Sacks Clinical Consulting PC, PC, PC

☐ Dr. Sacks, Ph.D ☐ Dr. Samelson, Ph.D ☐ Dr. Meyer, Psy.D. ☐ Dr. Niemi, Psy.D.

Client Information: (Please Print)

Last Name: ________________________ First Name: _______________________ MI ______

Street Address:________________________________ City, State, Zip: ________________________________

Date of Birth: _______________ SSN: __________________________ Age: _______ Gender:_________

Home Phone: ________________ Cell Phone: ________________ Email Address: ____________________
Okay to leave a message at home? ☐ Yes ☐ NO Okay to leave message on cell? ☐ Yes ☐ No Okay to text to cell phone? ☐ Yes ☐ No

Current Status: ☐ Employed ☐ Retired ☐ Student Marital Status: ☐ Married ☐ Single ☐ Other

Client Employer/City/State: ______________________ Client School and Grade Level: ___________________

Current Medications and Prescribing Doctor: ____

If Minor, Parent Information:

Father: ____ Address, City, State, Zip: ____________________________________

Home Phone: ___________________ Cell Phone: ___________ SSN: _____________________ Date of Birth: ______________

Employer/Employer Phone: ____

Mother: ____ Address, City, State, Zip: _______________________________

Home Phone: ___________________ Cell Phone: ___________ SSN: _____________________ Date of Birth: ______________

Employer/Employer Phone ____

Guardian: ____ Address, City, State, Zip: _______________________________

Home Phone: ___________________ Cell Phone: ___________ SSN: _____________________ Date of Birth: ______________

Employer/Employer Phone ____

Insurance:

Primary

Insurance Company Name: __________________________ Policy Holders Name: _____________________________

Policy Holders Date of Birth: _________________________ Policy Number: ___________________________________

Group Number: ___________________________________ Pre Certification Required?: ____________ Co Pay_______

Secondary

Insurance Company Name: __________________________ Policy Holders Name: _______________________________

Policy Holders Date of Birth: _________________________ Policy Number: ___________________________________

Continue on reverse side.

What brings you here today?

- ☐ Anxiety
- ☐ Depression
- ☐ Grief
- ☐ Relationship Concerns
- ☐ Parenting/Coaching
- ☐ Other

Please list current concerns:

1. ____

2. ____

3. ____

What are you hoping to accomplish with therapy?

____
____
____

Who may we thank for referring you to Sacks Clinical Consulting PC, PC?

____
____

Have you previously been in therapy?

When: ____

Where: ____

Sacks Clinical Consulting PC (SCC)
2020 Terms and Conditions

Welcome to Sacks Clinical Consulting PC. This document contains important information about our professional services and business practices. Please read it carefully and let us know if you have any questions. When you sign this document, it will represent an agreement between us.

PAYMENT
Co-Payments and other charges not covered by insurance are expected at the time of service. You are responsible for keeping your account current, not your insurance company. **SCC asks that you provide a credit card to pay your co-payment, co-insurance or payment in full. I give permission to use this card for any balance over 30 days. All unpaid balances must be paid prior to any appointments being scheduled.** Please ensure that your credit or debit card/HSA card or other financial information is always accurate and current.

INSURANCE AND THIRD-PARTY PAYMENT
Please contact your insurance company prior to treatment to confirm that SCC is an in-network provider. Pre-certification/authorization may also be necessary and should be taken care of prior to your first appointment. SCC can assist you with this process. **For Out-of-Network Insurance companies, full payment will be required at the time of service. Any unmet In-network Deductibles must be paid at the time of service.**

CANCELLATION POLICY
We request 24 hours' notice for cancellations. Cancellations made prior to this window are rescheduled with no penalty. Cancellations made without 24 hours' notice but prior to the start of the session time incur a $50 late-cancellation fee. No-shows or cancellations made after the start of the session time incur the full fee.

Initial Here ________

COMMUNICATION
SCC will communicate non-HIPPA (i.e. non-confidential) information via e-mail or text message. We use email and text messaging for purposes such as scheduling appointments, billing matters, etc. Please do not email or text information about clinical matters as it is not a secure way to communicate. We also do not communicate through social media venues. Regular office hours are Monday – Friday beginning at 9:30 a.m. Testing & Therapy Sessions are by appointment only. We will make every effort to return your call within 24 hours if you call outside of regular office hours. If you have an emergency and you are unable to reach us, please report to the nearest emergency room.

