Patient Information

***ALL FIELDS NEEDED TO PROCESS CLAIM**

***Patient's Name____**

*** Address ____**

____ *Zip Code___________

***Social Security Number _____________/______/___________________**

Telephone (Home) ______________________________________

(Work) ______________________________________

(Cell) _______________________________________

*** Email address ____**

***Date of Birth ___ / ___ / ___ Age ______ Sex ____ Marital Status ________________**

If the client is a child, do you have custody/guardianship of the child? *Yes* ____ *No* _____

(Documentation of custody is needed before child can be seen)

Employed by _________________________________ Phone _______________________

Occupation ____

Employer Address ____

____

Spouse/Parent's Name ____

Date of Birth ___ / ___ / ____ Age ______ Sex ___ Relation to client _________________

Social Security # ____________________________ Phone ________________________

Employed by ______________________________ Phone ________________________

*** These fields are <u>MANDATORY</u> in order for us to be HIPPA compliant. In addition, it assists us in electronically processing your bill. Clients who do not fill out these required fields will be listed as self pay.**

Number of Children ______ Names and date of birth for each child of client: ______________

____

____

Emergency Contact _____________________________ Phone ______________________

Name of Nearest Relative ________________________ Phone ______________________

Referred By ____

Family Doctor _________________________________ Phone ______________________

Have you ever received psychiatric services elsewhere? *Yes* _______ *No* _______

If so, where? ____

***Medical Insurance Company ____**

***Subscriber (name that appears on card) _______________________________________**

*** Subscribers Date of Birth ____ / ___ / ___ * SS# __________________**

***Relation to Patient ____**

***ID Number ______________________________ Group Number _____________________**

***Person responsible for payments_______________________________**

***Address____**

***Is the patient covered by more than one insurance company? *Yes* ______ *No* _______**

***If so, name and address of company? ____**

***ID number of other Company _______________________________________**

I, the undersigned, agree and accept financial responsibility for services rendered and consent to treatment.

____ ___________________

Client/parent/guardian signature Date

Middletown Counseling Patient Financial Policy

Patient's Name ____

Patient's Date of Birth ____ / ____ / _______

Patient agrees to pay for all of their portions of service due in full at the time of service(s) provided by our office.
Any outstanding balances, co-payments, and deductibles are due prior to checking in for your appointments.

Patient Financial Class Policies
You are required to present a valid insurance card as needed throughout your care. If there is a change in your insurance it is your responsibility to notify the front desk of that change.

Commercial Insurance Carriers
We bill most insurance carriers for you if proper paperwork is provided to us. Since your agreement with your insurance company is a private one, if your insurance carrier has not paid or paid less than you anticipated within 60 days of billing, fees are due and payable in full from you.

Medicaid
Our office is a Medicaid provider and we will bill Medicaid for you.

Worker's Compensation
If your visit is work-related we will need the case number and carrier number prior to your visit in order to bill the worker's compensation insurance company.

Secondary Insurance
We will bill your secondary insurance provided your therapist accepts this insurance. You must give us all of the necessary information during your first visit. This includes giving the receptionist your insurance cards and informing him/her which insurance is primary and which is secondary.

Methods of Payment
Our office accepts the following payment methods: cash, check, credit cards, debit cards, and patient financing options for those patients who are credit worthy.

For returned checks we assess a $35.00 NSF charge.

If not paid according to terms, the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections, the patient agrees to pay all additional fees accessed in the collection of the debt. Since your agreement with your insurance company is a private one, if your insurance carrier has not paid or paid less than you anticipated within 60 days of billing, fees are due and payable in full from you.

I have read, understood, and agreed to the above terms and conditions.

Signature ___________________________________ **Date ___________________**

<u>Limits of Patient Confidentiality</u>

We are required to disclose confidential information if any of the following conditions exist:

1. **You are a danger to yourself or to others.**
2. **You seek treatment to avoid detection or apprehension or enable to commit a crime.**
3. **Your therapist was appointed by the courts to evaluate you.**
4. **Your contact is for the purpose of determining your competence.**
5. **Your contact with your therapist is for the purpose of determining sanity in a criminal proceeding.**
6. **The contact is one of which your psychotherapist must file a report to a public employer or as information required to be recorded in a pubic office, if such a report or record is open to public inspection.**
7. **You are under the age of 18 years and are the victim of a crime.**
8. **You are a minor and your psychotherapist reasonably suspects you are the victim of child abuse.**
9. **You are a person over the age of 65 and your psychotherapist believes you are the victim of physical abuse. Your therapist may disclose information if you are the victim of emotional abuse as well.**
10. **You die and the communication is important to decide an issue concerning a deed or conveyance will or other writing executed by you affecting as interest in property.**
11. **You file suit against your therapist for breach of duty or your therapist files suit against you.**
12. **You have filed suit against anyone and have claimed mental/emotional damages as part of the suit.**
13. **You waive your rights to privilege or give consent to limited disclosure by your therapist.**
14. **Your insurance company paying for services has the right to review all records.**

