Dr. Michele Winchester-Vega & Associates
(845) 562-9816 Fax (845) 863-0351

3250 Route 9W
New Windsor, NY 12553

25 Main St, Suite 2-1
Goshen, NY 10924

Client Name:_____

WELCOME TO OUR OFFICE

The mission of our caring and compassionate professional staff is to provide welcoming, collaborative, evidenced based effective and cost effective treatment approaches to improve outcomes for those we serve. We respect the complexity and diversity of each individual/family served towards promoting improved mental health, wellness, self-determination, self-empowerment, and resiliency.

Please ask the Billing Coordinator if you have any questions about our fees, financial policy, or your requests in dealing with your insurance company. In order to have a satisfactory experience the following guidelines explain how we operate the business aspect of our practice. We are committed to providing you with the best possible care, and are available to discuss our professional services with you at any time. We want to know your experiences, so please feel free to provide feedback to our staff.

CONFIDENTIALITY

We recognize the privilege of confidential communication. By law, information about you will not be discussed with others, without your written consent and knowledge. If you request records to be released, your signature will be required.

I authorize Dr. Michele Winchester-Vega & Associates to contact me at:

☐ Cell Phone#_____ Can we leave a message? ☐ Yes ☐ No

☐ Home Phone#_____ Can we leave a message? ☐ Yes ☐ No

☐ Fax #_____

☐ Email address:_____
(Your email address should be set to privacy settings with encryption for HIPPA compliance)

☐ Text Messaging ☐ Yes ☐ No

Who referred you to our Practice?_____
How do you know them? _____
I would like you to speak with them about my treatment. ☐ Yes ☐ No Phone: _____

Why are you seeking treatment?

_____
_____
_____
_____

MEDICAL

1. Are you taking any over the counter or prescribed medications? _____

_____

2. Are you currently under the care of a health care professional (Dr.)? Name _____

HEALTH INSURANCE COVERAGE

If you would like us to bill your insurance company, we will do so as a courtesy to you**. Please notify us of both your primary and secondary insurance.** Any changes to your insurance coverage, including termination, must be brought to our attention. A change in insurance carriers will affect your benefits and payment schedules. Your therapist may be required to obtain pre-authorization for treatment services. If you fail to report any changes and insurance claims are subsequently declined for payment, you will be billed the regular session fee.

_____
Initials

In the event my insurance should send a payment directly to me instead of Michele Winchester-Vega & Associates practice, I will endorse the check and immediately forward to the therapist along with an explanation of benefits (which reflects the dates of services rendered) If I am unable to provide an endorsed check, (if check is for multiple providers), I will send payment for the same amount as issued by my insurance company.

I would like Billing Coordinator to bill my insurance company and will provide all billing information by 1st session.

I have primary insurance with _____

I have secondary insurance with _____

Teletherapy Sessions
I hereby consent to engage in teletherapy and have been given guidelines/informed consent form. _____ Initials

I understand that if a teletherapy session is used, it is my responsibility prior to session to verify my health insurance plan includes teletherapy._____ Initials

CANCELLATION AND MISSED APPOINTMENTS

Please keep all your scheduled appointments so your counselor can monitor your progress and treatment. Sessions are 45 minutes, unless otherwise agreed upon. Your time has been reserved for you. **Due to the overwhelming need for patient appointments, please cancel at least 24 hours prior to your scheduled appointment, so that we may offer that time slot to other patients**. **Missed appointments and late cancellations (less than 24-hours notice) will be billed at $75.00 out-of-pocket fee, as we are unable to bill your insurance for no shows**.

_____
Initials

PLAN BENEFIT AND ELIGIBILITY

It is your responsibility to contact your insurance company to verify coverage and benefit eligibility for outpatient mental health treatment. You need to verify your percentage of payment per visit, any copayments, or deductibles and limits of visits per calendar or benefit year. If you are accessing out-of-network benefits, it is important to confirm that this benefit is available to you. **The practice will make every effort to collect payment from your insurance company. However, you are ultimately responsible for the amount due.**

Fees are based on professional services provided and the amount for time involved. Please feel free to discuss finances openly with therapists and/or my Billing Coordinator. When multiple services are provided, fees for each service will be itemized (i.e., telephone sessions, preparation of special forms, reports, court time, etc.) The fee for these services should be discussed with us at the time of request, as some will not be covered by insurance.

