standard 45-minute individual psychotherapy session, $225.00 for 60 minute couples/family therapy. The initial intake fee for individual (&couples/family therapy) is $250.

2. Cancellations: Cancelled appointments 48 hours in advance will relieve you of any financial obligation for your reserved time slot. Failure to cancel 48 hours in advance will result in you being billed the full fee of your scheduled session for individual, couples, and or family therapy. This time is scheduled only for you so that without notice someone else in need of an appointment time cannot fill it. You will be responsible for payment for that missed appointment. Insurance reimbursement does not cover missed appointments. Payment in full for the missed appointment is charged to your credit card on file or expected at the next appointment.

3. Payment for professional services is expected at the time of each individual/couple/family session. Checks can be made out to Dr. Lewis and given to me at the beginning of the session. Or you may use Visa, MasterCard, or cash. You will then be given a receipt if needed.

4. Insurance: Many of the costs of outpatient psychotherapy are covered by health insurance. Please check with your insurance company. Your insurance will be billed, but it is your responsibility to know your deductible and or copayment information. There are a growing number of insurance companies with an assortment of different types of policies and contracts. It is crucial that you find out what your individual coverage is. These companies most often will only provide you with the information regarding your coverage. Benefit information can be obtained either through your personnel office at work or directly from your insurance company by dialing the number on the back of your insurance card. The following guidelines will be helpful:

Ask for details (how many visits per year, authorization requirements, copayment/deductible, etc.) about outpatient substance abuse and or mental health coverage •

These services are for outpatient psychotherapy by a fully licensed psychologist in-network •

5. Termination: An orderly end of therapy has positive effects for patients. It is suggested you discuss openly with me your wish to end therapy at least few sessions prior to your last session. A final closure session has proved to be very important for patients. Closure sessions help you acknowledge and summarize what you have accomplished and discuss any unfinished concerns you may have. While not required they are strongly recommended.

6. Notice of Privacy Practices (HIPPA): I acknowledge that I have read and understand the disclosures for which are included in this intake package, and I am aware of how my medical records may be used and or disclosed.

Client Name (print)

_____

Client Signature/Date

_____

Psychologist Signature/Date

_____

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About Cancelled and Missed Appointments

I take missed appointments very seriously. I understand that things come up which are out of your control which prompt the need to cancel an appointment in less than 48 hours. However, this remains your responsibility to pay for your time. This time is scheduled only for you so that without notice someone else in need of an appointment time cannot fill it.

Cancelled appointments 48 hours in advance will relieve you of any financial obligation for that time slot. This can be done by sending a voicemail or email. If done by email or text you need to have confirmation from me stating that I have received it. $100 No Show/Cancel Fee

Failure to cancel 48 hours in advance will result in your being billed the full fee of your scheduled session for individual, couples, and or family therapy.

If our schedules allow for another appointment in the same week, you will not be responsible for payment for that missed appointment.

Insurance reimbursement does not cover missed appointments. Payment in full for the missed appointment is charged with your credit card on file or expected at your next appointment.

I am willing to have a telephone session with you if you are unable to make it into the office for an appointment so that you can still receive my services.

As your Psychologist, I consider any feelings and thoughts you have about being charged for a missed appointment as therapeutic and invite you to discuss them with me.

Client Name (print)

_____

Client Signature/Date

_____

Psychologist Signature/Date

_____

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Name _____ Adult Intake

PRESENTING PROBLEM:

INTEGRATIVE FORMULATION (brief summary of assessment)

DSM DIAGNOSIS AND CODE NUMBERS

Axis I _____, _____. _____

_____, _____. _____

Axis II _____, _____. _____

Axis III _____

Axis IV _____

Axis V GAF: Current: _____

Clinically Recommended LOS: _____ (Months) _____ (# of Sessions)

Type of Treatment: ☐Individual ☐Group ☐Family ☐Didactics

Frequency: _____ _____ _____ _____

Modality: ☐OP ☐IOP ☐PHP ☐Other _____

_____ _____

Therapist signature (when needed) Date

_____ _____

Therapist signature Date

Physician's Comments (when needed):

_____ _____

Date

Therapist's Response (when needed):

_____ _____

Therapist signature (when needed) Date

CONSENT FOR DISCLOSURE

Client Name: _____

Social Security #: _____

I hereby request and authorize _____ written, verbal or electronic information or reports from my medical record to the source indicated below:

	NAME/TITLE	ADDRESS	PHONE	CLIENT INITIALS
*Hospital				____
*Physician				____
Employer Benefits\Personnel				____
EAP Representative			Monthly Reports? ___Y ___N	____
CDR\CRO\Gatekeeper (May be used regarding audit or reimbursement appeals)				____
Significant Other				____
*Emergency Contact				____
*Third Party Payor (Insurance) (May be used regarding audit or reimbursement appeals)				____
Card Holder/Insured				____
Parole/Probation Officer			Monthly Reports? ___Y ___N	____
Parent /Legal Guardian				____
Attorney				____
Responsible Party				____
Other				____

This consent may be revoked by me at any time by oral or written notice to this program, except to the extent that action has been taken in reliance on it. If not previously revoked, this consent expires one (1) year from date of signature unless more specific conditions are stated below.

EVENT, DATE, OR CONDITION: _____

I am aware that the purpose or need for this/these disclosure(s) is to assist the staff in establishing and carrying out my care plan. See reverse side for specific types of information to be disclosed. I have reviewed the information on both sides of this form.