Signature ____ Date _____________

<u>Release of Information</u>

I authorize Middletown Counseling Services to contact my primary care physician _________________________ regarding an appointment being made for follow up, as well as information pertaining to psychological and emotional function.

Signature ____ Date _____________

<u>Acknowledgement of Privacy and Security Policy</u>

I acknowledge that I have read a copy of the Limits of Patient Confidentiality and understand my rights as they are discussed in that document. I agree to allow Middletown Counseling Services to contact me at home, my place of employment, mobile phone, or by email to change or confirm appointments, gather information, or to inform me of a problem. I also agree to allow Middletown Counseling Services to leave messages pertaining to my involvement with my therapist on my voicemail. I further agree to allow Middletown Counseling Services to use my name in the lobby area when informing me that my session is about to begin.

I understand that Middletown Counseling Services will notify me that I will be asked to sign a separate permission form if any medical or behavioral information is to be released to another organization or to a person not involved with my treatment with Middletown Counseling Services. I understand that I have the right to refuse to allow this information to be released except where Middletown Counseling Services is required by law or contractual obligation.

Signature ____ Date _____________

Witness ____ Date _____________

Please Read Carefully and Sign

Thank you for choosing Middletown Counseling Services. Our goal is to provide high quality, thorough, and effective care for every client. In an effort to provide services to as many individuals as possible in an efficient manner, we ask each client to accept their financial responsibility and adhere to the following conditions:

1. You must give **24 hours notice** before canceling an appointment. You will be charged a **$25.00 fee** for appointments that are cancelled with less than 24 hours notice. You will be charged a **$35.00 fee** for any appointments of which you **do not show** and do not provide notice. These fees are not billable to your insurance company.
2. **Payment is expected at the time of service** and can be paid in check, cash, or credit/debit card. There will be a **$35.00 fee for every returned check**. If your account becomes delinquent, the outstanding balance will be sent to a collection agency and you will responsible for the collection fees.
3. A therapist can be contacted 24 hours a day for emergencies by calling 302-668-8582. All calls **longer than five minutes** will be billed at the rate of **$30.00 per 15 minutes** or portion there of regardless of your therapy fee. These fees are not billable to your insurance company.
4. If you have any questions, complaints, concerns, or compliments about your treatment or therapist, please contact Sandra Knauer, LCSW.
5. There is a **$65.00 fee per hour** for the preparation of client reports, for example: disability claims, FMLA paperwork, summary reports, certain types of correspondence that is prepared outside of our regularly scheduled therapy sessions, etc. Such requests for reports must be submitted in writing with a **$65.00 deposit**. A*ny additional time required to complete your request over the first hour will charged at $16.25/per quarter hour*. Should it be necessary to make excessive return calls to disability or other providers, the therapist has the discretion to bill accordingly.
6. The fee for copies of clients' records and clients' record transfers are as follows:
   - 1 - 20 pages $15.00
   - 21 - 50 pages $20.00
   - Over 50 pages $25.00

7. I understand that my professional relationship with Middletown Counseling is protected by confidentiality. I also understand that there are legal limits to confidentiality as in cases of suspected child abuse/neglect or when there is danger to self or others.

I have read and understand the above information. I also understand that my treatment at Middletown Counseling Services is contingent upon the above policies and I agree to abide by them. I also understand that my treatment at Middletown Counseling Services is completely voluntary and I consent to treatment under the terms above.

Signature_______________________________________ **Date**___________________

Printed Name____

CLIENTS WITH AN EMPLOYEE ASSISTANCE PROGRAM

Please complete the following information:

Name of EAP insurance company: ___________________________

Telephone number of EAP insurance company: _______________

Authorization number: _____________________________________

How many visits are authorized? ______________

Effective dates: _____ / ___ / ___ to _____ / ___ / ___

I understand, that if this information is not provided, my regular insurance company will be billed and I may be responsible for a copayment.

Signature of client: ____

Date: ______________

<u>Please Detach and Keep for Your Personal Records</u>

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