STONEBRIDGE FAMILY THERAPY

Co Pay $_____

DX_____.____

Office Use Only

Client Contact Record

Patient Name_____**D.O.B.**_____**Age**_____

Address_____**City**_____**State**_____**Zip**_____

Home Phone _____**Work Phone** _____ **Cell Phone**_____

Social Security Number _____**EAP/Insurance Co.**_____

E-Mail Address_____**Do you check daily?** _____

If Minor Client - Parent(s) Name_____ **Spouse's Name**_____

May we contact you by phone at the above number(s)? ____Yes ____No

Stop – The next section is for office use only.

Auths./ Session #	Date	Code/ Procedure	Persons Attending or Contacts	Initials Clinician/Staff

CPT CODES:

90801 – Psy. Eval./Intake **90808** – 75-80 min. session **90847 –** Family, Marital, Couple

90846 – Family w/o Pt **90853 –** Group **90830 –** Testing w/Report

PSYCHOTHERAPY ASSESSMENT CHECKLIST

PERSONAL DATA

Marital Status _____ **Insurance Co. _____**

Insurers Identification #_____ **Ins. Group # _____**

Spouse/Partner's Occupation _____ **No. of Children _____ Ages _____**

Person to contact in an emergency _____ Phone (____) _____

Address _____ Relation to you _____

MAIN PROBLEMS: Please list the major problems that you would like help with in therapy, and rate the severity of each one according to the scale below:

1 ---------2 --------- 3 --------- 4 --------- 5 --------- 6 --------- 7 --------- 8 --------- 9 --------- 10

Not a Problem Mild Problem Moderate Problem Severe Problem Couldn't be worse **RATING**

1._____ _____

2._____ _____

3._____ _____

Briefly describe what motivated you to seek therapy <u>at this time</u> (rather than some time earlier or later): _____

_____

MEDICAL PROBLEMS: Do you have any serious medical conditions? (If yes, please describe)..... No Yes

_____

Problems with: Headaches___ Indigestion___ Diarrhea ___ Constipation___ Circulation ___ Shortness of Breath ___ Frequent Urination ___

Body Aches/ Pain ___ Menstrual problems ___ **How would you rate your overall health? Excellent ___ Good ___ Fair ___Poor___**

Please list any medications you are taking:_____

In Past Year, how many: Visits to doctor____ Sick days____ Cigarettes-day ____ Alcoholic drinks/day _____ Psychotherapy sessions,**ever**____

Number of family members with: Alcohol/drug problems ___ Psychiatric problems (e.g., depression, psychosis) _____

CURRENT STRESSFUL EVENTS: Legal ___ Financial ___ Family problems ___ Family Illness ___

Other _____ **Are you in an abusive relationship?** No__ Somewhat__ Yes__

Recent losses (jobs, relationships, or difficult changes)_____

Self -Report of Assessment of Functioning

WORST TIME IN LIFE (Please briefly describe). (You may use the back of this page for answers in the following sections, if needed:)

_____

_____

Who helped you through it?_____

Are there things that cause you to feel ashamed or that would be difficult to talk about? (No need to specify) ..... No Yes

BEST TIME IN LIFE (Please briefly describe)_____

_____

_____ Was there someone to share it with? Yes No

Do you have a close friend who is supportive and someone you can confide in during difficult times?.....Yes No

What have you done that you are **MOST PROUD OF?** _____

_____

What are your **STRENGTHS** (How do you cope) when times are hard? _____

_____

Do you feel you are a person of worth at least on an equal basis with others? Very Much Much Somewhat A little No

How much enjoyment or pleasure are you currently getting out of living? Very Much Much Moderate A little None

What is your income range? Under $20,000___ /$20-39,000___ /$40-59,000___ /$60-80,000___ / Over $80,000___

SELF-ASSESSMENT OF FUNCTIONING: Please rate (from 1-10) how well you feel you are currently functioning in each of the three areas listed below, according the following scale:

10 ------- 9 -------- 8 --------7---------6 -------- 5 --------4---------3-------- 2 -------- 1

Excellent Functioning Mild difficulty Moderate difficulty Severe Difficulty Barely able to function

1. General Mood (Depression, Anxiety, etc.) _____ 2. Marital Relationship? _____ 3. Daily work or school?____

WE ARE NOT MEDICARE PROVIDERS. IF MEDICARE IS YOUR PRIMARY INSURANCE YOU WILL BE RESPONSIBLE FOR PAYMENT.
Please notify the receptionist of you have secondary insurance coverage.

