Clinical Psychology Associates

Client Information (Please Print) **Therapist name:** _____ **Date:** _____

Name_____
Last *First* *Initial*

Street_____ Unit #_____

City/State/Zip_____

Employer_____

Email_____
(*Please provide email address. Will only be used for clinic purposes.*)

Social Security#_____

Date of Birth _____

Home Phone _____

Cell Phone _____

Work Phone _____
(*Please circle your preferred number?)*

How did you initially discover us? (Please circle)

Google	*Bing*	*Yahoo! search*	*PsychologyToday.com*	*GoodTherapy.org*
Friend/family member	*Insurance Provider Panel*	*Facebook*	*Online therapist locator site*	*Other* _____

As a courtesy to our referral sources, may we thank your referral source? Please initial if yes :_____
(No names or identifying information will be used.)

Primary Insurance Information

Insurance Company Name _____

Billing Address of Insurance Co. _____

*Name of Policy Holder _____ Date of Birth _____

**Social Security # of Insured _____ ID/Subscriber# _____

Group # _____ Insurance Phone _____

Secondary Insurance Information

Insurance Company Name _____

Billing Address of Insurance Co ._____

*Name of Policy Holder _____ Date of Birth _____

**Social Security # of Insured _____ ID/Subscriber# _____

Group #_____ Insurance Phone _____

*If responsible party for client billing is different from policyholder information, please indicate name and address of responsible party here:
_____

**Many social security numbers are still used for billing purposes. Please include the social security number of the policyholder.

PLEASE TURN PAGE OVER

Clinical Psychology Associates

Terms of Agreement

I authorize the release of any information via paper or electronic means to process my insurance claim.
I authorize CPA to contact me via phone or email as needed.
I am aware of CPA's privacy policies and protecting my health information through HIPAA.
I authorize payment of insurance benefits directly to the provider of service.
I agree to pay any billed amounts rejected by insurance, deductibles and co-pays; these amounts are due at time of service.

I have read and agree to all the above terms and accept responsibility for payment of all fees.

SIGNED_____

DATE_____

RIGHTS OF CLIENTS OF CLINICAL PSYCHOLOGY ASSOCIATES

Any person who receives services for mental health, alcoholism, drug abuse or developmental disability is guaranteed certain rights by the State of Wisconsin. Among these rights are the following:

1. You must be treated with dignity and respect, free of any verbal or physical abuse.
2. You have the right to have staff make fair and reasonable decisions about your treatment.
3. You cannot be treated unfairly because of your race, national origin, sex, religion, age, disability or sexual orientation.
4. You must be provided prompt and adequate treatment and other services which are appropriate to your individual needs.
5. You must be allowed to participate in the planning of your treatment.
6. You have the right to discuss positive and negative effects of your treatment and to discuss alternative treatments with your therapist.
7. No treatment may be given without your consent except in an emergency.
8. You have a right to know the cost of your treatment and to discuss these costs with your therapist.
9. You will not be filmed or taped without your consent.
10. Information regarding your treatment must be kept confidential unless you have released them.
11. Your records cannot be released without your consent unless a valid court order or a valid HIPAA form is in effect and is produced, except to report child abuse or to prevent violence or suicide.
12. You have the right to see your records and to discuss them with your therapist.
13. You may challenge the accuracy of your records and have corrections placed into the record.
14. If any of your rights are violated you may make an informal complaint or file a formal grievance or seek legal redress in court.
15. To make an informal complaint discuss the issue with your therapist and ask for resolution.
16. To file a formal grievance contact the Clinic Director, Dr. Paul Hamilton at 262-251-1112.

You have other rights, which have been promulgated by the State of Wisconsin. If you would like to learn more about these rights ask your therapist for a copy of the brochure published by the state.

I have read and understood these rights. I have also been orally informed of my rights. I may request a copy of these rights. Please sign this copy and return it to your therapist; if desired, please request an extra copy for future reference.

Signature:_____

Clinical Psychology Associates

INFORMED CONSENT TO TREATMENT

Psychotherapy is a process designed to help people learn to function better and feel better in their daily lives. People seek therapy to change emotional, interpersonal or behavioral situations. In many instances people who do not receive treatment for emotional problems report that their distress increases and this can lead to a significant disruption in mental, interpersonal and physical functioning. Initially, many people report feeling an increase in distress as they come to grips with important issues. Through therapy people sometimes make changes in personal coping strategies, careers or relationships. These changes can be distressing to the individual, to family members and to friends. It is important that you understand the implications of beginning therapy, discontinuing therapy or changing your treatment plan. Your specific situation is unique and will be discussed in detail with your therapist.

