New Patient Information

Confidential

Date:_____

Patient Name:_____ SSN:_____-_____-_____
Last First M.I.

Address:_____

City:_____ State:_____ Zip:_____

Home Phone:(____)_____-_____ Work Phone:(____)_____-_____ Ext:_____

Cell Phone: (____)_____-_____ E-mail: _____

Is it OK to call and leave a message at these numbers: ☐ yes ☐ no

Please indicate your preference regarding appointment reminders: ☐ Call home ☐ Call cell

☐ Text message ☐ E-mail ☐ Do not call

Gender: [ ] Male [ ] Female Date of Birth:_____-_____-_____ Age:_____

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ] NA (child)

Employment Status:[ ] Employed [ ] Student [ ] Disabled [ ] Employed/student [ ] Unemployed

Employer (or) School:_____

Insurance Company:_____

Referral Source:_____
Permission to thank referral source? (circle one): Yes or No

Referral Type: [ ] internet [ ] family [ ] spouse [ ] friend [ ] physician [ ] EAP [ ] work
[ ] court [ ] school [ ] attorney [ ] other _____

Primary Care Physician: _____ Phone:_____
Permission to communicate with PCP about your treatment? (circle one): Yes or No

In Case of Emergency, Contact:

Name:_____ Relationship:_____

Phone:_____

For children & adolescents:
Parents marital status: ☐never married ☐married ☐separated ☐divorced ☐widowed

[ ] Mother (or Guardian) [ ] Father

Name: _____ _____

Address: _____ _____

_____ _____

(H) Phone: _____ _____

(W) Phone: _____ _____

Custody Arrangement (for divorced/separated parents):
☐informal (no court order) ☐ joint legal custody ☐ sole legal custody (mother)
☐ sole legal custody (father) ☐ other:_____
Primary residence of child is with: _____

Consent to Treatment & Evaluation

Obligations of Treating Provider

We will treat with great care all the information you share with us. It is your legal right that our sessions and our records about you are kept private. That is why we ask you to sign a "release-of-records" form before we can talk about you or send my records about you to anyone else. In general, we will tell no one what you tell us in confidence. We will not even reveal that you are receiving treatment from us without your prior written permission to do so.

In the majority of situations, your confidentiality (privacy) is protected by state law and by the rules of our profession; however, there are a few **exceptions in which confidentiality is *not* protected**:

1. If you make a serious threat to harm yourself (i.e., suicidal threat) or another person (i.e., homicidal threat), the law requires that we try to protect you or that other person. This typically means telling others about the threat to ensure your safety or the safety of a potential victim. The law does not require us to disclose you having and discussing thoughts of suicide or homicide, however, we will have to break your confidence if we feel that you intend to carry out a suicide or homicidal plan.

2. If I have reasons to suspect, on the basis of my professional judgment, that a child is or has been abused, I am required to report my suspicions to the authority or government agency vested to conduct child abuse investigations.

    a. I am required to make such reports even if I do not see the child in my professional capacity.
    b. I am mandated to report suspected child abuse if anyone aged 14 or older tells me that he or she committed child abuse, even if the victim is no longer in danger.
    c. I am also mandated to report suspected child abuse if anyone tells me that he or she knows of any child who is currently being abused.

3. If you were sent to us by a court or an employer for evaluation or treatment, the court or employer expects a report from us. If this is your situation, please talk with us before you disclose anything you do not want the court or your employer to know. You have a right to disclose only what you are comfortable with sharing.

4. Are you suing someone or being sued? Are you being charged with a crime? If so, and you tell the court that you are being seen here, we may then be ordered to show the court our records. Please consult your lawyer about these issues.

Consent to Treatment

I do hereby seek and consent to take part in the treatment or evaluation of myself or my child. I understand that developing an initial treatment plan or goals for the evaluation and regularly reviewing our work toward meeting the treatment goals are in my best interest; and I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of my treatment or evaluation; or of any procedures provided by Psychology Associates of Chester County contracted employees of the practice.

