Intake Information

Date: ____/____/ 20_____

Name: _____
(first) *(middle)* *(last)*

Preferred Name/Pronouns: _____ **G ender:**_____

Date of Birth: _____/_____/_____ **Age:** _____ **SSN** *(for insurance purposes)*: _____-_____-_____

Current Address: _____
(street) *(city and state)* *(zip code)*

Current Phone Number(s):_____
(please include area codes)

Email Address: _____

Health Insurance policy holder's name and date of birth: _____

Parent name and phone number, if for a minor: _____

Emergency Contact: _____
(name) *(relationship)* *(phone with area code)*

Military History: _____
(Branch of Military) *(Discharge Status)* *(Discharge Date)*

THIS SECTION IS FOR OFFICE USE ONLY

Diagnostic Codes	Procedure Codes
	90791 – Intake Session

THIS SECTION IS FOR OFFICE USE ONLY

Updated Diagnostic Codes	Procedure Codes
	CPT Code
	CPT Code
	CPT Code
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Psychotherapy & Forensic Services, LLC
Informed Consent & Policies

The following information is provided to you to assist you in understanding the policies and procedures at this office. I wish to provide you care that is both comfortable and has the highest quality. Please do not hesitate to ask questions of your therapist.

Appointments
Since clients are seen by appointment only (unless an urgent situation dictates otherwise), the appointment time given is reserved for you. Please give a minimum of a 24-hour notice if you must cancel your reserved time. You will be charged a $95.00 fee for appointments that are missed or not canceled 24-hours prior to your appointment time. Please understand that you are fully responsible for any charge due to a missed appointment.

Emergencies and Telephone Calls
While you will be seen at a reserved time which fits your schedule demands, there may arise occasions where you need to talk to me between appointments. Should you need to talk to me in between appointments and during normal office hours, I will return your call as promptly as I can. If it is a life-threatening or otherwise urgent issue, I encourage you to call 911, call Mobile Crisis 865-539-2409, and/or go to the nearest emergency room. There is not emergency on call coverage.

Fees for Service
All accepted forms of insurance claims will be filed through Billing Specialist, Kim Judkins, (865) 579-2694. Co-payments, deductibles, and/or private payments are due upon your arrival. Please read, initial, and sign the *Service Payment Agreement* for details regarding additional fees.

Insurance Usage and Issues of Confidentiality
Psychotherapy & Forensic Services' Billing Specialist, Kim Judkins, will file insurance claims for you once you authorize us to do so and provide the necessary information for filing such claims. In filing insurance claims, you are granting Psychotherapy & Forensic Services and Kim Judkins permission to reveal confidential information, such as the dates you were seen, length of the appointments, and your diagnoses. Your insurance carrier requires this type of information for filing claims that are to be covered by your benefits program.

Additionally, most insurance companies perform an audit and/or utilization review of your treatment progress in order to approve additional sessions. Nearly all companies require participation in outcome and quality care studies such as patient satisfactory surveys. If your carrier requires such activities in order for you to use your insurance, I will comply with those requirements. It is my responsibility to inform you of potential compromises of your privacy and confidentiality. The compromising of your privacy and confidentiality is standard in today's marketplace whenever one elects to use third party insurance coverage for services.

Privileged Communications
Fortunately, Federal HIPAA regulations do provide you with an increased degree of privacy and confidentiality regarding your protected health information (PHI). Therapists are bound by a strong privileged communication law in Tennessee, which carries the same legal right status as that of attorney-client communications. What you talk about in your established relationship with me is protected by privilege communication laws and confidentiality principles, with the exception of certain specific actions (i.e. clear and imminent danger to self and/or others, suspected child or elder abuse, worker's compensation related cases, if your psychiatric or psychological health becomes an issue in a lawsuit, whatever information is shared in utilization review reports for authorization of care, and/or compliance with audits by your insurance carrier).

Privileged Communications cont.