_____ _____

CLIENT SIGNATURE DATE

Client is unable to give consent because: _____

_____ _____

AUTHORIZED SIGNATURE/RELATIONSHIP DATE

_____ _____

WITNESSED BY DATE

(*Must be completed for every client)

SOURCE	INFORMATION TO BE RELEASED (Mark all □'s that apply with an "x" or "√")	CLIENT INITIALS
*HOSPITAL	□ Emergency medical/clinical information □ Other _____ □ All	_____
*PHYSICIAN	□ Emergency medical/clinical information □ Status in treatment □ Other _____ □ All	_____
EMPLOYER BENEFITS/ PERSONNEL	□ Dates of treatment □ Status in treatment □ Diagnosis □ Attendance □ Progress reports □ Treatment recommendations □ Discharge Summary □ Aftercare Plan □ Other _____	_____
EAP REP	□ Dates of treatment □ Status in treatment □ Diagnosis □ Attendance □ Progress reports □ Treatment recommendations □ Discharge Summary □ Aftercare Plan □ Other _____	_____
CDR/CRO/ GATEKEEPER	□ Dates of treatment □ Status in treatment □ Diagnosis □ Attendance □ Progress reports □ Treatment recommendations □ Discharge Summary □ Aftercare Plan □ Other _____	_____
SIGNIFICANT OTHER	□ Dates of treatment □ Status in treatment □ Diagnosis □ Attendance □ Progress reports □ Treatment recommendations □ Discharge Summary □ Aftercare Plan □ Other _____ □ All	_____
*EMERGENCY CONTACT	□ Emergency medical/clinical information □ Dates of treatment □ Status in treatment □ Diagnosis □ Attendance □ Progress reports □ Treatment recommendations □ Other _____ □All	_____
*THIRD PARTY PAYOR	□ Basic demographic information □ Diagnosis □ Services provided □ Dates of treatment □ Cost of services □ Other _____ □ All	_____
CARD HOLDER/ INSURED	□ Dates of treatment □ Status in treatment □ Diagnosis □ Attendance □ Progress reports □ Billing □ Other _____ □ All	_____
PAROLE/PROBATION OFFICER	□ Dates of treatment □ Status in treatment □ Diagnosis □ Attendance □ Progress reports □ Treatment recommendations □ Discharge Summary □ Aftercare Plan □ Other _____	_____
PARENT/LEGAL GUARDIAN	□ Dates of treatment □ Status in treatment □ Diagnosis □ Attendance □ Progress reports □ Treatment recommendations □ Discharge Summary □ Aftercare Plan □ Other _____ □ All	_____
ATTORNEY	□ Dates of treatment □ Status in treatment □ Diagnosis □ Attendance □ Progress reports □ Treatment recommendations □ Discharge Summary □ Aftercare Plan □ Other _____	_____
RESPONSIBLE PARTY	□ Dates of treatment □ Status in treatment □ Diagnosis □ Attendance □ Progress reports □ Billing □ Other _____ □ All	_____
OTHER	□ Status in treatment (Specify below exactly what is to be released, including purpose for release):	_____

_____

_____

_____

If any information to be released is different from above, state here:

_____

_____

_____

_____

NOTICE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization of the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

(*Must be completed for every client)

Name:_____

TREATMENT PLAN:

Clinical Problem # _____(in client's own words) Goal (desired outcome)(in client's own words)		Staff Responsible	Date Established	Expected Achievement Date	Date Achieved
Strengths:_____ _____ Needs:_____ _____ Abilities:_____ _____ Preferences:_____ _____ **PROJECTED DISCHARGE DATE:** Objectives(steps client will take)	Health & Safety Risks/Needs: _____ _____ _____ Relapse Prevention Plan: _____ _____ _____ _____ Interventions(methods/modalities-therapist)				

(I have participated in the development of my treatment plan and have been offered a copy of my plan.

_____ _____

Client Signature Date

_____ _____

Staff Signature Date

G:spm2word\IP\Treatment Plan.doc
01/04
08/06, 12/07

- Your insurance is billed as a courtesy. If payment is refused, for any reason, you are responsible for payment of charges in full. (Please read and sign full disclosure of "Financial Agreement and Record Policy")
- **Payment is due at the time of the session by cash or check** (credit and/or debit cards are also accepted). A $35.00 fee will be charged for all checks returned by the bank for NSF or any other reason (payment is due before any further sessions).
- Sessions not canceled or rescheduled (48) hours in advance will result in a charge to the patient of $100.00.
- I understand if I am more than 20 minutes late for your scheduled appointment, I may not be seen that day. *Please attempt to call if you will be more than 10 minutes late.*
-

- I understand it is my responsibility to obtain information about whether my insurance carrier covers the services rendered.
- I am also responsible for obtaining initial authorizations for treatment and information about my co-payment and deductible.
- Any costs (i.e. collection/legal fees) incurred in the collection of delinquent payments will be added to the original charges, in addition to a $25.00 administration fee.
- I will inform Dr. Lewis in writing of any changes in address, telephone numbers, and/ or Insurance Coverage.
- Additional Fee's are: $100.00-150.00/ hour for report writing forms to be filled out, consultation with others, letters, etc.
- The therapeutic session is 45-50 minutes long from the scheduled time of the appointment.
- The patient or guardian, if the patient is a minor, consents to counseling, psychological and psychiatric treatment, understanding that such treatment may or may not be of benefit.
- I understand that if I miss two appointment without informing the office, all future appointment may be cancelled.
- I understand Dr. Lewis is a treating psychologist and I agree to the terms of this agreement for services.
- I have read or will read the "***HIPPA PRIVACY INFORMATION***" that is attached to this Intake Form.

Please Print Patient's/Responsible Parties Name: _____

Signature of Patient/Guardian/ Responsible Party:

_____ **Date:**_____
(Please Sign Name and date)

(Please Circle Relationship to patient (must be 18 years of age or older)):
Patient; Parent; Legal Custodial Parent; Guardian

Witness: _____ **Date:**_____