HIPPA PRIVACY NOTICE ACKNOWLEDGEMENT
I understand that I have been given an opportunity to read a copy of Privacy Practices provided by SCC. I understand that if I have any questions, I can direct them to SCC.

CONFIDENTIALITY
You have the absolute right to the confidentiality of your therapy. SCC cannot and will not disclose to anyone that you are a client of SCC or any session content without your written permission. The following are legal exceptions to your right to confidentiality. SCC will inform you when these are put into effect.

- If a minor child is at risk of being abused or neglected.
- If you present an imminent risk of serious injury to yourself.
- If you threaten serious harm to another person.

You should also be aware that most insurance companies require you to authorize SCC to provide them a clinical diagnosis. Sometimes we must provide additional clinical information such as treatments plans, summaries or copies of the entire record (in rare cases). This information will become part of the insurance company files.

TREATMENT OF MINORS
The custodial parent, the only one who can legally authorize treatment, is responsible for all fees incurred. If there is joint legal custody, the parent who is presenting the child for treatment is responsible for making the financial arrangements for all fees incurred and sign for permission to treat the minor. Parents may be required to show proof of custody.

AGREEMENT
These terms and conditions shall be incorporated by reference and shall prevail as the Client's Agreement with Sacks Clinical Consulting PC (SCC). SCC makes no warranty or guarantee, express or implied, with respect to any services performed by SCC.

Initial Here ________

RELEASE OF INFORMATION TO THIRD PARTY PAYORS/AGENTS, AUTHORIZATION AND ASSIGNMENT OF BENEFITS AGREEMENT FOR PAYMENT OF SERVICES AND RELEASE OF INFORMATION TO REFERRING PHYSICIANS:

I authorize Sacks Clinical Consulting PC to disclose portions of the clinical record on the client named below to my insurance company and/or its contracted managed care/utilization review company for the purpose of reimbursement of services rendered at this facility. Such disclosure may include review and release of copies of the psychological and/or substance abuse diagnosis, history and physical examinations, intake assessment, treatment plan, progress notes, discharge summary and any other information or records reasonably necessary for the discharge of the legal contractual obligations of the insurance company. In addition, I hereby authorize Sacks Clinical Consulting, PC to disclose evaluation reports and coordination of care to referring Physicians for Psychological Evaluations, Psychological Testing and ongoing treatment.

I hereby release Sacks Clinical Consulting PC, its officers, agents, employees and any clinician associated with my case from all liability that may arise as a result of the disclosure of information to the insurance company and/or its contracted managed care/utilization review company.

By signing this release, I acknowledge the following:

1. I am aware that I may revoke this authorization at any time except to the extent that action has been taken in reliance hereon.
2. I agree that this authorization will be valid during the pendency of the claim.
3. I further authorize that payments be made to Sacks Clinical Consulting PC on my behalf.
4. I understand that I am financially responsible for all charges not covered by insurance and/or those stated to be client responsibility by the third-party payor.
5. I understand that any expense that is incurred by Sacks Clinical Consulting PC, associated in collecting the balance on the account, such as collection fees and/or attorney's fees will be my responsibility to pay.
6. I understand Sacks Clinical Consulting, PC and its Clinicians may release Clinical Documents, Notes and Diagnosis to VirtualConsult, MD and its Staff to assist in coordination of care, provided I am a patient of both parties.

Name (Print):____ Date: _________________

Signature: ____

MEDICARE/MEDICAID AUTHORIZATION AND ASSIGNMENT OF BENEFITS:

I request that payment of authorized Medicare benefits be made on my behalf for services provided by Sacks Clinical Consulting PC. I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefits for related services.

Name (Print) ____ Medicare Number: _______________

Signature: ____ Date: ______________________

ENTIRE AGREEMENT
This agreement contains the entire agreement between the parties and there are no agreements, representations, statements or understanding which have been relied on by the parties which are not contained herein.

Your signature below shows that you have read and understood the above information.

Patient____ Date: ___________________

I authorize treatment of my minor child:
Patient/Guardian Signature: ____ Date:___________________