With these exceptions, unless you specifically sign a release of information authorizing me to speak with someone regarding your treatment, all communications here are kept private, confidential, and are privileged. You may revoke a release of information at any time by submitting in writing your wishes to do so. Once a revocation is received by me, communications between myself and the identified party will immediately cease. Otherwise, all releases of information automatically expire one year from the date you signed the document.

Use of Technology

Sessions are primarily conducted face-to-face. Under *rare or unusual circumstances*, sessions can be conducted by phone or through a HIPAA compliant video program. When this occurs, your therapist cannot guarantee your confidentiality of information due to the session taking place outside of the office environment. Therefore, it is important that you consider securing your environment to ensure your protection. Regarding communication, unless you specifically disagree, your therapist may contact you via telephone and voicemail, text message, email and/or delivered mail. Your therapist will not audio or video record your sessions without your signed consent. Your therapist will utilize HIPAA complaint electronic communications services. Your therapist will not engage in communications or public acknowledgment of the therapeutic relationship via social media.

Your Informed Consent to Care

According to the Tennessee Annotated Legal Code (33-3-104), the following individuals may provide consent for care and for the disclosure of information: "The service recipient who is sixteen (16) years of age or over; The conservator of the service recipient; The attorney in fact under a power of attorney who has the right to make disclosures under the power; The parent, legal guardian, or legal custodian of a service recipient who is a child; The service recipient's guardian ad litem for the purposes of the litigation in which the guardian ad litem serves; The treatment review committee for a service recipient who has been involuntarily committed; The executor, administrator or personal representative on behalf of a deceased service recipient; The caregiver under title 34, chapter 6, part 3; An individual acting as an agent under the Tennessee Health Care Decisions Act, compiled in title 68, chapter 11, part 18 or a person's surrogate as designated under title 68, chapter 11, part 18."

Photography, video and/or audio recording devices of any kind are not allowed during sessions without the explicit consent of the session therapist. The purpose of this restriction is to protect the therapeutic process and all individuals who are participating in therapy sessions. If a therapist has determined and/or discovered that therapy participants are recording a session without the consent of all individuals (therapist, client, family members, etc.), then the person responsible for recording the session(s) will be dismissed from Psychotherapy & Forensic Services without an opportunity to return during a later date.

X _____ _____

Signature acknowledging the restriction of recording devices during sessions **Date**

I have provided this information to you in the hope of fully informing you about the policies of our office and some of the parameters of care you will receive here, such as the importance of confidentiality. Psychological care, like other things in life, offer no absolute guarantee of success and there are limitations to any form of care offered a patient. By signing below, you acknowledge having read, understood, and agree to these policies and procedures. Your signature acknowledges your informed consent for care with your provider.

X _____ _____

Signature acknowledging informed consent **Date**

Psychotherapy & Forensic Services, LLC

Service Payment Agreement

Please provide the following information about the financially responsible person ☐ Self ☐ Other

Name:_____ DOB:_____ SS# _____

Phone: (Cell) _____ (Home) _____ (Work) _____

Billing Address: _____

Email Address:_____

PLEASE READ AND INITIAL EACH LINE

_____ I understand that Psychotherapy & Forensic Services **requires keeping my debit/credit card on file via Square Inc., as a convenient method of payment for any balance that is due.** This includes but is not limited to deductibles, copays, coinsurance, fees for missed appointments, fees for billable work, & balances that are not covered by my insurance carrier, but for which I am liable. If utilizing insurance &/or EAP (Employee Assistance Program), charges to my debit/credit card are made only after claims have been filed & processed by your insurer &/or when it has been determined by Consulting Billing Representative, Kim Judkins, that there is a balance due. If utilizing private-pay, charges to my debit/credit card are made at the time services are rendered &/or when it has been determined by Consulting Billing Representative, Kim Judkins, that there is a balance due.

_____ I, the undersigned, authorize Psychotherapy & Forensic Services **to charge the portion of my bill that is my financial responsibility**, to my debit/credit card on file. I understand that my debit/credit card will be charged when there is a balance due & I will not seek a charge back. I agree to inform Psychotherapy & Forensic Services about changes/updates to my debit/credit card information. I understand that a $50.00 fee will be added to my account if my credit card is declined.

