

Stephen C. Allen, Ph.D.

LPC, LMFT

NEW PATIENT INFORMATION

Patient Information

Name _____ Today's Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Date of Birth _____ Social Security Number _____

Marital Status: Single Married Divorced Separated Widowed

Gender: Male Female

Employer or School _____

Referred by: Physician, Name _____

Other Professional, Name _____

Friend Former or Current Client Phone Book

Other, Please specify _____

Responsible Party Information

Who is responsible for the charges for this client?

Client (Not necessary to complete below information)

Other (Please complete information below)

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Date of Birth _____ Social Security Number _____

Marital Status: Single Married Divorced Separated Widowed

Gender: Male Female

Employer or School _____

Parent or Guardian of Minors Information

Father's Name _____

Mother's Name _____

FINANCIAL POLICY

We are committed to providing caring and professional health care to all our patients. As part of the delivery of health services, we have established a financial policy which provides payment policies and options to all consumers. The financial policy of the Clinic is designed to clarify the payment policies as determined by the management of the Clinic.

The person Responsible for Payment of Account is required to sign the form, *Payment for Contract Services*, which explains the fees and collection policies of the clinic. We do accept assignment of benefits for the insurance carriers for which we are a Network Provider. Please note that services not covered in your plan are solely the responsibility of the Person Responsible for Payment.

The Person Responsible for Payment (as noted in the Payment Contract for Services) will be financially responsible for payment of such services. Payments for services rendered are due at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied non-emergency service unless charges have been preauthorized to an approved credit plan, charge card or payment at the time of service.

Missed appointment or cancellations made less than 24 hours prior to the appointment time are charged as noted in the *Payment Contract for Services*.

Payment methods include exact cash, check, or the following charge cards: MasterCard, and Visa. Clients using charge cards may either use their card at each session or sign a document allowing the clinic to automatically submit charges to the card prior to each session.

Questions regarding the financial policies can be answered by Dr. Allen.

I (We) have read, understand, and agree with the provisions of the Financial Policy.

Signature of Person Responsible for Payment of Account

Date

Signature of Co-Responsible Party

Date

Payment Contract for Services

Name(s): _____

Address: _____
Street City State Zip

Bill to: Person(s) Responsible for Payment of Account _____
Address: _____

Federal Truth in Lending Disclosure Statement for Professional Services

Part One Fees for Professional Services

I (we) agree to pay The Center for Learning and Development, hereafter referred to as the Clinic, any and all fees as described below:

ADHD Evaluations – Child/Adolescent	\$635.00
ADHD Evaluations – Adult	\$380.00
Initial Counseling Assessment (75-90 minutes)	\$180.00
Counseling Session (45-50 minutes)	\$125.00
Counseling Session (25-30 minutes)	\$ 62.50
Group Session (45-75 minutes)	\$ 50.00
Phone consultation (1/4 hour increments)	\$ 30.00
Court Testimony	\$200.00 per hour (including travel time)

Part Two Payment of Services

The Provider does accept assignment of insurance benefits for any insurance panels for which he is a Network Provider. All copayments, coinsurance, deductibles, and payment for non-covered services are due at the time the services are rendered and prior to beginning of services. Payment is accepted in the form of cash, personal checks, and the following credit cards: *MasterCard*, and *Visa*.. Additional appointments may not be scheduled until all balances are paid in full.

Part Three Late Cancellation and Missed Appointment Policy

The full contracted fee is charged for missed appointments or cancellations of less than 24 hours notice. Voice mail cancellations are charged according to time received. Clients who have not signed a *Preauthorization for Health Care* authorizing charges to their credit card will not be scheduled for another appointment until missed appointment and late cancellation fees are paid in full.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Signature(s) of Person(s) Responsible for Payment Date

Limits of Confidentiality

The contents of an intake, assessment, or counseling session are considered confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the clients or client's legal guardian. It is the policy of this clinic not to release any information about a client without a signed release of information. Noted exceptions are as follows:

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases where the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child or vulnerable adult is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances

Health care professional are required to report to the appropriate authorities admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death

In the event of a client's death, the spouse or parents of a deceased client have a right to access that child's or spouses records.

Professional Misconduct

Professional misconduct by a health care professional must be reported by other health care professionals in cases in which a professional or legal disciplinary meeting is being held regarding the health care professionals actions. Related records may be released in order to substantiate disciplinary concerns.

Court Orders

Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor clients have right to access the client's records.

Other Provisions

When fees for services are not paid in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (eg; diagnosis, treatment plan, case notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, time frame, and the name of the clinic.

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Insurance companies and other third-party payers may be given information that they request regarding services to clients. Information which may be requested includes: type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries. If you wish this information to be released to your insurance company, you must sign a *Release of Information Consent Form*. Legal Guardians must sign for minor children. In the case of couple or family therapy, all adults must sign the *Release of Information Consent Form*.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed.

In some cases, notes and reports are dictated/typed within the clinic or by outside sources specializing (and held accountable) for such procedures.

In the event in which the clinic or health care professional must telephone the client for purposes such as appointment cancellations/changes/reminders, or to give/receive/ other information, efforts are made to preserve confidentiality. Please list where we may reach you by phone and how you would like us to identify ourselves.

If this information is not provided to us (below), we will adhere to the following procedure when making phone calls: First, we will ask to speak to the client (or guardian) without identifying the name of the clinic. If the person answering the phone asks for more identifying information, we will say that it is a personal call. We will not identify the clinic (to protect confidentiality). If we reach an answering machine or voice mail we will follow the same guidelines. Please be aware that if you have caller ID, the name of the clinic and phone number may be revealed.

PLEASE CHECK PLACES WHERE WE MAY REACH YOU BY PHONE. Included phone numbers and how you would like us to identify ourselves when phoning you. Please be aware that we cannot guarantee confidentiality in the case of cellular phones. If we are calling from a cellular phone, we will apprise you of this before continuing the call.

___ HOME _____ Yes ___ No
Phone number How should we identify ourselves? May we say the clinic name?

___ WORK _____ Yes ___ No
Phone number How should we identify ourselves? May we say the clinic name?

___ CELL _____ Yes ___ No
Phone number How should we identify ourselves? May we say the clinic name?

May we contact you by (check all that apply): ___ email ___ fax ___ cell phone

I/We agree to the above limits of confidentiality and understand their meanings and ramifications

Client's name(please print)	Client's/Guardian's Signature	Date
Client's name(please print)	Client's/Guardian's Signature	Date

LATE CANCELLATION/MISSED APPOINTMENT POLICY

Missed appointments represent a cost to my practice, to you, and to the clients who could have been seen in the time set aside for you. Cancellations are requested by phone 24 hours prior to the scheduled appointment. Cancellations may be left on the voice mail if made after business hours, but still must be made 24 hours prior to your scheduled appointment. **I do not accept appointment changes or cancellations by email.**

It is my policy to charge for missed or late-cancelled appointments. The charge for a missed or late-cancelled appointment is \$60.00. **This charge is not reimbursable by your insurance plan and is your sole responsibility.** Any late-cancelled or missed appointment fee is due in full at the next appointment. Repeated “no show” appointments may result in referral out to another therapist. It is understood that there might be a situation where a client cannot give a 24 hour notice. Therefore it is my policy to waive the late-cancellation/missed appointment charge one (1) time. Beyond this, there will be no exceptions to the policy.

I HEREBY CERTIFY that I have read and agree to abide by the conditions set forth above. I understand that if I am charged a late-cancellation or missed appointment fee that this fee is not a covered benefit under my insurance policy and is my sole responsibility.

Signature of Client or Responsible Party

Date

Printed Name