ORANGE COAST
Psychological Associates, P.C.

10061 Talbert Avenue, Suite 104, Fountain Valley, CA 92708. Phone: (714) 965-3622 / Fax: (714) 965-3672

NEW CLIENT INFORMATION

PATIENT NAME: _____ TODAY'S DATE: _____

DATE OF BIRTH: _____ SEX:____ MARITAL STATUS:_____

HOME ADDRESS: _____ CITY/STATE/ZIP:_____

HOME PHONE: _____ CELL PHONE:_____

STUDENT STATUS: ____Nonstudent ____Full Time ____Part Time ____Unknown

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Person financially responsible for payment of services and/or subscriber of the primary insurance plan:

SUBSCRIBER:_____ HOME ADDRESS:_____

CELL PHONE:_____ CITY/STATE/ZIP_____

HOME PHONE:_____ BUSINESS PHONE:_____

OCCUPATION/TITLE:_____ EMPLOYED BY:_____

SUBSCRIBER DATE OF BIRTH:_____ POLICY ID NUMBER:_____

INSURANCE COMPANY:_____ PLAN NAME/GROUP #:_____

Subscriber relationship to patient: ____Self ____Parent ____Spouse ____Dependent ____Other

Employment: ____Full Time ____Part Time ____Not Employed ____Retired ____Other

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Below For Office Use Only:

Provider Name:_____ Co Pay:_____

Services: ____Individual ____Family ____Testing ____Group ____Other

Diagnosis Code:_____ Description:_____

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THERAPISTS: PLEASE ATTACH COPY OF INSURANCE CARD (front & back) TO THIS FORM.

Office Policies and General Information Agreement to Provide Psychological Services

CONFIDENTIALITY

All written or spoken material from any and all sessions, including psychological testing, will be considered confidential unless:

1. The patient authorizes release of information with his/her signature.
2. The patient presents a physical danger to self.
3. The patient presents a danger to others.
4. Child/elder abuse/neglect is suspected.

In the latter two cases, psychologists are required by law to inform potential victims and legal authorities so that protective measure can be taken. It is understood that cases are sometimes discussed among professionals for educational, consultation and/or research purposes. Text messaging is not considered HIPPA compliant, and is held under unprotected information.

Health Insurance: Disclosure of confidential information may be required by your health insurance carrier or HMOs, PPOs, MCOs, or EAPs in order to process claims. This office has no control or knowledge over what insurance companies do with the information submitted or who has access.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to matters which may be of a confidential nature, **it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.), neither you (clients) nor anyone else acting on your behalf will call on your therapist or agents of this office to testify in court or at any other proceedings, nor will a disclosure of the psychotherapy records be requested.**

CONSENT FOR TREATMENT

I authorize and request that my therapist(s) at Orange Coast Psychological Associates, P.C., carry out psychological examinations, treatments, and/or diagnostic procedures that now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable. I am aware that therapists are independent contractors and are not employees of Orange Coast Psychological Associates, P.C..

TERMINATION

If at any point your therapist determines that he/she is not able to provide the exact services you require, this will be discussed with you and, if appropriate, treatment will be terminated. In such a case, you will receive a number of referrals that may be of help to you. You have the right to terminate therapy at any time. If you choose to do so, you will be provided with names of professionals whose services you might prefer.

DUAL RELATIONSHIPS

Therapy never involves sexual or business relationships; nor does it involve any other dual relationship that can be exploitive in nature or that can impair your therapist's objectivity, clinical judgment or therapeutic effectiveness.

RELEASE OF INFORMATION

I authorize the release of information for claims, certification/case management, and other purposes related to the benefits of my Health Plan.

NOTICE OF PRIVACY PRACTICES

A notice of privacy practices in compliance with the Health Insurance Portability and Accountability Act (HIPAA), describing how information may be used and disclosed and how you can get access to this information is provided to you. Please review it carefully.

****I have received the Notice of Privacy Practices. I have been provided an opportunity to review it.**

I understood and agree to all of the above information.

_____

PRINTED Patient (or Parent/Guardian Name)

_____ _____

SIGNATURE Patient (or Parent/Guardian) DATE

FEE AGREEMENT

MANAGED CARE, HMO, PPO, POS, IPA

INSURANCE AS PAYMENT FOR SERVICES:

Upon verification of your eligibility and benefits, your insurance carrier will be billed for you. **The patient will be responsible for any applicable deductibles and copayments at the time of service.** If you are not eligible at the time services are rendered or if your insurance carrier does not authorize services, you are responsible for payment. **All fees are to be paid at the time of service.**

PROFESSIONAL FEES: SERVICES COVERED BY INSURANCE PLAN

Consultation or Intake (Initial Visit)_____ Co-pay set by plan

Individual, Family, Marital, or Group Psychotherapy_____ Co-pay set by plan

Telephone Therapy/Consultation_____ Co-pay set by plan

Psychological Testing (including scoring and interpretation)_____ Co-pay set by plan

The fees for all services listed above are negotiated between Orange Coast Psychological Associates, P.C., and your insurance carrier. In no case will you be asked to pay more than your co-pay as set in your insurance plan. Your therapist operates as an independent professional and he/she is responsible for negotiating your fees, other than those set by contract with your insurance carrier. If you have any questions regarding your fees, discuss them with your therapist.

ADMINISTRATIVE FEES:

Returned Check_____$15.00

Document Copy Services_____$15.00+ (15 cents/copy)

CANCELLED/MISSED APPOINTMENTS

Sessions normally are scheduled for 45-55 minutes. A scheduled appointment means that time is reversed only for you. If an appointment is missed or canceled with less than 24 hours notice, the patient will be billed as determined by each therapist. This charge cannot be billed to your insurance plan.

DELINQUENT ACCOUNTS

If accounts become delinquent (past 30 days) our office will begin collection procedures. We will attempt to contact you directly. If your account remains delinquent (past 90 days) an outside collection agency may be used and/or small claims court action taken. In such cases, non clinical information may be released to assist in the collection of the amount due. Patient will be responsible for all court and legal fees incurred if above action is necessary. A fee of one and one half percent per month (18% per year) may be added to all outstanding accounts in excess of thirty days.

Print Client Name_____

Date_____

Signature of Person Financially Responsible_____