All co-payments, co-insurance and deductibles are due for services at the time of the visit. Insurance contracts restrict us from waiving these amounts. We offer debit and credit card processing but there will be a 3.5% credit card fee that will also be charged, payment by personal check is also accepted. If a check is returned for insufficient funds, you will be charged the bank fee in addition to the amount of the check. If insurance benefits pay you directly, you must forward these checks to our office.

After the insurance company has paid their portion of your claim, should your financial responsibility be unpaid after 90 days (unless other financial arrangements have been made) the account will be turned over to a collection agency. Collection agencies charge 33% of the unpaid bill. Should these additional costs be incurred, you will be responsible for them in addition to any unpaid balance.

I authorize the release of any medical information necessary to my insurance carrier to process claims. I permit a copy of this authorization to be used in place of the original. I hereby authorize Michele Winchester-Vega, DSW, LCSW-R and Associates to bill and correspond with my insurance for services rendered. I request that payment from my insurance company be made directly to Dr. Michele Winchester-Vega & Associates. I certify that the information I have reported with regard to my insurance coverage is correct. I understand **that if I fail to** report any changes to my insurance coverage, including termination, I will be responsible for any unpaid balances on my account.

Please sign below indicating that you have reviewed and understand these guidelines. A copy of these procedures will be provided to you upon request.

_____ _____

Patient or Parent/Guardian Signature Date Therapist's Signature Date

Patient Name:_____ DOB:_____ Date:_____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0 ☐	1 ☐	2 ☐	3 ☐
2. Not being able to stop or control worrying	0 ☐	1 ☐	2 ☐	3 ☐
3. Worrying too much about different things	0 ☐	1 ☐	2 ☐	3 ☐
4. Trouble relaxing	0 ☐	1 ☐	2 ☐	3 ☐
5. Being so restless that it's hard to sit still	0 ☐	1 ☐	2 ☐	3 ☐
6. Becoming easily annoyed or irritable	0 ☐	1 ☐	2 ☐	3 ☐
7. Feeling afraid as if something awful might happen	0 ☐	1 ☐	2 ☐	3 ☐
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐
Somewhat difficult ☐
Very difficult ☐
Extremely difficult ☐

Scoring

Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD. It is moderately good at screening three other common anxiety disorders - panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%) and post-traumatic stress disorder (sensitivity 66%, specificity 81%).

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Client Name_____

Today's Date_____

INTAKE PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble falling or staying asleep, or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐ 0	☐ 1	☐ 2	☐ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐ 0	☐ 1	☐ 2	☐ 3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐ 0	☐ 1	☐ 2	☐ 3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Name:_____ Date:_____

Brief Trauma Questionnaire

The following questions ask about events that may be extraordinarily stressful or disturbing for almost everyone. Please circle "Yes" or "No" to report what has happened to you.

If you answer "Yes" for an event, please answer any additional questions that are listed on the right side of the page to report: (1) whether you thought your life was in danger or you might be seriously injured; and (2) whether you were seriously injured.

If you answer "No" for an event, go on to the next event.

Event	Has this ever happened to you?	If the event happened, did you think your life was in danger or you might be seriously injured?	If the event happened, were you seriously injured?
1. Have you ever served in a war zone, or have you ever served in a noncombat job that exposed you to war-related casualties (for example, as a medic or on graves registration duty?)	No	No	No
2. Have you ever been in a serious car accident, or a serious accident at work or somewhere else?	No	No	No
3. Have you ever been in a major natural or technological disaster, such as a fire, tornado, hurricane, flood, earthquake, orchemical spill?	No	No	No
4. Have you ever had a life-threatening illness such as cancer, a heart attack, leukemia, AIDS, multiple sclerosis, etc.?	No	No	N/A
5. Before age 18, were you ever physically punished or beaten by a parent, caretaker, or teacher so that: you were very frightened; or you thought you would be injured; or you received bruises, cuts, welts, lumps or other injuries?	No	No	No
6. Not including any punishments or beatings you already reported in Question 5, have you ever been attacked, beaten, or mugged by anyone, including friends, family members or strangers?	No	No	No
7. Has anyone ever made or pressured you into having some type of unwanted sexual contact? Note: By sexual contact we mean any contact between someone else and your private parts or between you and some else's private parts	No	No	No
8. Have you ever been in any other situation in which you were seriously injured, or have you ever been in any other situation in which you feared you might be seriously injured or killed?	No	N/A	No
9. Has a close family member or friend died violently, for example, in a serious car crash, mugging, or attack?	No	N/A	No
10. Have you ever witnessed a situation in which someone was seriously injured or killed, or have you ever witnessed a situation in which you feared someone would be seriously injured or killed? Note: Do not answer "yes" for any event you already reported in Questions 1-9	No	N/A	N/A

