

Patient Name: _____ Male _____ Female _____
(First) (Middle) (Last)

Date of Birth: _____ Social Security # _____
Address: _____ City: _____ State: _____ ZIP: _____
Home phone: _____ Marital Status: _____ Name of spouse: _____
Patient Employer/School: _____ Work phone: _____
Who referred you here: _____ May we send them a thank you letter? Yes No

May we leave a message at your home with other residents? Yes No On your voice mail? Yes No

Who may we talk to about your medical concerns? _____

Is this contact for emergency purposes only? Yes No Relationship: _____

For MINORS:

Child lives with: Both parents Mother Father Other _____

Mother: _____ Address (if different): _____
Date of Birth: _____ Home Phone: _____ Work Phone: _____
Employer: _____ SSN# _____

Father: _____ Address (if different): _____
Date of Birth: _____ Home Phone: _____ Work Phone: _____
Employer: _____ SSN# _____

Name of parent responsible for the minor child's appointments: _____

INSURANCE INFORMATION

Primary Insurance Co.: _____ ID# on the card: _____ Group# _____
Policyholder: _____ D.O.B. _____ SS# _____
(First) (Middle) (Last)

Place of employment: _____
Patient's relationship to cardholder: Self Spouse Dependent Card Copied: Yes No

Secondary Insurance Co.: _____ ID# on the card: _____ Group# _____
Policyholder: _____ D.O.B. _____ SS# _____
(First) (Middle) (Last)

Place of employment: _____
Patient's relationship to cardholder: Self Spouse Dependent Card Copied: Yes No

Identification of other physicians/health care entities involved with my medical care whom I authorize ongoing release of information for continuity of care:

Primary Care Physician: _____ Phone: _____
Address: _____

Referring Doctor (if different): _____ Phone: _____
Address: _____

I understand that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information provided on the office policies and have completed the above answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Patient Signature (parent if patient is a minor) Date: _____

Center for Solutions in Brief Therapy, Inc.
OFFICE POLICIES FOR SERVICES RENDERED

Updated and to take effect January 1, 2002

In order to insure that you have been informed about our office policies, we would appreciate that you review the following information and sign.

A. GENERAL

- **Confidentiality** – The therapeutic relationship is based on confidentiality. Neither the therapist/supervisor, nor any employee at Center for Solutions in Brief Therapy, Inc. will divulge information about any patient without the patient's written consent with the following exceptions:
 - When required by the individual's insurance, the patient having signed a waiver when signing the insurance.
 - Information will be provided to the referring physician, when applicable.
 - When it is felt that the patient is in danger to himself or others.
- The professional patient – therapist relationship will remain so throughout therapy: dual relationships, i.e. friend/therapist, business partner/therapist are not permitted.

B. FEES

- **You will be charged the full amount of \$130.00 for any missed appointments**, unless this office is notified at least 24 hours prior to your set appointment time. This is necessary because there is usually someone waiting to be scheduled, someone who could have used the time slot that was reserved for you. Your insurance company will NOT allow us to bill them for any missed appointments. Therefore, when we do not have the benefit of a 24 hour notice, you will be billed directly for the **entire** amount of the missed appointment and you alone will be responsible for paying this fee.
- If your account were to become past due, the person listed as being financially responsible for the account may be sent to our collection agency. Any account that is over ninety days past due with no payment arrangements will be sent to collections.

C. PAYMENT

- We will bill your insurance company as a courtesy to you. If your insurance company fails to pay for your services, you will be held responsible. We will do our best to **estimate** the amount you owe at the time of the session. This amount, whether it be a deductible, copayment, or full pay is due at the time of service. If you are unsure of your insurance coverage and we are unable to verify your benefits, we will require full payment at the time of your visit until the exact amount of your co-payment is determined. We reserve the right to reschedule your appointment if you do not have your payment.
- If you have coverage with a Health Maintenance Organization (HMO), Paramount, etc., you will be responsible for your necessary co-pay at the time of service, if applicable, providing that you have followed the correct referral procedure in obtaining authorization for these services. If you have not followed the referral procedure, you will be responsible for all charges which are denied by your HMO.
- In the case of divorce, the parent or guardian who is bring the child in for services will be held responsible for payment, regardless of a divorce decree.

Your signature below will indicate your understanding of our policies and your agreement to pay for services rendered. If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

Signature of Patient (or Guardian, if patient is a minor)

Date

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare or the healthcare of my minor child, Center for Solutions in Brief Therapy, Inc. originates and maintains health records for describing my health history, symptoms, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routing healthcare operations such as assessing the quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a HIPAA Privacy Notice that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

- I request the following restrictions to the use or disclosure of my health information.

