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PATIENT INFORMATION

Welcome to my practice. This document contains important information about my professional services and business policies. Please read this document completely, once this agreement is signed, it will represent an agreement between us.

Name: _____Date:_____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Email Address: _____

Address:_____
Street Address City Zip Code

Social Security No.:_____ Date of Birth_____

Responsible Party:_____ Drivers License No._____
Relationship to Patient

Name of
Employer:_____

Address of
Employer:_____
Street Address City Zip Code

Telephone Number of Employer: _____ Occupation: _____

Nearest
Relative:_____
Name Telephone Number

_____
Street Address City State Zip Code

INSURANCE INFORMATION: (Please submit insurance card for photocopying)

Insurance Company:_____
Name Telephone Number

_____
Street Address City State Zip Code

_____
Name of Insured Social Security Number Group Number

Referral Source: _____

Describe your reason for seeking treatment and when did your symptoms begin?
_____
_____
_____

List any medical problems or physical limitations you may have:
_____
_____
_____

List any current medications you may be on, including your physician's name and how long you have been on them:
_____
_____

List any allergies:
_____

List any serious illnesses or accidents; please give the dates they occurred:
_____

Have you ever had any previous psychotherapy or psychological testing (including in-patient hospitalizations)? If so, please state the reason, name and telephone number of your previous therapist and how long you attended.
_____
_____

Is there any family history of mental illness? If so, please give a detailed history of every member:

_____

_____

Check any and all of the following symptoms that apply to you?

_____Depressed Mood

_____Low Self Esteem

_____Tension

_____Anxiety

_____Concentration

_____Sleep Problems

_____Nightmares

_____Headaches

_____Loss of Energy

_____Loss of Sex Drive

_____Appetite Problems

_____Irritation

_____Suicidal Thoughts

_____Suicide Attempts

_____Medical Problems

_____Anger Problems

_____Family Problems

_____Marital Problems

_____Work Problems

_____Financial Stress

_____Legal Problems

_____Eating Disorders

_____Alcohol Problems

_____Drug Problems

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION FOR BILLING PURPOSES

I hereby authorize my insurance and/or third party payer benefits to be paid directly to the doctor, _____ (signature of insured). I hereby authorize the attending doctor to release any information related to processing my insurance claim and/or third party payer claim for treatment rendered to me or my minor child _____ (signature of insured).

PAYMENT OF SERVICES

Due to the complex nature of the healthcare insurance industry, it has become increasingly more difficult to understand what your benefits may be. It is your responsibility to understand your benefits and handle a problem if it arises. Managed health care, such as HMOs or PPOs often require preauthorization before entering psychotherapy.

My hourly rate is $150.00/$200.00 per hour. The length of our session is 45 minutes. It is hereby understood and agreed upon that you will be financially responsible for all fees associated with services rendered to yourself or your dependent. Any telephone conversations outside of treatment, over 5 minutes (either with yourself or another professional), letter writing or filling out forms, etc. will be billed at the rate of $200.00 per hour or part thereof to you.

It is further understood and agreed upon that in the event that my account balance becomes 30 days delinquent, a late fee of 10% per month will be charged on your account until the account is paid in full. If the portion you owe becomes delinquent more than 60 days, it is understood and agreed upon, your account will be turned over to collections or litigation and if there has been any adjustments or credits made to the account they will be reversed.

It is further understood and agreed upon that any late or missed appointment will be charged in full $200.00 unless a 24 hour cancellation notice is given. Insurance companies do not pay for no show appointments and will not be billed for your missed session. If you miss a session you are obligated to pay the full amount of $200.00 at the next session. Additionally, there will be a $15.00 charge on all returned checks.

CONFIDENTIALITY

Your records will be held in strict confidence except where disclosure is required by law and/or as noted in this section. You may give your written permission to release all or part of your confidential file to a specified agency or person(s) at any time and at your discretion. Dr. Handley, upon using good personal judgment, may discuss aspects of your case with other mental health professional that would be providing coverage for her.

Examples of situations in which confidentiality and the patient/psychotherapist privilege is waived include but are not limited to:

1. Where there is reasonable suspicion of child or elder abuse (physical, sexual, emotional or neglect).
2. Where a threat of violence is made by the patient against a third party who triggers a duty to warn.
3. Where the patient has been a victim of a crime, as specified in Penal Code Section 111.60 (i.e., injuries by deadly violence, assaultive or abusive conduct).
4. Where the patient has waived or tendered his/her emotional condition pursuant to any legal proceeding.
5. Where the services of the psychotherapist are sought or obtained to enable or aid anyone to commit or plan to commit a crime or tort.

INFORMED CONSENT

By signing this document you are or you are giving consent for your minor child; willingly participating in psychological treatment and are giving my Informed Consent for psychological treatment, which includes, but is not limited to, psychotherapy and psychological testing.

Please feel free to discuss any of the conditions above with me today. By signing below, you are indicating you understand, consent and agree to all of the terms and conditions above.

Signature: _____ Date:_____

Please print your full
name:_____

Parent or Guardian's
Signature_____