MIDDLETOWN
COUNSELING SERVICES, INC.

# PATIENT INFORMATION

***Denotes MANDATORY to process claim**
**Please use a black pen & press firmly when printing.**

*Patient's Name _____

*Address _____

_____ *Zip Code _____

*SS# _____/____/_____ *E-mail address _____

*Date of Birth ____/____/____ Age _____ Sex _____ Marital Status _____

Home Phone _____ Cell Phone _____

Work Phone _____

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)*

Employer _____

Occupation _____

Employer Address _____

_____

Spouse/Parent's Name _____

Date of Birth ____/____/____ Age _____ Sex _____ Relationship to Client _____

SS# _____/____/_____ Phone _____

Employed by _____ Phone _____

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 yes, where? _____

The following fields are **MANDATORY** 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.

Medical Insurance Company _____

Subscriber (name that appears on card) _____

Subscribers Date of Birth ____/____/____ SS# _____/____/_____

Relationship 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 SERVICES, INC.

# PATIENT FINANCIAL POLICY

Patient's Name _____ Date of Birth _____/_____/_____

Patient agrees to pay for all of their portions of service 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.

### REFERRALS

If your insurance requires a referral, it is your responsibility to get the necessary referral for our office in order for your services to be covered. If the referral is not received in a timely manner, your insurance may not back-date and it will then be your financial responsibility for the dates not covered until a referral is received.

### MEDICAID/MEDICARE

Our office accepts both Medicaid & Medicare. (Mental Health is not covered during your first 30 days of coverage. You will be responsible for all services that are not covered by your insurance.)

### 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.

### RETURNED CHECKS

We assess a $35 NSF charge for returned checks.

If not paid according to these 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 agree to the above terms and conditions.

_____ _____

Signature Date

MIDDLETOWN
COUNSELING SERVICES, INC.

# LIMITS OF PATIENT CONFIDENTIALITY

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 ins a public 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 _____

## RELEASE OF INFORMATION

In order to authorize Middletown Counseling Services to release or obtain information regarding any appointments being made, as well as information pertaining to psychological and emotional function, please see the front desk to fill out an authorization form.

## ACKNOWLEDGEMENT OF PRIVACY & SECURITY POLICY

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 e-mail 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 voice mail. 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 low or contractual obligation.

Signature _____ Date _____

Witness _____ Date _____

MIDDLETOWN
COUNSELING SERVICES, INC.

# FEE POLICY

## PLEASE READ CAREFULLY & SIGN

1. **Payment is expected at the time of service** and can be paid in cash, check, or credit/debit card. There will be a $35 fee for every returned check.

2. **Middletown Counseling Services charges a "No-Show" fee of $50.** If you are unable to keep an appointment, please give the office 24 hours advance notice to ensure that you will not be charged for the appointment. **Appointments not canceled 24 hours in advance are subject to a fee of $50.**

3. **All "No-Show" fees must be paid prior to next appointment in order to be seen.**

This policy applies to new and established clients and will be billed directly to the client/guarantor, NOT the client's insurance. 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 _____

MIDDLETOWN
COUNSELING SERVICES, INC.

# EMPLOYEE ASSISTANCE

If you have an Employee Assistance Program through your employer, please complete the following information:

Name of EAP Insurance Company _____

Phone of EAP Insurance Company _____

Authorization Number _____

How many visits are authorized? _____

Effective Dates: _____/_____/_____ to _____/_____/_____

I understand that if EAP information is not provided within 24 hours of appointment, my regular insurance company will be billed an I may be responsible for a co-payment or coinsurance deductible payment.

Signature _____ Date _____

MIDDLETOWN
COUNSELING SERVICES, INC.

**FOR YOUR RECORDS**

## PLEASE KEEP THIS PAGE FOR YOUR PERSONAL RECORDS

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 **$50 FEE** for appointments that are cancelled with less than 24 hours notice. You will also be charged a **$50 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 FEE FOR EVERY RETURNED CHECK**. If your account becomes delinquent, the outstanding balance will be sent to a collection agency and you will be responsible for the collection fees.