Signature of Patient or Legal Representative _____

Date: _____

Witness Signature _____ Title _____

Date _____

Informed Consent to Receive Mental Health Treatment

I, _____ hereby voluntarily consent to, and authorize, Center for Solutions in Brief Therapy, Inc. to render mental health treatment to myself and/or minor child. The treatment plan and/or form of treatment to occur will be discussed with me. I understand that I can, at any time, withdraw my consent in writing.

Patient Signature (or parent if patient is a minor)

Date

Witness

PSYCHOLOGICAL EVALUATIONS

Thank you for choosing Center for Solutions in Brief Therapy, Inc. for the purpose of psychological evaluation of possible learning disabilities, attention-deficit/hyperactivity disorder, developmental delays, personality/emotional issues, and in some cases, memory problems.

At the Center for Solutions in Brief Therapy, we attempt to be comprehensive and thorough in the assessment of the problem.

The psychological testing typically takes five hours and testing sessions generally last one hour at a time as insurance rarely pays for more than one hour. The testing covers the measurement of intelligence, achievement (reading, math, writing), attention, personality/emotional issues, and sometimes memory.

We will work closely with you regarding co-pays and insurance. After all of the testing is completed, there will be a final meeting with the psychologist, Dr. Marc Dielman. This meeting will discuss the testing results and recommendations. Dr. Dielman then generates a report for the parent, school, and physician. It takes him 2-3 hours to complete this report and a one time charge of \$130 (our hourly session fee) is required for the report to be completed and released. This fee is not paid for by insurance and will need to be paid by the final appointment. We also require that any outstanding balance must be paid in full before your report will be released.

If you have any questions, please feel free to discuss them with our receptionist, Laurie Moser, or any of the therapists doing the testing. Thanks you.

Name Date

****ATTENTION****

Effective June 1, 2009

Effective June 1, 2009, we will be implementing a statement fee of \$10 per month on any patient accounts with outstanding balances. All copays, deductibles, coinsurance, etc. are due at the time of service.

We are also extending the option for our patients to keep a credit card number on file with our office that is authorized for use if a balance should arise in order to avoid the additional monthly statement charge. This is optional and is not required. If you choose this option, your credit card will be billed automatically at the end of the month for any outstanding balance on your account. As such, you will not incur any statement fees on your account. You may request a summary of your statement at any time from our office.

However, if your insurance processes a claim and this results in a balance due, the statement fee will be added to your account if the balance is not paid by the first of the month or taken care of with a credit card on file. There are no exceptions and this also applies to any accounts with no show charges.

Please be advised that we do require 24 hours notice for canceling an appointment. We have voicemail available 24 hours a day, 7 days a week. You will be charged \$130 for any missed appointment or late cancellation. The statement fee will apply to accounts with no show balances as well.

In order to prevent a statement fee from being added to your account, you will need to either: 1) ensure that you have paid all amounts due at the time of service or 2) keep a credit card on file for any balances you incur.

Any accounts that are sent to collections for nonpayment will also incur a \$25 collection fee.

If you have any questions regarding this policy, please do not hesitate to contact our office. You may also contact our office at any time to place your credit card # on file.

PLEASE CHOOSE ONE OF THE FOLLOWING OPTIONS:

_____ **I will keep a credit card # on file for account balances and will not incur any statement fees. (A separate credit card authorization form will need to be filled out).**

_____ **I do not want to put a credit card on file. I will incur a \$10 monthly statement fee if my account incurs a balance that results in a statement being processed at the beginning of each month.**

I have read the policy above and understand that this is effective as of June 1, 2009. I may change the option elected above at any time by completing a new form.

Signature

Printed name

Date

CREDIT CARD AUTHORIZATION:

Charges will take place at the end of each month when there is a balance on your account. You may obtain a summary of your account at any time from our office. You may revoke this credit card authorization at any time by signing the bottom of this form.

Patient Name: _____

Name on card: _____

CC Number: _____

CC Type: Mastercard VISA

Expiration date: _____ 3 digit code: _____

Cardholder signature: _____

By signing, I authorize all balances on my account at the Center for Solutions in Brief Therapy, Inc. to be charged to this card at the end of each month.

DISCONTINUE CREDIT CARD BILLING:

Date: _____ Signature: _____

By discontinuing my credit card authorization, I understand that my account will incur a \$10/month statement fee if my account incurs a balance that results in a statement being processed at the end of the month.