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25 Main St., Suite 2-1, Goshen, NY 10924
Tel: (845) 562-9816 Fax: (845) 863-0351
www.winchester-vega.com

Teletherapy Informed Consent Form

I _____ (client) hereby consent to engage in teletherapy with Dr. Michele Winchester-Vega & Associates, PLLC. I understand that "teletherapy" includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical/mental information, both orally and visually. I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. Unless explicitly agreed otherwise, the teletherapy exchange is confidential. Any personal information I choose to share will be held in the strictest confidence. The laws that protect the confidentiality of my medical information also apply to teletherapy. Just as with face-to-face clients, the clinician will not release your information to anyone without your prior approval, or required to do so by law. In New York mental health providers are required to notify authorities if they become convinced a client is about to physically harm someone; or if they are abusing, or about to abuse, children, the elderly, or the disabled.

3. You understand that this teletherapy occurs in the state of New York, (USA), and is governed by the laws of that state. In a manner of speaking, you use modality to visit the clinician in his/her New York office.

4. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the clinician, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

5. In addition, I understand that teletherapy based services and care may not be as complete as face- to-face services. I also understand that if the clinician believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a I will be referred to a professional who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychologist, my condition may not be improve, and in some cases may even get worse.

Cont.

6. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.

7. I accept that teletherapy does not provide emergency services. During our first session, the clinician and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support.

8. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session, (4) if I decide to keep copies of emails or communication on my computer, it is up to me to keep that information secure.

9. I understand that while email may be used to communicate with the clinician, confidentiality of emails cannot be guaranteed.

10. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law. I have read, understand and agree to the information provided above.

Client Name: _____ Client Signature:_____

Date:_____

Dr. Winchester-Vega + Assoc.
3250 US RT9W
New Windsor, NY 12553

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? * YES ☐ NO ☐ *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

***Secondary Insurance**

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER
1						
2						
3						
4						
5						
6						

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, complete items 9, 9a, and 9d.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Dr. Michele Winchester-Vega & Associates

3250 Rte 9W, New Windsor, NY 12553
Office Phone: (845) 562-9816 | Billing Phone: (800) 819-7570 option 4

Patient Demographic Update Form

We are currently updating all patient files with our new billing staff. Please provide the most current information regarding yourself, and your insurance company.

Client		Date of Birth	
Email		Address	
Phone		City State Zip	
Parent / Guardian		Email	
Relationship to Client		Phone	
Insurance Company		Policy Number	

Patient Information Regarding Credit Card on File Policy

We have implemented a policy requiring a credit card held on file. As you may be aware, the current healthcare market has resulted in insurance policies increasingly transferring costs to you, the insured. Some insurance plans require deductibles and copayments in amounts not known to you or us at the time of your visit. Similar to hotels and car rental agencies, you are asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share, then you will receive a statement.This card can be charged for the following reasons:

-Copays, Coinsurances, and Deductibles
-No show or late cancellation charges ($75)
-Insurance discrepancies that are not resolved within 90 days of the date of service
-Outstanding balance greater than 90 days past due

Client's Name		Cardholder's Name	
Email		Phone Number	
BIlling Address		City, State, Zip Code	
Credit Card #		Expiration Date	
CVV			

By signing this form, I am authorizing IOUBilling to charge my credit card for copays the morning after the session, and any balances that are left after insurance payments.

Signature:_____

Relationship to Patient: _____ Date:_____/____/_____

Office Use Only
Client ID_____