Your Rights

I am aware that I may stop my treatment or my child's treatment at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.) I also have the right to ask questions about my/my child's therapist's clinical background and qualifications or questions about any procedures or methods used in treatment, as well as, information about alternative methods of treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____
Signature Date

_____ _____
Printed name Parent or Guardian (If necessary)

PAYMENT AGREEMENT

Our Fees

- Diagnostic Assessment & Evaluation: $165 (60 minutes; $41.25 each additional 15 minutes)
- Individual Therapy (30 Minutes = $85) (45 Minutes = $130): (60 Minutes = $165)
- Couples or Family Therapy (30 Minutes = $85) (45 Minutes = $130): (60 Minutes = $165)
- Crisis Psychotherapy – complex or life threatening circumstances that require immediate attention ($175 first 60 minutes, $80 each additional 30 minutes)
- Group Session (60 Minutes): $60
- Psychological Testing/ Assessment: $160 per Hour
- Court related work including preparation of letters and evaluations, testimony, travel time, time away from office due to legal proceedings and review of records for legal purposes: $175 per hour
- Educational Consultation : $160 per hour (30 minute minimum)
- Telephone consultation, non-routine paperwork, review of medical & school records >5 minutes: prorated at $165/hr.

Please note that billable time is calculated to the nearest 15 minute interval. For example, a session lasting 40 minutes will be billed as a 45 minute session and a session lasting 53 minutes will be billed as a 60 minute session.

Insurance Payment

If you are using your insurance to pay for services, it is your responsibility to be aware of your policy benefits and limitations. Please provide your insurance card at your initial appointment. **Payments are due at the beginning of each appointment.**

INSURANCE COMPANY: _____

Amount due each session: _____ Deductible: _____

It is your responsibility to be aware of your policy benefits, financial obligations, insurance limitations as well as to verify that we are in network with your insurance plan. Please note that if you have a deductible you will be responsible for paying 100% of your insurance company's allowable rate for the service until your deductible is met. Services provided in good faith will be billed directly to you if later determined that your policy has expired, lapsed or does not cover the service(s) provided. Please note that some insurance companies require pre-certification of services and may require personal information related to your diagnosis and treatment plan. Please refer to the "Notice of Privacy Practices" or "HIPPA Notice" for more specific information which is available online at: www.chestercountypsychology.com on the "Resources" page. You are entitled to receive a paper copy upon request.

If we do not accept your insurance, or if you request a service not covered by your insurance (e.g., review of records, telephone consultation, court related work, etc.) you will be responsible to pay our full fees as listed above. Upon request, you will be provided with a statement for any services rendered, which you may submit to your plan for reimbursement if your policy has "out of network" benefits.

Payment:

Payment is due at the beginning of each session unless other arrangements have been made. Payment options include cash, check, Visa, MasterCard, Discover and American Express. For your convenience, you may complete a credit card authorization form that authorizes us to make regular payments on your account as you specify. Please note that you will be responsible for any bank fees for returned checks.

If paying by check, please make checks payable to:

"Psychology Associates of Chester County" or "PACC."

Missed Appointments:

You agree to accept financial responsibility for any missed appointments not cancelled within 24-hours of your scheduled appointment time. **The missed appointment or late cancellation fee is $ 50 and is not billable to your insurance company.**

Late Payment Fee:

A $10 late fee will be added to your account if payment is not received within 30 days upon receipt of a bill for your account.

Financial Hardship:

You agree to contact us to establish a payment plan if you are experiencing financial problems that make it difficult to pay your bill.

Non-payment:

Account statements shall be deemed to be accepted by you unless we are notified in writing within 14 days of the statement being issued that you dispute the charges. You also acknowledge that your account may be referred to IC System, a national collection agency if your account becomes 60 days past due. You will be notified of our intent to do so in advance and will be offered the opportunity to settle your account to avoid being sent to collections. By virtue of this agreement you are providing your consent to release your account balance and necessary contact information (name, address, date of birth, social security number) to IC System in an effort to collect your debt. Please be aware that if your account continues to be unpaid, IC System is authorized to report all outstanding debts to the four major national credit agencies.

Additional Cost of Collection Services:

In the event that your account is sent to collections, you will be charged legal and debt collection fees incurred by Psychology Associates of Chester County, PC. in relation to the recovery of outstanding debt, which is 35% of the balance due on your account.

