Sacks Clinical Consulting, PC
Client Profile

☐ Dr. Sacks ☐ Dr. Samelson ☐ Belinda Witherow

Client Information: (Please Print)

Last Name: _____ First Name: _____ MI _____

Street Address:_____ City, State, Zip: _____

Date of Birth: _____ SSN: _____ Age: _____ Gender:_____

Home Phone: _____ Cell Phone: _____ Email Address: _____
Okay to leave a message at home? ☐ Yes ☐ NO Okay to leave message on cell? ☐ Yes ☐ No Okay to text to cell phone? ☐ Yes ☐ No

Current Status: ☐ Employed ☐ Retired ☐ Student Marital Status: ☐ Married ☐ Single ☐ Other

Client Employer/City/State: _____ Client School and Grade Level: _____

Current Medications and Prescribing Doctor: _____

If Minor, Parent Information:

Father: _____ Address, City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ SSN: _____ Date of Birth: _____

Employer/Employer Phone: _____

Mother: _____ Address, City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ SSN: _____ Date of Birth: _____

Employer/Employer Phone _____

Guardian: _____ Address, City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ SSN: _____ Date of Birth: _____

Employer/Employer Phone _____

Insurance:

Primary

Insurance Company Name: _____ Policy Holders Name: _____

Policy Holders Date of Birth: _____ Policy Number: _____

Group Number: _____ Pre Certification Required?: _____ Co Pay_____

Secondary

Insurance Company Name: _____ Policy Holders Name: _____

Policy Holders Date of Birth: _____ Policy Number: _____

Continue on reverse side.

What brings you here today?

- ☐ Anxiety
- ☐ Depression
- ☐ Grief
- ☐ Relationship Concerns
- ☐ Parenting/Coaching
- ☐ Other

Please list current concerns:

1. _____
2. _____
3. _____

What are you hoping to accomplish with therapy?

_____
_____
_____

Who may we thank for referring you to Sacks Clinical Consulting?

_____
_____

Have you previously been in therapy?

When: _____

Where: _____

Sacks Clinical Consulting, PC
2017 - Terms and Conditions

Welcome to Sacks Clinical Consulting. This document contains important information about my professional services and business practices. Please read it carefully and let us know if you have any questions. When you sign this document, it will represent an agreement between us.

AGREEMENT

These terms and conditions shall be incorporated by reference and shall prevail as the Client's Agreement with Sacks Clinical Consulting (SCC). SCC makes no warranty or guarantee, express or implied, with respect to any services performed by SCC.

HIPPA PRIVACY NOTICE ACKNOWLEDGEMENT

I understand that I have been given an opportunity to read a copy of Privacy Practices provided by SCC. I understand that if I have any questions, that I can direct them to Sacks Clinical Consulting, PC.

PAYMENT

Co-Payment and other charges not covered by insurance is expected at the time of service. You are responsible for keeping your account current, not your insurance company. **SCC asks that you provide credit card information which will be used to pay your co-payment, full payment or any balance over 30 days.** Please insure that your credit or debit card/HSA card or other financial information is accurate and current at all times.

CANCELLATION POLICY

All appointments must be cancelled 24 hours in advance of appointment date and time. **If you do not cancel within 24 hours you will be charged a $25 cancellation fee.**

COMMUNICATION

SCC will communicate non-HIPPA (i.e. non-confidential) information via e-mail or text message. We use email and text messaging for purposes such as scheduling appointments, billing matters etc. Please do not email or text information about clinical matters as it is not a secure way to communicate. We also do not communicate through social media venues. I am often not immediately available by telephone. We are in the office Monday through Friday after 9:30 AM. We will make every effort to return your call within 24 hours if you call outside of regular office hours. If you have an emergency and you are unable to reach us, please report to the nearest emergency room.

TREATMENT OF MINORS

The custodial parent, the only one who can legally authorize treatment, is responsible for all fees incurred. If there is joint legal custody, the parent who is presenting the child for treatment is responsible for making the financial arrangements for all fees incurred. Parents may be required to show proof of custody. All parents must sign "permission to treat minor child" below.

CONFIDENTIALITY

You have the absolute right to the confidentiality of your therapy. SCC cannot and will not disclose to anyone that you are a client of SCC or any session content without your written permission. The following are legal exceptions to your right to confidentiality. SCC will inform you of when these are put into effect.

1. If a minor child is a risk of being abused or neglected.
2. I you present an imminent risk of serious injury to yourself.
3. If you threaten serious harm to another person.

You should also be aware that most insurance companies require you to authorize me to provide them a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatments plans or summaries or copies of the entire record (in rare cases). This information will become part of the insurance company files.

INSURANCE AND THIRD PARTY PAYMENT

Please contact your insurance company prior to treatment to ensure that SCC is an in-network provider. Pre-certification/authorization may also be necessary and should be taken care of prior to your first appointment. SCC can assist you with this process. **For Out-of-Network Insurance companies, full payment will be required at the time of service. SCC will provide you with the necessary information to submit your claim to the carrier for direct reimbursement to you.**

Sacks Clinical Consulting, PC
Terms and Conditions

RELEASE OF INFORMATION TO THIRD PARTY PAYORS/AGENTS AND AUTHORIZATION AND ASSIGNMENT OF BENEFITS AGREEMENT FOR PAYMENT OF SERVICES:

I authorize Sacks Clinical Consulting, to disclose portions for the clinical record on the client named below to my insurance company and/or its contracted managed care/utilization review company for the purpose of reimbursement of services rendered at this facility. Such disclosure may include review and release of copies of the psychological and/or substance abuse diagnosis, history and physical examinations, intake assessment, treatment plan, progress notes, discharge summary and any other information or records reasonably necessary for the discharge of the legal contractual obligations of the insurance company.

I hereby release Sacks Clinical Consulting, its officers, agents, employees and any clinician associated with my case from all liability that may arise as a result of the disclosure of information to the insurance company and/or its contracted managed care/utilization review company.

By signing this release, I acknowledge the following:

1. I am aware that I may revoke this authorization at any time except to the extent that action has been taken in reliance hereon.
2. I agree that this authorization will be valid during the pendency of the claim.
3. I further authorize that payments be made to Sacks Clinical Consulting, on my behalf.
4. I understand that I am financially responsible for all charges not covered by insurance and/or those stated to be client responsibility by the third party payor.
5. I understand that any expense that is incurred by Sacks Clinical Consulting, associated in collecting the balance on the account, such as collection fees and/or attorney's fees will be my responsibility to pay.

Name (Print):_____ Date: _____

Signature: _____

MEDICARE/MEDICAID AUTHORIZATION AND ASSIGNMENT OF BENEFITS:

I request that payment of authorized Medicare benefits be made either to me or on my behalf for services furnished by Sacks Clinical Consulting. I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefits for related services.

Name (Print) _____ Medicare Number: _____

Signature: _____ Date: _____

ENTIRE AGREEMENT
This agreement contains the entire agreement between the parties and there are no agreements, representations, statements, or understanding which have been relied on by the parties which are not contained herein.

Your signature below shows that you have read and understood the above information.

Patient_____ Date: _____

I authorize treatment of my minor child:
Patient/Guardian Signature: _____ Date:_____