3. A therapist can be contacted 24 hours a day for emergencies by calling 302-668-8582. All phone calls **LONGER THAN FIVE MINUTES** will be billed at the rate of **$30 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-King, Owner or Megan Sartin, Co-Owner.

5. There is a **$65 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 our regularly scheduled therapy sessions, etc. Such requests for reports myst be submitted in writing with a **$65 DEPOSIT**. Any additional time required to complete your request over the first hour will be charged at $16.26 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 |
| 21-50 pages | $20 |
| Over 50 pages | $25 |

7. I understand that my professional relationship with Middletown Counseling Services 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.

MIDDLETOWN
COUNSELING SERVICES, INC.

Patient's Name _____ Date of Birth _____/_____/_____

**NOTE: After 2 missed appointments, we reserve the right to contact Medicaid about your missed appointments even though we cannot bill for them.**

Starting with your childhood and proceeding up to the present, list all diseases, illnesses, important accidents, and inuries, surgeries, hospitalizations, periods of loss of consciousness, convulsions, seizures, and any other medical conditions you have had. Please list your age at the time of the occurance, what the illness or diagnosis was, by whom you were treated, and the result of the treatments.

_____

_____

_____

_____

Please circle if there is any family history of any of the following: Mental Retardation, Epilepsy, Schizophrenia, Birth Defects, any Mental Health Diagnosis, or any serious health problems.

**Circle ANY of the following that may apply to you:**

| | | | | |
|---|---|---|---|---|
| Headaches | Dizziness | Depressed | Concentration Difficulties | Unable to Relax |
| Suicidal Ideas | High Fevers | Fainting Spells | Take Drugs | Pneumonia |
| Palpitations | Sexual Problems | Encephalitis | Bowel Disturbances | Stomach Trouble |
| Allergies | Convulsions | Anxiety | Don't Like Weekends & Vacations | |
| Head Inury | Fatigue | Over Ambitious | Vision Problems | No Appetite |
| Shy with People | Hearing Problems | Anger | Can't make Friends | Flu |
| Weight Problems | Take Sedatives | Inferiority Feelings | Can't have a Good Time | Insomnia |
| Anemia | Nightmares | Can't keep a Job | High/Low Blood Pressure | Feel Panicky |
| Memory Problems | Sinus Problems | Can't make Decisions | Often use Aspirin or Painkillers | |
| Hyperactivity | Home Conditions Bad | Conflict Tremors | Excessive Sweating | Lonely |
| Financial Problems | Accident Prone | Asthma | Feel Tense | Alcoholism |

Any other health issues: _____

_____

Please list any additional problems or difficulties here: _____

_____

Have you ever injected drugs? _____ Ever share needles? _____

Any family history of substance abuse? _____ If so, what substance? _____

Is your Father alive? _____ If yes, his age? _____ If deceased, when? _____ Cause of death? _____

Is your Mother alive? _____ If yes, his age? _____ If deceased, when? _____ Cause of death? _____

Are there any members of the family about whom information regarding illness, etc. is relevent? _____

_____

Is there any other health information you feel would be helpful for your therapist to know so he/she may better understand you? _____

| | | |
|---|---|---|
| May we leave a message at your home number?<br>If yes, Detailed: Call back number only: | Yes | No |
| May we leave a message on your cell phone?<br>If yes, Detailed: Call back number only: | Yes | No |
| May we leave a message on your work phone number?<br>If yes, Detailed: Call back number only: | Yes | No |
| May we email you written communications?*<br><br>If yes, email address: | Yes | No |

If "NO" to all above listed, how may we contact you regarding this information?

Please list any other restrictions regarding messages or reminders about your healthcare:

***DISCHARGE: If you are discharged from the practice, you can no longer schedule appointments, or consider the treating therapist as your provider. You will have to find another practice, which we can provide a list of agencies for you.***

Reasons for discharge include, but are not limited to:

- Failure to keep scheduled appointments/ frequent no shows or cancelling within 24 hours of an appointment
- Noncompliance, which means not following the treatment or providers instructions about important health issues, or disregarding the plan(s) the therapist has set forth to better help you achieve your goals.
- Being verbally or physically abusive to the provider or front desk staff.

Signature_____ Date _____