I realize that my initial treatment plan should be developed with my therapist and approved by me. My treatment plan will evolve as my needs change and each change should also be discussed and approved by me. I understand that my therapist and I should regularly discuss the implications of my continuing in therapy, adjusting the modality of therapy, seeking alternative treatment, and the implications of terminating therapy. I also understand that it is my right to make any of these decisions. I further understand that my therapist is responsible to provide therapy, which he/she believes to be effective and appropriate to my needs. Finally, I understand that any communication via cell phone or email may be heard or read by a third party. I hereby consent to begin therapy.

Signature:_____

Date:_____

Clinical Psychology Associates

Clinic Policies

Billing rates

Your therapist's billable rate is $_____ per 45-minute session ($_____ for the initial session). Other lengths of sessions are available for similar prorated costs. If we require psychological testing, that is typically billed at $100 per testing hour. We do offer a sliding scale for some hardship cases. Please consult your therapist for that rate. Please ask your therapist if you would like a separate fee sheet for other services available.

Paying your bill

It is expected that you bring co-payment to each session. Insurance companies consider it a form of insurance fraud when you do not pay co-pays at time of service. If further money is owed, you will receive a bill from us each month. You can bring your payment into the office or mail a check in the return envelope that is provided. We also accept VISA and MasterCard. If the portion of the bill owed by you exceeds $200, we require immediate payment of the bill.

If you default on your payments (overdue by 30-days), it is a clinic requirement that we must have a current credit card on file. If this requirement is not met, then you must bring in payment at each session. You may be referred to another agency if your account is not in good financial standing with the clinic. If you continue to default on your payments, you understand that after a reasonable amount of time, a collection agency or court-related action may be taken against you.

Interest

We charge a monthly interest rate of 1.5% on any unpaid client balance. An account is considered past due if full payment has not been received after 30-days of the receipt of your bill. We charge a monthly minimum $1.50 postage and handling fee for all overdue accounts.

No-shows/late cancellations

We reserve the right to charge up to our full billable rate for late cancellations (within 24-hours of appointment time) and no-show appointments. Because of the nature of our business, and the amount of time we schedule for an appointment, we view that appointment time as a contract between you and Clinical Psychology Associates. Please do not cancel appointments via email as email is typically checked nightly.

Billing Service

We utilize an independent contractor for our billing. *JL Billing* is our billing consultant. They handle all claims, payments, and billing questions. If you have any questions regarding your bill, *JL Billing* can be reached via phone at (262) 679-5040. or via email at: JLBilling@ymail.com.

Emergency services

We are available for emergency consultations. Please call 262-251-1112 and press "0" to have us paged.

Other services

We are available for phone and email consultations at the rate of $2.50 per minute. These services will not be billable to your insurance company and will need to be paid out of pocket.

Referral services

If you require more intensive care, such as day treatment or inpatient care, we have a very good relationship with Rogers Memorial Hospital (800-767-4411) and are confident in their abilities to meet your treatment needs. If you require group therapy, we are quite pleased with the offerings at the Counseling Center of Milwaukee (414-271-2565). Other referral services are available also.

Please sign below if you agree to the aforementioned policies.

Client signature:_____ Date:_____

Clinical Psychology Associates

Please note: ***We request that all clients have credit cards on file. They will not be used unless the client requests this or the client has an overdue balance for 60 or more days and has not responded to our attempts to establish a payment plan. It is policy of Clinical Psychology Associates that clients with more than a $500 deductible or a balance that exceeds $200 have a credit card on file.***

Credit Card Authorization Form
Clinic Copy Only

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Clinical Psychology Associates is now using **PayPal** online to pay your office bill/copays. Please visit the clinic website at: **www.clinical-psychology-associates.com** and click on the **"Contact Us"** tab to pay your bill. Thank you!

Pay Now

Please complete the following: Must Be Completely Filled Out

Please initial:

_____ **Anytime I** owe the clinic money for services, please charge my card.
_____ **On file only** (See clinic policy statement above)

Patient Name: ____

Cardholder Name: ____

Cardholder Address: ____

City, State: ________________________________ Zip: ____________

Phone Number: ( ) ________________________

Email Address: ____

Card Number:																

Please Circle: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Expiration Date: ____________________

CSC (three digit security code on back): ________________

Cardholder Signature: _________________________ Date: __________________
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