NEW PATIENT INFORMATION

(Please Print) **Today's Date** ________________

Patient Name: ______________________ ______________________ _________ **Sex:** ☐ **Male** ☐ **Female** ☐ **Transgender**
Last First Middle Initial

Date of Birth: ____ ____ ______ Age: ______ **Social Security #:** _____ **-** ____ **-** _______
Month Day Year

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Home Address: ____________________________ Apt #________
____
City State Zip Code

Home Phone: (____) _____ - _______
Cell Phone: (____) _____ - _______
Work Phone: (____) _____ - _______

Email Address: _____________________________________ **Correspondence sent via Email:** ☐ opt in ☐ opt out

Where would you like for me to leave messages for you? ☐ Home ☐Work ☐Cell ☐Email ☐None

If we must cancel your appointment, how do you prefer that we reach you? ☐ Home ☐Work ☐Cell ☐Email ☐None

Occupation: (check all that apply) ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Full Time Student ☐ Part Time Student ☐ Retired
Name of Employer/School: ____
Address: ____
____
City State Zip Code

Family Information:
Person Responsible for Account: ☐ Patient ☐ Spouse ☐ Parent ☐ Other

Name: (If different from Patient) ______________________ ______________________ _________
Last First Middle Initial

Responsible Party's Date of Birth: ____ /____/______ Social Security #: _____ - ____ - _______
Month Day Year

Address: (If different from Patient) ____ Apt #________
____
City State Zip Code

Responsible Party's Employer ______________________________ Work Phone: (____) _____ - _______
____
City State Zip Code

Referral Information:
Referred by: ☐ Physician ☐ Employer ☐ Relative ☐Friend ☐ Website

Name & Address: ____

Primary Care Physician: Name ______________________________ Phone: (____) _____ - _______
Address ______________________________
____

Emergency Contacts: (whom may we contact in the event of an emergency)

Name ______________________________ Phone: (____) _____ - _______
Relationship to you (i.e., friend, employer, relative, spouse) ________________________

Name ______________________________ Phone: (____) _____ - _______
Relationship to you (i.e., friend, employer, relative, spouse) ________________________

Name ______________________________ Phone: (____) _____ - _______
Relationship to you (i.e., friend, employer, relative, spouse) ________________________

Is this the first time you are seeking counseling? ☐ Yes ☐ No
Why are you seeking counseling? ____

Approximately how long have you had the issue(s) _______________

In what ways have you attempted to deal with the issue(s) ________________________________

Which of the items below would you like to work on during our time together: (feel free to number them in order of importance)

FAMILY/RELATIONSHIP:

- ☐ family changes
- ☐ relationship problems
- ☐ discipline issues
- ☐ parenting problems
- ☐ sibling issues
- ☐ divorce/separation
- ☐ grief or illness
- ☐ abandonment
- ☐ religious/spiritual concerns
- ☐ domestic violence/fighting

ABUSE:

- ☐ current or past physical abuse
- ☐ current or past emotional abuse
- ☐ current or past sexual abuse
- ☐ current or past neglect

SCHOOL/ACADEMIC RELATED:

- ☐ attendance
- ☐ behavior
- ☐ learning difficulties
- ☐ problems with friends
- ☐ problems with teachers/those in authority
- ☐ bad grades
- ☐ bullying
- ☐ not fitting in

MOOD RELATED:

- ☐ nightmares
- ☐ suicidal thoughts
- ☐ sleep issues
- ☐ irritability
- ☐ sadness/depression
- ☐ feelings of guilt/shame
- ☐ stress
- ☐ excessive worry or fear
- ☐ anxiety

INSURANCE:

☐ Please check if electing NOT to use insurance coverage for our provided services. ***Note: Payment is expected in full at the beginning of each session – We accept checks, cash, and most major credit cards.***

☐ Please check if using insurance and complete the information below:
Note: If a referral is needed, it is the patient's responsibility to obtain the number and provide it to Atlantic Coastal Therapy.

Primary Insurance:

Name of Insurance Company: ____

ID Policy #: _______________________Group#_____________

Address to Send Mental Health Claims: __________________________________
____
____

Policy Holder/Insured: _________________________ SSN: ________-________-__________ DOB: _______________

Policy Holder's Employer: ____

Address: ____
____

Phone: (____) _____ - _______

Patient's relationship to insured: ☐Self ☐Spouse ☐Parent ☐Child

Secondary Insurance:

Name of Insurance Company: ____

ID Policy #: _______________________Group#_____________

Address to Send Mental Health Claims: __________________________________
____
____

Policy Holder/Insured: _________________________ SSN: ________-________-__________ DOB: _______________

Policy Holder's Employer: ____

Address: ____
____

Phone: (____) _____ - _______

Patient's relationship to insured: ☐Self ☐Spouse ☐Parent ☐Child

Authorization/Assignment of Benefits:

Please sign below to authorize Atlantic Coastal Therapy to release your records to your insurance company for medical information necessary to process insurance claims and for payments to be made directly to us. This authorization will remain in effect until revoked by you in writing. A photocopy of this authorization is to be considered as valid as the original copy. I understand that partial payments made by insurance carriers are not accepted as full payment for the services rendered and I will be responsible for any charges not covered by insurance. I agree to the stated fees and I understand that I am financially responsible for all charges, including interest accrued on unpaid balances.

Patient's Signature____ DATE _____________

Patient's Printed Name ____

Our No-Show/Cancellation Policy:

Your appointment time has been reserved for you on our schedule. If you must cancel or reschedule, Atlantic Coastal Therapy requires a notice of at least 24 hours or you may be charged for the missed session.