_____ **I understand that the billed rate is $95.00** & I am responsible for paying the full fee, the deductible, the copay/coinsurance, fees for missed/late canceled appointments, fees for billable work, & any balance due that is not covered by my insurance/EAP carrier. Payment for any charges denied or not covered by my insurance company become my responsibility & I agree to pay these charges.

_____ I understand & agree that **I will be required to pay for appointments that are not canceled at least 24 hours prior** to my scheduled appointment time (late cancellation) **&/or for missed appointments** (no show). The fee for a late cancellation or missed appointment is $95.00.

_____ **I understand that if I no-show or late cancel appointments repeatedly**, I will be responsible for the $95.00 fee for each session missed & I understand that I may be dismissed from therapy for non-compliance with treatment.

_____ **I understand that time spent during phone calls to/from my therapist &/or on my behalf with another entity is billable** at the rate of $95.00 per hour, which can be prorated for time less than 60 minutes.

Psychotherapy & Forensic Services, LLC

Service Payment Agreement

_____ Should it become necessary to summon an employee of Psychotherapy & Forensic Services into Court or into any professional organization, I understand that I am responsible for payment at the rate of **$250.00 per each hour** that the employee of Psychotherapy & Forensic Services is required to be present. This amount will be due regardless of whether or not a testimony is provided. **I understand that a deposit payment of $750.00 is due** prior to an employee of Psychotherapy & Forensic Services' appearance in court. I understand that, should an employee of Psychotherapy & Forensic Services provide a testimony, all materials in the medical record remain the property of Psychotherapy & Forensic Services. I realize that such action could require a release of information to attorneys, court, &/or other organizations, for the sharing of information which identifies the parties involved, identifies diagnoses, & describes the dates & nature of treatment, as well as all other information discussed during treatment.

_____ I understand & agree that any documents which may be requested by a court system, probation &/or parole officers, law enforcement, therapists or other treatment agencies, or any other professional or government entity, will not be released without my consent. I also understand & agree that Psychotherapy & Forensic Services **will not release any requested documents, regardless of consent, if I currently have an overdue balance** for rendered services.

_____ I understand & agree that **requested documents, such as letters written by an employee of Psychotherapy & Forensic Services, on my behalf** to any court system, therapist, insurance company, other medical provider, probation/parole officers, attorneys, law enforcement, or any other professional or government entity will incur an additional charge that i**s not covered by my insurance/ EAP**. I understand that **the fee is $95.00-$250.00** to compensate for time spent writing, editing & communicating with the entity for which the document(s) are to be shared. **I understand this fee is due prior to the release of the document(s).**

_____ Should it become necessary to employ a collection agency &/or the courts in the event of delinquent payment, it is specifically agreed that **I will pay all such costs**, including reasonable attorney's fees & court costs (35% or more of the balance). All materials in the medical record remain the property of the Psychotherapy & Forensic Services. I understand that efforts to collect on any debt owed by me requires that the following information become released to the collection agency, attorneys, and/or the courts: information which identifies the parties involved, gives the patient diagnoses, & describes the dates & nature of the charges, as well as all other information contained on any claim filed.

_____ I understand that a 2% per month interest charge will be added onto accounts that are **not paid within 30 days** of the date services are rendered.

_____ I understand that billing for Psychotherapy and Forensic Services is provided by Consulting Billing Representative, Kim Judkins. I understand that demographic and diagnostic information will be shared with my insurance company (if filing through your insurance) & with Consulting Billing Representative, Kim Judkins.

_____ I understand that for utilization review, quality assurance, & other claims review purposes, my insurance/EAP company may conduct an audit that may require my therapist to provide the following confidential information: case history, presenting problem(s), or treatment plan(s), progress diagnoses, dates & type(s) of service(s) rendered.

_____ _____

(Client Signature) **Date**

_____ _____

Parent or legal guardian of patient less than 16 years of age or responsible party **Date**