The Suites at Clinical Psychology Associates

Please print, complete, sign all pages, and scan/photo copy to Office@Clinical-Psychology-Associates.com. *Thanks!*

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?)*

Clinic use only: *Dx* *M/F*

Clinic/School location:

How did you initially discover us? (Please circle)

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

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 the party responsible for client billing is different from policyholder information, please indicate name and address of responsible party.

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

Terms of Agreement

I authorize the release of any information via paper or electronic means to process my insurance claim.
I authorize my therapist to contact me via phone or email as needed.
I am aware of my therapist'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.

Signature:_____

Date:_____

Rights of Clients

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: 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:_____

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 there may be limits of confidentiality with any communication via cell phone or email. I hereby consent to begin therapy.

Client signature: _____

Date: _____

For parents/guardians of children: I have the legal right to consent for treatment for this child.

Signature:_____

Date:_____

Signature:_____
(Signature of minors aged 14 and older.)

Date:_____

Therapist Policies

Billing rates

Your therapist's billable rate is $_____per 38-minute session and $_____per 53-minute session. Other lengths of sessions may be available for similar prorated costs. Some therapists 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 his/her services.

Paying your bill

Each therapist expects that you bring co-payment to each session. If further money is owed, you will receive a bill each month. You can bring your payment into the office or mail a check. All therapists also accept VISA and MasterCard. If the portion of the bill owed by you exceeds $200, ethically therapists require immediate payment of the bill.

Interest

There may be a monthly interest rate charge of 2.0% 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.

No-shows/late cancellations

Each therapist reserves the right to charge up to their 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, the appointment time is a contract between you and your therapist.

Billing Service

Most therapists utilize an independent contractor for billing, LK Billing, Inc. LK Billing handles all claims, payments, and billing questions. If you have any questions regarding your bill, LK Billing can be reached via phone at 262-259-1384 or via email at LKBilling@Clinical-Psychology-Associates.com.

Other services

Most therapists are available for phone and email consultations at the rate of up to $3.00 per minute, rounded up to the nearest 5-minute increment. These services will need to be paid out of pocket. Please consult with your therapist for his/her rate.

Referral/emergency services

If you require more intensive care, such as day treatment or inpatient care, Rogers Memorial Hospital (800-767-4411) is a possibility to meet your treatment needs. As always, if your situation requires immediate attention, please go to your nearest emergency room or call 911.

Please sign below if you agree to the aforementioned policies.

Client signature:_____ Date:_____

The Suites at Clinical Psychology Associates

Please note: We request that all clients have credit cards on file. They will not be used unless the client has an overdue balance for 60 or more days and has not responded to our attempts to establish a payment plan OR initial at the bottom if you'd like us to run the card when there is a balance due.

Credit Card / HSA/ FSA Authorization Form

Please complete the following:  Form Must Be Completely Filled Out

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

City, State: _____ Zip: _____

Phone Number: (_____) _____

Email Address: _____

Card Number:

Please Circle: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

HEALTH SAVINGS ACCOUNT/ HSA FLEX SPENDING ACCOUNT/ FSA

Expiration Date:_____

CSC (Security code on back):_____

Cardholder Signature: _____ Date: _____

If you would like us to charge your card for any deductibles/co-pays due please initial here:_____(Your card will only be run if initialed)

Cards are processed twice monthly on the 15th of every month and or around the last day of each month. *

CLIENT COPY - PLEASE REMOVE AND TAKE HOME

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