Please inform us if at any time you wish to discontinue receiving our services.

Please initial to mark your understanding of this policy. _______________ (patient's initials)

Credit Card Authorization:

By providing the information below, I consent to having Atlantic Coastal Therapy process charges/fees against my credit or debit card (this includes any missed appointments due to not providing sufficient advanced notice of 24 hours). My signature also signifies that I am the card holder authorized to make transactions using this card.

Type of Card (Visa/MasterCard/Am Express/Discover) _____________________________

Name as it Appears on Card ____

Relationship to Patient ____

Card Number ____

Expiration Date __________________________ Security Code on Back of Card _________________

Billing Address for the Card ____

____

Card Holder's Signature ____ Date ___________________________

HIPAA-Patient Acknowledgement Form

Our notice of Privacy Practices (NPP) provides information about how Atlantic Coastal Therapy may use and disclose protected health information (PHI) about you. The practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). The NPP contains a Patient Rights section describing your rights under the law. Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. In the event that terms of the Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our Practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

I give permission for Atlantic Coastal Therapy to:

Leave a message regarding an appointment

- ▢ At (Home phone number) and/or
- ▢ At (Cell phone number) and/or
- ▢ At (Work phone number)

Share medical information with:

1. Name ___________________________________Relationship_______________
   Phone ____________________________

2. Name ___________________________________Relationship_______________
   Phone ____________________________

I assume responsibility to inform the practice of any changes in the above information.

Print Patients Name: ____

Patient's Date of Birth: ______/_____/_____ Relationship to Patient:__________________

Signature: ____Date: _____________

Informed Consent for Therapy Services – Adult

COUNSELOR-CLIENT SERVICE AGREEMENT

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES
Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

APPOINTMENTS

Appointments will ordinarily be 45-50 minutes in duration, once per week at a time we agree on, although some sessions may be more or less frequent as needed. The time scheduled for your appointment is assigned to you and you alone. If you need to cancel or reschedule a session, I ask that you provide me with at least 24 hours of notice. If you miss a session without canceling, I reserve the right to charge you for the full session unless we both agree that you were unable to attend due to circumstances beyond your control. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. If it is possible, I will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time. If you are late, your appointment will still need to end on time and the full fee will apply.

PROFESSIONAL FEES

The standard fee for the initial intake is $150.00 and each subsequent session is $100.00. You are responsible for paying at the time of your session unless prior arrangements have been made. Payment must be made by check or cash; I am not able to process credit card charges as payment. Any checks returned to my office are subject to an additional fee of up to $25.00 to cover the bank fee that I incur. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

In addition to weekly appointments, it is my practice to charge this amount on a prorated basis (I will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of me. If you anticipate becoming involved in a court case, I recommend that we discuss this fully before you waive your right to confidentiality. If your case requires my participation, you will be expected to pay for the professional time required even if another party compels me to testify.

INSURANCE

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. With your permission, my billing service and I will assist you to the extent possible in filing claims and ascertaining information about your coverage, but you are responsible for knowing your coverage and for letting me know if/when your coverage changes.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. Managed Health Care plans such as HMOs and PPOs often require advance authorization, without which they may refuse to provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients

feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. (Diagnoses are technical terms that describe the nature of your problems and whether they are short-term or long-term problems. All diagnoses come from a book entitled the DSM-IV. There is a copy in my office and I will be glad to let you see it to learn more about your diagnosis, if applicable.). Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier if you plan to pay with insurance.

In addition, if you plan to use your insurance, authorization from the insurance company may be required before they will cover therapy fees. If you did not obtain authorization and it is required, you may be responsible for full payment of the fee. Many policies leave a percentage of the fee (called co-insurance) or a flat dollar amount (referred to as a co-payment) to be covered by the patient. Either amount is to be paid at the time of the visit by check or cash. In addition, some insurance companies also have a deductible, which is an out-of-pocket amount, that must be paid by the patient before the insurance companies are willing to begin paying any amount for services. This will typically mean that you will be responsible to pay for initial sessions with me until your deductible has been met; the deductible amount may also need to be met at the start of each calendar year. Once we have all of the information about your insurance coverage, we will discuss what we can reasonably expect to accomplish with the benefits that are available and what will happen if coverage ends before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above, unless prohibited by my provider contract.

If I am not a participating provider for your insurance plan, I will supply you with a receipt of payment for services, which you can submit to your insurance company for reimbursement. Please note that not all insurance companies reimburse for out-of-network providers. If you prefer to use a participating provider, I will refer you to a colleague.

PROFESSIONAL RECORDS

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in the office. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve

danger to yourself, you have the right to a copy of your file. Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional, which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is my policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised. [See <u>Adolescent Consent Form, to be signed by both adolescent and parent(s)</u>.]

CONTACTING ME

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on my confidential voice mail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe:

1) go to the nearest Local Hospital Emergency Room, or

2) call 911 and ask to speak to the mental health worker on call.

I will make every attempt to inform you in advance of planned absences, and provide you with the name and phone number of the mental health professional covering my practice.

OTHER RIGHTS

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another therapist and are free to end therapy at any time.

You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

CONSENT TO PSYCHOTHERAPY
Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

____
Signature of Patient or Personal Representative

____
Printed Name of Patient or Personal Representative

Date ____

Description of Personal Representative's Authority:_______________________________

____