Supportive Psychological Services, PLLC

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New Client Registration

Client Name: _____
Last First MI

Client's Date of Birth (MM/DD/YY): ____/____/____ Gender: M F

Client's Address: _____

City, State, Zip Code: _____

Phone: _____ _____ _____
Home Work Cell

Email Address(s): _____

Insurance Name and ID Number: _____ Group Number: _____

Emergency Contact: _____ Phone Number: _____

Client Status (circle all that apply): Single Married Divorced Widowed Other Employed Student Retired

Is your condition related to (circle if applicable): Employment? Y/N Auto Accident? Y/N Other Accident? Y/N

If you are not the primary card holder:

Primary Cardholder's Name: _____
Last First MI

Primary Card Holder's Date of Birth: ____/____/____ Phone #: _____ Gender: M F
MM DD YYYY

Primary Card Holder's Social Security Number: _____

Primary Card Holder's Address: _____

City, State, Zip Code: _____

Referred By: _____

I authorize the release of information necessary to process my claim for services and pay my benefits. A photocopy of this authorization is considered valid as an original. I understand that I am responsible for fees for service.

_____ _____
Signature of Responsible Party Date

CONSENT FOR TREATMENT

CONTRACT FOR PROFESSIONAL SERVICES

Welcome! I look forward to working with you. I am a psychologist licensed in the state of Arizona. My work is based in the ethical codes of the American Psychological Association that serve as guidelines for psychotherapy, assessment and educational services that I conduct. This document contains information about my professional services and business policies. Please read it and note any questions you have so we can discuss them. Once you sign this document it will constitute a binding agreement between us.

CONTACTING ME

I am often not immediately available by telephone. Please leave non-urgent messages on my voicemail (602-717-2589) and I will make every effort to return your call promptly. Please leave your call-back number and message. If you are unable to reach me and are experiencing an urgent or life-threatening situation, dial 911, the 24-hour EMPACT Crisis Line at (480) 784-1500, contact your physician, or go to the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, one of my colleagues who is covering for me will reply to your message.

PSYCHOTHERAPY SERVICES; RIGHTS AND RESPONSIBILITIES

The purpose of psychotherapy is to help with adjustment issues or specific life problems that have caused the client to seek assistance on client's behalf. It requires a very active effort on both our parts. Psychotherapy may elicit uncomfortable, unsettling, or painful thoughts and feelings. However, often psychotherapy leads to significant reduction of distress, increased satisfaction with life, and the resolution of specific problems. There are many ways to approach complex problems and there is no guarantee about what will happen in our work together. My agreement with you is that I will act in a professional manner, be attentive to your issues and respectful of your time and financial resources. I will make efforts to inform you promptly and reasonably in advance of any necessary change in scheduling, anticipated absences, or the need for treatment to end. You have the right to stop our therapeutic relationship at any time, and again, I would be happy to assist with referrals. I also reserve the right to terminate treatment immediately should there be any threat to myself, my family or acquaintances, or to my property. To date I have not needed to follow through on this.

MEETINGS

Our initial one to two sessions are a period of evaluation and may last longer than one hour to identify what brings you in for therapy and what you hope we can accomplish together. I will ask about your history and current circumstances to develop an initial diagnosis and treatment plan. During this time we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. Regular sessions are typically 45-55 minutes.

PROFESSIONAL FEES

My therapy fee is $200.00/session which includes a 55 minute therapy session plus note writing. Fees for work under 1 hour will be divided by quarter hour. You will be expected to pay for each session or session co-pay at the time it is held, unless we agree otherwise or you have insurance coverage I will be billing. Fees for other professional services will be agreed to when they are requested. There will be a $50.00 charge for missed appointments that are canceled with less than 24 hours notice unless we both agree that you were unable to attend due to circumstances beyond your control. Insurance coverage will not pay for canceled or missed appointments, so those charges will also become client's responsibility. In the case of unusual financial hardship, I may be willing to use a sliding fee scale to negotiate a fee adjustment or payment installment plan. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information such as your name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

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. Before our initial visit you are expected to provide your insurance information so I can contact your insurance company about your mental health benefits, including deductibles, co-pays, and treatment authorization. I

will complete and bill your insurance for all of our appointments. I use an online electronic billing registry which conforms with HIPAA requirements. You are expected to pay any deductible or co-pays at the time of the appointment.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your insurance company. Your insurance company's number is on the back of your insurance card. Of course I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf. All insurance companies require you to authorize me to provide them with a clinical diagnosis. 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.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. You are entitled to receive a copy of your records or I can prepare a summary for you instead. If you wish to see your records, I recommend you review them in my presence so that we can discuss the content. Fees will be charged for professional time spent in responding to information requests.

CONFIDENTIALITY

I will follow the standards of my profession in preserving your confidentiality. While these standards strictly limit the communication of psychologists, you should know that there are a number of exceptions. Please be aware that in issues related to concern over potential harm to self or others, the abuse of children or the elderly or disabled, and in response to court orders, there are some limits and overrides to the general status of confidentiality. For example, it may be necessary to contact family members or others who can help provide protection in the event that there is a grave threat of harm. As part of my professional growth, for purposes of peer review, and in problematic situations, it is my practice to periodically consult professional colleagues regarding my therapeutic approach. Your signature below constitutes understanding of this practice and a release for me to discuss case issues with my professional colleagues on an as-needed basis. The professionals with whom I may consult are also bound to keep the information confidential.

Increasingly, insurance companies have been requiring more extensive clinical information before approving payment for services. They may require advanced authorization and ongoing detailed reports of specific progress on therapeutic goals. All insurance companies claim to keep this information confidential, but once it leaves my office, I have no control over what happens to it. Utilization of insurance benefits typically constitutes permission to release any information, which they request to make payment determinations. In all situations, I will strive to use my best clinical judgment regarding issues of your confidentiality. Additional detail regarding HIPAA Rights and Responsibility are provided at the end of this document.

PRACTICE CLOSING

In the event I close my practice, or upon my death, you may contact the Arizona Psychological Association or the Arizona Board of Psychologist Examiners to get information on how to access your records.

CONSENT FOR TREATMENT

Your signature below indicates that you have read this entire agreement and agree to its terms and also serves as an acknowledgement that you have received the HIPAA notice form (below). Clients under 18 require a parent or guardian's signature. Your signature implies your informed consent to treatment, and acceptance of my stated business practices and policies. You may revoke this Agreement in writing at any time. *Please continue to feel free to talk with me throughout our work together about any clinical or business policy issues as they may arise. I truly appreciate the opportunity to be of professional service to you and look forward to our work together.*

Client Signature: _____ Date: _____