Client Information Sheet

Date________________ Client's Social Security # ____________________
Client's First Name ______________________ Last Name __________________MI _______________
Date of birth _____/_____/_____ Age ______ Gender _____F _____M Race _________________
Address _______________________________ City _________________ State_______ Zip___________
Telephone (Home/Cell) ___________________________ (Work) _______________________________

Guardian Information:
Name____
Address ______________________________City____________________ State ________ Zip ________
Date of Birth _______________________Soc. Sec. # _________________________

Please describe your presenting problems:
____
____
____

Have you ever met with a social worker, psychologist, psychiatrist, or any other mental health professional? Yes ______ No____

Are you currently being treated by any mental health professional or taking any psychiatric medications? Yes____ No____ If yes, name the prescriber, name of medication, dosage, start date of medication and reason medication was prescribed.
____
____

Have you ever been hospitalized for mental health reasons? Yes____ No____. If yes, what are the approximate dates and reason for admission?
____
____

Do you have any significant medical issues?
____
____

Insurance Information:
Primary Insurance Carrier Name: ____
Member/Policy ID:____
Group Number: ____
Secondary Insurance Carrier Name: ____
Member/Policy ID:____
Group Number: ____
Please email a copy of your medical insurance card (including back) and drivers licensed, for insurance verification to: **info@bestpracticepsychotherapy.com**
***If insurance is under a spouse or parent, please provide name, address, and date of birth.**
First Name ______________________ Last Name ___________________MI ____________________
Address _______________________________ City _________________ State_______ Zip___________
Telephone (Home/Cell) ___________________________ (Work) _______________________________
Date of birth _____/_____/____ Social Security # ___________________

Financial Policy
And
Payment Contract for Service

The staff at Best Practice Psychotherapy hereafter referred to as the Practice are committed to providing caring and professional mental health care to all our clients. As part of the delivery of mental health services, we have established a financial policy that provides payment policies and options to all consumers. The financial policy of the Practice is designed to clarify the payment policies as determined by the management of the Practice.

The Person Responsible for Payment of Account is required to sign the form Financial Policy and Payment Contract for Services, which explains the fees and collection policies of this Practice.

As a service to you, the Practice will bill insurance companies and other third-party payers but cannot guarantee such benefits or the amounts covered and is not responsible for the collection of such payments. In some cases, insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases the Person Responsible for Payment of Account is responsible for payment of these services. We charge our clients the typical rates for the area. Clients are responsible for payments regardless of any insurance company's arbitrary determination of typical rates.

The Person Responsible for Payment (as noted below in the Payment Contract for Services) will be financially responsible for payment of such services. **The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 60 days**. **Payments not received after 120 days are subject to collection. A 5% per month interest rate is charged for accounts over 60 days**.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that were prior to the first session at the clinic), this amount will be collected by the clinic until the deductible payment is verified to the Practice by the insurance company or third-party provider.

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 nonemergency service unless charges have been preauthorized to an approved credit plan, charge card, or payment at the

time of service.

Missed appointments or cancellations less than 24 hours prior to the appointment are charged an unnegotiable fee of $95 (subject to changes).

Payment methods include check, cash, or the following charge cards: Amex, Discover, Visa, Mastercard. Clients using charge cards may either use their card at each session or sign a document allowing the Practice to automatically submit charges to the charge card after each session.

Questions regarding the financial policies can be answered by the Office Manager.

Payment Contract for Service

Client Name(s)____

Date of Birth_______________ SSN________________ Phone Number___________________

Address __________________________________City_________________________________

Region/State/Province____

Postal / Zip code____________________________ Country____________________________

Bill to:

Person Responsible for payment:____

Date of Birth_______________ SSN________________ Phone Number___________________

Address __________________________________City_________________________________

Region/State/Province____

Postal / Zip code____________________________ Country____________________________

Consent to Treatment, Client Rights and Telehealth

I, _________________________the undersigned, hereby attest that I have voluntarily entered treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at Best Practice Psychotherapy, LLC, hereby referred to as the Practice. Further, I consent to have treatment provided by a psychiatrist, psychologist, social worker, counselor, or intern in collaboration with his/her supervisor. The rights, risks, and benefits associated with the treatment have been explained to me.

I understand that the therapy may be discontinued at any time by either party. The Practice encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Client Rights: I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content.
Nonvoluntarily Discharge from Treatment: A client may be terminated from the Practice nonvoluntarily. if: (A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the Practice and/or (B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the nonvoluntary discharge by letter. The client may appeal this decision with the Practice Director or request to reapply for services later.

Client Notice of Confidentiality: The confidentiality of client records maintained by the Practice is protected by federal and/or state law and regulations. Generally, the Practice may not say to a person outside the Practice that a client attends the program or disclose any information identifying a client as an alcohol or drug misuser unless: (1) the client consents in writing, (2) the disclosure is allowed by a court order, or (3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Practice's duty to warn any potential victim when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about the client, not clinical information.

Risks of Opting for In-Person Services
You understand that by coming to the office, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

If You or I Are Sick
You understand that we are committed to keeping you, our staff, and all our families safe from the spread of this virus. If you show up for an appointment and you are visibly sick, we will ask that you leave the office immediately. We can follow up with services by telehealth as appropriate.

If a staff member tests positive for the coronavirus, you will be notified so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection
If you have tested positive for the coronavirus, staff may be required to notify local health authorities that you have been in the office. If we must report this, we will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that we may do so without an additional signed release.

I understand that Best Practice Psychotherapy, LLC will use Doxy.me which is an approved HIPAA compliant software for Telehealth services. All clients who agree to Telehealth must visit Doxy.me/Charmaine for each virtual therapy session. Acknowledging receipt of this document shows an awareness of these issues and a decision by this client to use this system for Telehealth services. I will not hold Best Practice Psychotherapy, LLC liable for gathering or use of client information by this service provider.

I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer-based psychotherapy services. If I am in crisis or experiencing an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility. By acknowledging receipt of this document in writing, I understand that an emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threatening or emergency situation, and/or if I am abusing drugs or alcohol and are not safe. I acknowledge I have been told that if I feel suicidal, I will call 911, local county crisis agencies, or the National Suicide Hotline at 1-800-784-2433.

Please sign and date below to acknowledge receipt of all document.

I consent to treatment and agree to abide by the above-stated policies and agreements with Best Practice Psychotherapy, LLC:

Minor Client Name:________________________________ **Date of Birth**____________________

Client/ Guardian Signature_______________________________________ **Date**______________