PATHWAY CENTER

for Psychotherapy

Robert P. Roney, D.Min

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INDIVIDUAL INFORMATION FORM

Patient's
Full Name: _____ Today's Date: ____/____/____

Address: _____ City/State: _____ Zip: _____

Social Security Number: _____ For Insurance Purposes: Married Single Other

Age: _____ Birth Date: _____ Email: _____

Telephone: Home:_____ Work: _____ Cell: _____

Emergency Contact Name: _____ Number: _____

Employer and Occupation: _____

Education: _____

Spirituality/Religious Preference: _____

How important are spiritual/religious matters to you?

☐ Not Important ☐ A Little Important ☐ Very Important

Who is your regular physician? _____

List of Medications: _____

☐ I give my therapist permission to inform my physician that I am receiving treatment from my therapist *(if checked, please provide contact information for your physician)*

Physician's Address: _____ City/State: _____ Zip: ____

Physician's Telephone: _____

Describe any major health problems you have had: _____

_____

List medications you use regularly: _____

Do you smoke: _____ Now _____ In past
Do you use caffeine? _____ Now _____ In past
Do you drink Alcohol _____ Now _____ In past
If now, about how many drinks per day? _____ Per week? _____
Have you ever tried to stop drinking? _____
Has anyone ever told you they had a problem with your drinking? _____
Have you ever been treated for alcohol use or abuse? _____
If yes, where and when? _____

Do you use any other substances? _____ Now _____ In past
If now, which substances and how often? _____
Have you ever had treatment for substance abuse? _____
If yes, where and when? _____

Describe your reason for seeking help: _____

_____

_____

What efforts have you made to handle the problem? _____

_____

_____

Do you see any other person as being involved in your problem? _____

If so, who? _____ Relationship _____

How? _____

To whom have you turned to for help or support? _____

How were they of assistance? _____

Who suggested you contact us? _____

Have you ever received psychiatric or psychological help or counseling of any kind before? ____

When and where? _____

Please circle any of the following problems that pertain to you:

Nervousness	Depression	Alcohol Use	Temper	Shyness
Friends	Suicide	Children	Separation	Divorce
Self-Control	Appetite	Drug Use	Nightmares	Marriage
Sexual Problems	Anger	Finances	Being a parent	Fears
Stomach trouble	Unhappiness	Career Choices	Stress	Sleep
Relaxation	Headaches	Bowel Troubles	Legal Matters	Work
Concentration	Inferiority	Energy	Insomnia	Memory
Decisions	Loneliness	Unusual sounds	My thoughts	Ambition
Education	Unusual visuals	Health problems	Tiredness	

Please list any other problems not on this list: _____

Please list members of your family and others in your home:

Name	Age	Relationship	Occupation

INSURANCE COVERAGE: _____

Policy Number: _____ I.D. No. _____

AGREEMENT FOR THERAPY

1. Therapy sessions are scheduled, as much as possible, for your convenience. Therefore, cancellations should be made at least 24 hours in advance, or you will be billed for the session.

2. Therapy sessions will be 50 minutes in length unless otherwise agreed upon by you and your therapist.

3. Payment for services are due at the time they are rendered unless prior arrangements are agreed upon with your therapist. If you have insurance coverage that will apply to the cost of your therapy, your therapist will cooperate in providing any appropriate information and signatures required.

4. There will be a monthly administrative fee of five ($5.00) dollars for those patients who have their insurance filed by our office. This charge will appear on your account at the first of every month. Unfortunately, insurance companies will not cover administrative costs. You, the patient, will be responsible for this five dollar fee. Some insurance companies give you the choice as to who files their insurance – you do have that option.

5. If we are unable to collect payment from you (or your insurance company), the bill will be forwarded to a collection agency.

6. By signing this form, I acknowledge that I have read, understand, and agree to the above, including a treatment plan of psychotherapy to address the presenting problem.

_____ _____

Signature Date

Pathway Center for Psychotherapy

OUTPATIENT SERVICES CONTRACT
For Robert P. Roney, D. Min.
And those under supervision of Dr. Roney

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

COUNSELING AND PSYCHOTHERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and patient and the particular problems you will bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you have experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money and energy, so you should be very careful about the therapist you select. If you have any questions about my procedures, we should discuss them whenever they arise.

MEETINGS

Therapy sessions are scheduled, as much as possible, for your convenience. Therefore, cancellations should be made at least 24 hours in advance or you will be billed for the session.

Therapy sessions will be 50 minute in length unless otherwise agreed upon by you and your therapist.

PROFESSIONAL FEES

Hourly fees depend upon which psychotherapist is treating you. In addition to regular appointments, there may be other charges for professional services you may need. Other services may include report writing, telephone conversations lasting more than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and time spent performing any other service you may request of me. If you become involved in legal proceedings that

require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty or legal involvement, I charge $150 per hour for preparation and attendance at any legal proceeding.

BILLING AND PAYMENTS

Payment for services are due at the time they are rendered unless prior arrangements are agreed upon with your therapist. If you have insurance coverage that will apply to the cost of your therapy, your therapist will cooperate in providing any appropriate information and signatures required.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going though small claims court. (If such legal action is necessary, its cost will be included in the claim.) In most patient's treatment is his/her name, address, and any phone numbers that you can be reached at, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that **you** find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course I will provide you with whatever information I can, based on my experience, and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf after you have made the initial call.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. (Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.)

CONTACTING ME

I am often not immediately available by telephone. While I am usually in my office between 9 AM and 5 PM, I will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by voice mail, office manager, or one of my colleagues. I will make every effort to return

your call on the same day you make, with the exception of weekends, and holiday. If you are difficult to reach, please inform me of some times when you are available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because these are professorial records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents. (I am sometimes willing to conduct a review meeting without charge.) Patients will be charged an appropriate fee for any time spent in preparing information requests.

Some of the records may be kept in electronic form in a password-protected, HIPPA-compliant database secured by an online medical records company contracted specifically for this purpose. If yours will be in an electronic form, I will use extreme caution to avoid disclosing unnecessary details in the records; I have sole access to the records. I will back up the records to a secured drive using industry-standard security measures regularly to avoid loss of information. In the event that the company suffers a breach of security it is their responsibility to do everything within their power to notify their customers. I, in turn, will inform you of the extent of the breach. Any records, notes, payment information or appointments kept in my office are secured under double locks. I also use a confidential voice mail that is password protected. If you have any questions regarding the measures I take to maintain confidentiality, please bring it to my attention in the first session. Should a breach in confidentiality occur, we will discuss the matter and work together toward a plan to remedy the situation.

MINORS

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

CONFIDENTIALITY

In general, the privacy of all communications between a client and a psychotherapist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issue demands it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I must file a report with the appropriate state agency.

If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship. Due to the new HIPPA laws and regulations, it is now necessary to have an expiration date on this contract. This contract will expire on December 31, 2019.

_____ _____

Patient Therapist

_____

Date

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) 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. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

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

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

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

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

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: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (Relate Items 1,2,3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

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

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

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.

33. BILLING PROVIDER INFO & PH. # ( )

a. b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB 0938-0999 FORM CMS-1500 (08/05)

WCMS-1500CS

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SECOND FOLD

FIRST FOLD WHCF-10-ENV / WHCF-10-ENV-SS