Authorization for Insurance Billing/Assignment of Benefits

I authorize the release of information necessary to process insurance claims, and assign my benefits directly to Psychology Associates of Chester County, PC

Acknowledgement & Agreement

I have carefully read, understand and agree with all the terms of this agreement and agree to abide by its guidelines. I have had an opportunity to ask questions and I acknowledge that I may receive a copy of this agreement upon request.

_____ _____

Signature of Patient/ Responsible Party Date

THE FOLLOWING TWO PAGES DO NOT NEED TO BE COMPLETED FOR CHILDREN 13 AND YOUNGER

BRIEF PATIENT HEALTH QUESTIONNAIRE (Brief PHQ)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip a question.

Name_____ **Age**_____ **Sex:** ☐ **Female** ☐ **Male** **Today's Date**_____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

		Not at all	Several days	More than half the days	Nearly every day
a.	Little interest or pleasure in doing things	☐	☐	☐	☐
b.	Feeling down, depressed, or hopeless	☐	☐	☐	☐
c.	Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d.	Feeling tired or having little energy	☐	☐	☐	☐
e.	Poor appetite or overeating	☐	☐	☐	☐
f.	Feeling bad about yourself, or that you are a failure, or have let yourself or your family down	☐	☐	☐	☐
g.	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h.	Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
i.	Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

2. Questions about anxiety.

		NO	YES
a.	In the last 4 weeks, have you had an anxiety attack—suddenly feeling fear or panic?	☐	☐
	If you checked "NO," go to question 3.		
b.	Has this ever happened before?	☐	☐
c.	Do some of these attacks come suddenly out of the blue—that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
d.	Do these attacks bother you a lot or are you worried about having another attack?	☐	☐
e.	During your last bad anxiety attack, did you have symptoms like shortness of breath, sweating, your heart racing or pounding, dizziness or faintness, tingling or numbness, or nausea or upset stomach?	☐	☐

3. If you checked off any problems on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ **Not difficult at all** ☐ **Somewhat difficult** ☐ **Very difficult** ☐ **Extremely difficult**

Continued on page 2 ➡

4. In the last 4 weeks, how much have you been bothered by any of the following problems?

		Not bothered	Bothered a little	Bothered a lot
a.	Worrying about your health	☐	☐	☐
b.	Your weight or how you look	☐	☐	☐
c.	Little or no sexual desire or pleasure during sex	☐	☐	☐
d.	Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend	☐	☐	☐
e.	The stress of taking care of children, parents, or other family members	☐	☐	☐
f.	Stress at work outside of the home or at school	☐	☐	☐
g.	Financial problems or worries	☐	☐	☐
h.	Having no one to turn to when you have a problem	☐	☐	☐
i.	Something bad that happened recently	☐	☐	☐
j.	Thinking or dreaming about something terrible that happened to you in the past—like your house being destroyed, a severe accident, being hit or assaulted, or being forced to commit a sexual act	☐	☐	☐

5. In the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone, or has anyone forced you to have an unwanted sexual act? ☐ NO ☐ YES

6. What is the most stressful thing in your life right now?_____

7. Are you taking any medication for anxiety, depression, or stress? ☐ NO ☐ YES

8. FOR WOMEN ONLY: Questions about menstruation, pregnancy, and childbirth.

a. Which best describes your menstrual periods?

☐ **Periods are unchanged** ☐ **No periods because pregnant or recently gave birth** ☐ **Periods have become irregular or changed in frequency, duration, or amount** ☐ **No periods for at least a year** ☐ **Having periods because taking hormone replacement (estrogen) therapy or oral contraceptives**

		NO (or does not apply)	YES
b.	During the week before your period starts, do you have a serious problem with your mood—like depression, anxiety, irritability, anger, or mood swings?	☐	☐
c.	If YES, do these problems go away by the end of your period?	☐	☐
d.	Have you given birth within the last 6 months?	☐	☐
e.	Have you had a miscarriage within the last 6 months?	☐	☐
f.	Are you having difficulty getting pregnant?	☐	☐