This '**PHYSICIAN RELEASE**' permits your therapist to inform your Primary Care Physician (PCP) of your therapy. May we release your therapy information to your Primary Care Physician? Yes _____ No _____

Please Notify: Dr. _____ Tel: ( ) _____-_____ Fax: ( )_____-_____

Address: _____ State: _____ Zip Code: _____

Release of Medical Information

I authorize payment of insurance benefits to Stonebridge Family Therapy. I understand that I am financially responsible for any charges not covered by insurance or third party payer.
I authorize the release of any medical information necessary to process this claim. Oklahoma State Law (O.S. 63 Sec. 1-5022) requires the following statement: The information may include records which may indicate the presence of a communicable or venerable disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immune Deficiency Virus, and Acquired Immune Deficiency Syndrome (AIDS).

Signature of Responsible Party: _____ Date: _____

FINANCIAL POLICY AND MISSED APPOINTMENT POLICY

Welcome to Stonebridge Family Therapy. Please read over our financial and missed appointment policy. If you have questions feel free to ask the Stonebridge Counseling staff.

FINANCIAL POLICY

Fees. Counseling sessions are 50 minutes long. The fee for a 50 minute session, either face-to-face or by phone, is $125. A first time patient is charged $75 by credit card to hold their appointment time. This fee is non-refundable but it is deducted from your first visit. Payment is collected at the first of the session. We also ask you to place a credit card on file for future billing.

Insurance Patients. If you have health insurance Stonebridge Family Therapy is happy to call your insurance company and verify your insurance benefits. They will also file your insurance for you. If your insurance covers a portion of your therapy we will be happy to wait for 30 days for your insurance to pay their portion. You will, however, be responsible for your deductible and co-pay or co-insurance. That portion of your care will be due at the time of your appointment. You will be responsible for all charges not covered by your insurance company.

Self-Pay Patients. Patients without insurance or with high deductibles are responsible for the cost of their care. Payment is expected at the time the service is rendered.

Methods of Payment. Stonebridge Family Therapy accepts cash, checks, and major credit cards.

Payment in Advance. If your therapist suggests more than ten visits, you may pay for them in advance and receive a discount of 15%. Payment for multiple visits must be made by the third visit.

MISSED APPOINTMENT POLICY

Twenty-four hour notice is required for the cancellation of an appointment. Appointments canceled with less than 24 hours notice will be charged your full fee. Appointments missed because of inclement weather or other major problem will not be charged. Your charge will be applied to your credit card on file.

I have read and agree to the above conditions.

Name _____ Date _____

Informed Consent

Before We Begin…

Perhaps one of the hardest parts of this process is already over. Deciding to undertake therapy is an important step in your life that requires a clear understanding and agreement between you and your therapist. The following information will orient you to the legal and ethical considerations and rights for clients in a mental health care setting. Please initial each section to show that you have read and agree to the material presented.

Consent to Treatment

I am voluntarily seeking psychotherapeutic services. I understand that I am responsible for my part in the therapy process, which includes providing honest information to my therapist, and follow therapeutic instruction and completing homework and reading exercises. I realize that refusal to follow recommendations, being dishonest or withholding of information related to my problem could jeopardize my well-being. I understand that there are uncontrollable factors and that no guarantee is expressed or implied.

If I feel the urge to hurt myself or someone else, I agree to contact my therapist, dial 911, call my physician or go to a hospital.

_____ Initial

Confidentiality

Communication between a client and therapist is confidential. Your therapist will never repeat what you say, or tell what is in your records or test results to any family member, employer, school, doctor or anyone else without your permission. If you wish any information to be shared with a third party, you must sign a written release. You may revoke your release at anytime by putting it in writing and delivering it to the Stonebridge staff.

