OVERTON
PSYCHOLOGICAL SERVICES

Geri Smith MA. MFT
Office (702) 563-1000
Fax (702) 563-1001
8975 S. Pecos Rd., Suite 8D
Henderson, NV 89074
Business Email: overtonstaff@icloud.com

Initial Intake

Patient Demographics

Name [Last] [First] [MI]			DOB
SSN	Home Phone	Work Phone	Cell Phone
Address [Home]		Preferred Phone: Home/ Work/ Cell	[Martial Status] Single / Married /Other
City State Zip Code		Male Female	E-Mail

Emergency Contact Information

Contact Name	Relationship to patient	
Address [Home]	Home Phone	Cell Phone
City State Zip Code	Work Phone	

Employment Information

Name		Phone Number	
Address	City	State	Zip Code

I understand that I will be charged a fee of $90 for any appointments cancelled or broken without 24 hour advance notice to the office.

Should I pay by check and the check be return to the office for any reason by my financial institution, the office reserves the right to change me a $25.00 fee per check if returned by my bank.

Patient Signature Date

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Patient Name:_____

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Financial Policy

I am committed to providing my patients with the best possible care. I must emphasize that as a healthcare provider, my professional relationship is with you, and not a third paying party. This policy is consistent with legal and ethical business regulations.

I am only In-Network for NEVADA MEDICAID, MEDICARE, Clark County Victim Witness/Victims of Crime, Teachers Health Trust, Health Plan of Nevada, United Health Care, Aetna, Cigna, Painters Health Trust, Health Scope, Health Smart, Anthem Blue Cross Blue Shield, UMR, and Culinary. At this time, I am NOT In-Network with any other insurance company. With these as the exception, this office is a cash pay practice only. **Please know that all charges are your responsibility and fees are due at the time of service. You may not access health insurance for court related services**. If you do not plan on accessing health insurance, you may move on to the cancellation policy below. If you may be interested in accessing your health insurance, the following is very important. **Initials** _____ **Date** _____

If you have a health insurance other than Full Coverage Medicaid, neither I nor my employees have any knowledge pertaining to your healthcare plan. As always, you have the option of accessing any benefits that are available to you through your health insurance. I offer two options in attempting to access your Out-of-Network Mental Healthcare benefits.
With the first option, I can provide you with a copy of your Superbill for you to submit to your insurance company or employer so that you may negotiate maximum healthcare benefits for you or your dependent. **Please familiarize yourself with your insurance policy and its requirements if you plan to submit the Superbill for insurance benefits. This option would NOT involve Overton Psychological Services billing your insurance company. You would be responsible for contact.
The second option you have is for our office staff to send billing directly to your health insurance. If and when insurance benefits are accessed through our offices, the full service fee billed by us will remains due at the time of service. As a result, if your insurance company at any time sends our office payment, we will in turn send you reimbursement accordingly. Reimbursement is very simply determined: The difference between the full charge and any payment received by an insurance company is the full responsibility of the patient. We will happily reimburse you for any payment exceeding the full charge. Our office staff is happy to work with you in billing your insurance company Out of Network, simply ask if you are interested. **REMEMBER that all charges are your responsibility and fees are due at the time of service. **Initials** _____ **Date** _____

Cancellation Policy

If you do not give a 24 hour advance notice for your cancellation or do come to your appointment, you will be required to pay a fee of $90.00 for the reservation of Geri Smith's time. You will be required to pay this fee prior to scheduling your next appointment. **Initials** _____ **Date** _____

Phone Consultations

Please be advised, telephone consultations, to discuss psychological management of your condition will be billed directly to yourself. Insurance companies do not pay for phone consultations therefore, you will be held responsible for the costs.
Initials _____ **Date** _____

Returned Checks

A $25 non-sufficient funds fee will be charged for checks initially returned unpaid by your bank. We report and forward all returned checks to the Clark County District Attorney's Office. **Initials** _____ **Date** _____

Collection Fees Policy

I, (Patient/Legal Guardian name) _____, herby agree to be financially responsible for all charges incurred. In the event that my account is referred to a collection service due to lack of payment on my part, I agree to pay all collection/ legal fees that may be added to my account.

_____ _____
Signature of Patient (18 years or older) Date

_____ _____
Signature of Mother, Father or Legal Guardian Date

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep PHI about you in a Clinical Record. It includes information about your reasons for seeking psychological services, a description of the ways in which your problem affects your life, your diagnosis, treatment goals, your progress towards those goals, your medical, social, and psychological history, records from other providers, various professional consultations, reports produced for other professionals, billing records and insurance clinical reports when applicable.

PATIENT RIGHTS

HIPAA provides you with several rights with regard to your Clinical Records and disclosures of your PHI. These rights include: a request to amend your record; a request to restrict information disclosed to others from your Clinical Records; a request of an accounting of all PHI disclosures; a request to have any complaints you make about my policies and procedures recorded in the record; and the right to a paper copy of this Agreement, and my practice policies and procedures. Please know that I am happy to discuss any of these rights with you.

MINORS & PARENTS

For patients under 18 years of age, the law requires the record of a minor must be maintained for not less than 5 years after the last date of service was rendered or 1 year after the patient reaches 21 years whichever is longer. Parental review of treatment records is permitted unless the psychologist believes there is a serious and immediate threat to the minor's health and well-being. Because the minor's privacy is often crucial to successful treatment progress it is my policy to request an agreement from parents to forfeit their access to their child's/teen's records so a healthy therapeutic relationship may be formed. Please keep in mind that this agreement is nullified if there is a serious threat of bodily harm to self, others or property at which point parent's are immediately notified and appropriate action is pursued.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is provided. Please review the Superbill for specific rates. The clinical hour is 45 minutes in length. Any legal fees related to psychological services provided by Geri Smith or her associates are the responsibility of the client or legal guardian and is due 24 hours prior to the legal procedure. On the rare occasion an account balance is created, and timely payment is not received I have the option of using legal means to secure the payment. This may involve a collection agency or small claims court. This requires disclosure of otherwise confidential information. A finance charge and any collection fees will be applied to an outstanding balance.

