

Siegel Counseling Services

Welcome to this office. I am pleased to be able to offer you and your family mental health services. As a Licensed Mental Health Counselor, my responsibility lies in offering you the needed diagnostic and therapeutic services for the emotional and behavioral difficulties you and/or your family are currently experiencing. Enclosed you will find some forms that will aid me in assisting you more effectively. I am happy to discuss with you my services, charges, insurance billing, appointments, as well as any other questions you may have.

If you cannot attend a scheduled appointment, kindly notify me as soon as possible. Please be aware that you will be charged the full agreed upon fee for any appointment that is not cancelled twenty-four (24) hours in advance. You will be solely responsible for this charge as I cannot bill an insurance company for a service not provided.

Confidentiality is of primary importance in mental health practice. Consequently, I adhere to very strict standards regarding the release of records and/or information related to you or your family for your own protection. All communication between us is confidential and privileged, with the following three exceptions:

1. In staff supervision and with consultants, as needed, in order to challenge and/or confirm decisions about diagnosis, treatment, and medication.
2. Should you choose to use insurance to cover the cost of therapy, detailed treatment reports are frequently required by the managed care companies on a regular basis in order to access benefits and determine medical necessity.
3. By statutory law, "DUTY TO WARN", outweighs the limits of confidentiality and privilege in case of reported act, which may endanger yourself or others.

Finally, good communication is essential for successful treatment. Please feel free to share with me any of your concerns.

Informed Consent and Authorization for Treatment

I hereby consent to psychotherapeutic evaluation and treatment. I have read and agreed with the terms stated herein.

Patient's Signature

Therapist's Signature

Parent/Guardian's Signature

Date

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INTAKE INFORMATION

PATIENT INFORMATION

NAME: _____, _____ DATE: _____

ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ PAGER/BEEPER: _____

EMAIL: _____ SS #: _____

SEX: M ___ F ___ AGE: _____ DATE OF BIRTH: _____

MARITAL STATUS: MARRIED ___ SINGLE ___ DIVORCED ___

SEPARATED ___ WIDOWED ___

LIVING WITH SIGNIFICANT OTHER ___

REFERRED BY: _____

REASON FOR REFERRAL: _____

EMPLOYER/SCHOOL: _____ OCCUPATION: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMERGENCY CONTACT INFORMATION:

NAME: _____ RELATION TO YOU: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

PRESENT HOUSEHOLD

NAME	AGE	RELATIONSHIP	OCCUPATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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OTHER SIGNIFICANT FAMILY MEMBERS NOT LIVING AT HOME

NAME	AGE	RELATIONSHIP	OCCUPATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PRIMARY CARE PHYSICIAN:

NAME: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE: _____ FAX: _____

MEDICAL HISTORY:

ILLNESS/MEDICAL CONDITIONS: _____

PRESCRIPTION/OTC DRUGS: _____

ALLERGIES AND MEDICATION: _____

TOBACCO, ALCOHOL, DRUG USE HISTORY: _____

PREVIOUS PSYCHOTHERAPY/PSYCHIATRIC TREATMENT? YES: ___ NO: ___

WITH WHOM: _____
HOW LONG: _____
WITH WHOM: _____
HOW LONG: _____

INSURANCE/ BILLING INFORMATION (IF APPLICABLE):

INS CO: _____ AUTH/REFERRAL# _____

INSURED/RESP.PARTY: _____ D.O.B. _____

ADDRESS (IF DIFFERENT): _____

CITY: _____ STATE: _____ ZIP: _____

SS# _____ HOME PHONE: _____

EMPLOYER: _____ WORK PH: _____

PLEASE HAVE AVAILABLE YOUR INSURANCE CARD IN ORDER FOR US TO PHOTOCOPY

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FINANCIAL AGREEMENT

I, _____ agree that the responsibility for the hourly charge of \$_____ and/or a co-payment of \$_____ at Siegel Counseling Services is mine. I agree to assign to Siegel Counseling Services any insurance benefits available to me. However, should said insurance not provide for the expected coverage, I am fully responsible for the full agreed upon fee.

I understand and have discussed the above conditions. I am willing to accept treatment under these conditions.

Date

Patient

Parent or Guardian

In an effort to avoid difficulties with your account, please provide credit card information on the space below.

This information will only be used in processing payments due to one or more of the following: co-payment/hourly balance, returned bank checks, other declined credit cards, missed or late cancelled appointments (\$ _____ each), denial of expected coverage by insurance companies, and phone/Skype sessions.

Please rest assured that I will make every effort to discuss your account before using this avenue to bring you balance up to date. Thanks you for your cooperation.

CREDIT CARD MASTERCARD VISA AMEX DISCOVER

CARD NUMBER _____

EXP. DATE: _____ / _____ CVV: _____

I agree to let Siegel Counseling Services charge my credit card above after each session for the amount of \$ _____ per session until this authorization expires on _____.

SIGNATURE: _____

PRINT NAME: _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our signatures below acknowledge that we have reviewed and discussed the “Notice of Privacy Practices” and acknowledge that the client and/or the client’s legal guardian has/have received a copy of the document.

I have read this document and have been given the opportunity to ask any questions and receive any clarification.

(NAME OF CLIENT)

DATE

(SIGNATURE OF CLIENT OR LEGAL GUARDIAN)

(NAME OF THERAPIST)

DATE

(SIGNATURE OF THERAPIST)

____ **Copy accepted by Client**

____ **Copy kept by Therapist**

This is a strictly confidential client medical record

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INSURANCE CONSENT

Your insurance benefits may be limited by the number of visits granted per calendar year or by the total dollar amount available. Furthermore your insurance company may impose limits on the number of visits you receive based on their definition of medical necessity.

When I accept assignment of insurance benefits for payment of your bill I am in effect acting as the insurance company's agent or provider. It's also important for you to understand that when you sign an authorization to release information on your insurance form, I may be asked to discuss, in a verbal or written report, information related to your case with a case manager. A case manager is a clinical representative of the insurance company and will not reveal information to your employer. This contact may be necessary to facilitate continuing payment for your psychotherapy.

I understand and have discussed the above conditions. I am ready to accept treatment under these conditions.

Patient

Date

Parent or Guardian

SIGNATURE ON FILE AND ASSIGNMENT OF BENEFITS AGREEMENT

I understand that Siegel Counseling Services will use my signature below as a *signature on file*. I authorize the release of any medical information necessary to process my or my family member's claim or related claims.

I hereby authorize payment directly to Siegel Counseling Services of the insurance benefits otherwise payable to me for their professional services. I understand that I am financially responsible to Siegel Counseling Services for all charges not covered by this assignment

SIGNED:

Patient

SIGNED:

Insured