Oklahoma Law specifies a few situations involving safety for yourself or others where disclosures may be made without your consent. These are:

1. If you are a danger to yourself and you refuse appropriate care.
2. If you are threatening to harm someone else or pose a threat to the safety of others.
3. When child or elder abuse is disclosed.
4. When case consultation is presented in an anonymous manner to other professionals.
5. When legally ordered by a court of law.
6. In order to collect debt or defend your therapist in court.

_____ Initial

Billing, Payment, Insurance and Managed Care

In order for this office to file insurance claims on your behalf, we must document your permission to give certain private information about you to your insurance or health care company. Typically, this includes the date of service and your diagnosis. Other data may be necessary from time to time in order to ensure that you receive the appropriate benefits. Some mental health treatments and diagnostic procedures are not covered by insurance. In that case you will be responsible for payment. Feel free to discuss your insurance coverage with our insurance department.

_____ Initial

Newsletter

I agree to receive the monthly newsletter from Stonebridge Family Therapy with the full understanding that I can unsubscribe at any time. I agree that this is not a condition of my treatment and I and there are no obligations toward the therapist for receiving this information.

_____**Initial**

Charges

Fees for services rendered to you are dependent on the type of service and the length of time involved. These fees can be discussed with our billing department at any time. You are responsible for any debt incurred for services rendered to you by your therapist. Fees for court related work are not covered by insurance. Court related services are charged at $300.00 per hour, are based on door to door time and must be paid in advance**.** Our therapists do not perform child custody evaluations or forensic assessments.

_____ **Initial**

I understand and agree to these policies and accept responsibility for any debt for services rendered to me by the Stonebridge therapists.

_____ _____

Patient's Signature Date

Professional Disclosure

Welcome to my practice. In order to let you know important information as you enter into therapy, I have provided you with this statement of professional disclosure. If you have any questions after reading this information, please let me know so that we can begin our work with no misunderstandings.

I am licensed to practice as a Licensed Professional Counselor (#4738) by the Oklahoma State Department of Health. I am also certified by the National Board of Professional Counselors as a National Certified Counselor (#301929). The professional ethics required by both of these licenses help guide my practice and offer you quality professional mental health care.

My Master of Science is from Northeastern State University in Counseling Psychology. I have practice in two out-patient mental health settings with individuals, families, and couples since 2000. I have managed a group practice with several employees, and currently am the Founder and CEO of Stonebridge Family Therapy. If you would like to discuss my training or credentials further, please feel free to initiative any questions or concerns you may have.

Psychotherapy is a cooperative effort between you and your therapist. We will discuss your personal goals for treatment and find a treatment plan that is most likely to be workable for you. The treatment modalities that I use involve primarily talking in an office setting. Persons who may be helpful to your progress may be included in your sessions if appropriate. The orientations that inform my therapies include, but are not be limited to: cognitive/behavioral, psychodynamic, and family systems type therapies. If I feel that I am unable to help you with your treatment in a manner that is appropriate, I will assist you in locating another therapist.

Please make certain that you understand the concepts of informed consent, confidentiality, duty to warn, how to reach help in an emergency and how you will pay for your treatment before continuing in your therapy. These issues are discussed at length in other paperwork that you complete at your intake session.

I look forward to working with you as you begin this important step in your life.

Tom Philp, LPC, NCC

For official information you may contact (without giving your name):
Oklahoma State Department of Health
1000 N.E. 10th Street
Oklahoma City, Oklahoma 73117-1299
(405)271-6030

By signing, I am indicating that (*the therapist*) has adequately explained her credentials to me and given me a copy of this page.

_____ _____

Patient's Signature (Parent or Guardian if Patient is a Minor Child) Date

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. Psychotherapy contact notes are not available for the patient to review. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below. You may revoke that permission, in writing, at any time.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the therapist has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Name of Patient Date

For further information regarding this notice, please contact our therapist at 918-398-7678.