INSURANCE REIMBURSEMENT

It is important to evaluate what resources you have available to pay for your treatment. Most insurance policies require you to pay a co-pay and/or a deductible. Your pursuit for reimbursement for out of network services is beyond the scope of my service and will be your responsibility. In regards to insurance paperwork, if it becomes cumbersome you may incur a nominal fee to be discussed and determined prior to the completion of insurance forms.

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HIPAA

PSYCHOLOGICAL PATIENT SERVICES AGREEMENT [NEVADA]

Welcome to my office. This document (the Agreement) contains important information about my professional services, business policies, and Health Insurance Portability and Accountability Act (HIPAA). Federal law provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) and requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The law requires that I obtain your signature acknowledging that I have provided you with this information. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time.

PSYCHOLOGICAL SERVICES

Psychotherapy varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. 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. It calls for a very active effort on your part. In order to maximize treatment success, you may have to practice during your session and at home.

Psychological treatment can have benefits and risks. Treatment may involve discussing unpleasant aspects of your life leading to uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. Initially biofeedback techniques can lead to initial feelings of frustration and discouragement. Psychological interventions are reported in the scientific literature to be quite helpful in the alleviation of symptoms and may lead to improved self-regulation, improved personal performance at home,/work /school, better relationships, solutions to specific problems, and significant reductions in feelings of distress. Despite the benefits I can make no guarantees related to treatment outcome.

MEETINGS

I normally conduct an evaluation that will last from 1 to 2 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If we agree, I will detail a treatment regimen with or without biofeedback typically 1-2x per week or 2-8x per month. During a crisis the frequency may increase. **A 24 hours advance notice of cancellation is required to avoid a $90 No Show Fee,** unless you clearly establish you missed your scheduled appointment due to an emergency or illness. Parent's of children receiving Medicaid benefits will be billed personally for no show/no call or appointments cancelled with less than 24 our notice.

PROFESSIONAL FEES

Individual and Family Consultation $120.00
Psychotherapy Combo with EEG Neurofeedback&/ Alpha-Stim Therapy $120.00
Interactive Psychotherapy $170.00
Psych/Neuropsychological testing $150.00 per hr
Report Writing $200.00 per report
Professional Phone Consultation $30.00 per (15 min.)
Legal Testimony $400.00 per hr
Record Review and/or Deposition $250.00 per Hour

If you become involved in legal proceedings that requires my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party or the hearing is cancelled with 48 hours. Full payment is required 72 hours prior to any legal proceedings including testimony, report writing or consultation.

CONTACTING ME

Due to my work schedule, I am usually not immediately available by telephone. If you have a life threatening emergency call 911. If there is a threat of suicide for you or your child, immediately go to the nearest emergency room. **If your situation is urgent you may contact me by cell phone at *702—610-1086* If your situation is non-urgent call my front desk at 702-563-1000.** When I am unavailable my phone will be answered by voicemail. I will make every effort to return your call on the same day with the exception of weekends and holidays.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without your consent or authorization:

If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege. I cannot provide any information without your written authorization, however I may be compelled to disclose information pursuant to a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information in order to ensure your privacy.

If a government agency is requesting the information for health oversight activities, I maybe required to provide it. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself. If a patient files a worker's compensation claim, I must, upon appropriate request, disclose relevant information to the insurer or a third party administrator.

There are some situations in which I am legally obligated to take actions. If I know or have reasonable cause to believe that a child or older person has been abused or neglected, the law requires that I file a report with the appropriate governmental agency. Once such a report is filed, I may be required to provide additional information. If I believe that a patient presents a risk of imminent serious harm to another person, I may be required to take protective action. These actions may include notifying the potential victim, contacting the police, and/or seeking hospitalization for the patient. If a patient presents an imminent risk of harm to self, I may be obligated to seek hospitalization for the patient, or to contact family members or others who can help provide protection.

_____
Patient's Name Printed

_____
Signature of Patient, Parent or Legal Guardian

_____
Date

_____
Witness

Edited 06.25.2013 CC

INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ Age: _____ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Domestic Partnership □ Married □ Separated
□ Divorced □ Widowed

Please list any children/age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: (_____)_____ May we leave a message? □Yes □No

Cell/Other Phone: (_____)_____ May we leave a message? □Yes □No

E-mail: _____ May we email you? □Yes □No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?

□ No

□ Yes, previous therapist/practitioner: _____

Are you currently taking any prescription medication?

□ Yes

□ No

Please list:

_____

_____

Have you ever been prescribed psychiatric medication?

□ Yes

□ No

Please list and provide dates:

_____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in: _____

4. Please list any difficulties you experience with your appetite or eating patterns.

_____

5. Are you currently experiencing overwhelming sadness, grief or depression?
□ No
□ Yes

If yes, for approximately how long? _____

6. Are you currently having any suicidal feelings or behaviors?
□ No
□ Yes

If so, for how long? _____

7. Have you had suicidal feelings or behaviors in the past?
□ No
□ Yes

If yes, please explain.

8. Are you currently experiencing anxiety, panic attacks or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

9. Are you currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe? _____

10. Do you drink alcohol more than once a week? □ No □ Yes

11. How often do you engage recreational drug use? □ Daily □ Weekly □ Monthly
□ Infrequently □ Never

12. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

13. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation:

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

3. What do you consider to be some of your strengths?

4. What do you consider to be some of your weakness?

5. What would you like to accomplish out of your time in therapy?