SPECTRUM Psychotherapy Centers, LLC
Billing Demographic Sheet

PLEASE PRINT

Patient's Name: (Last Name, First Name, Middle Initial)	Patient's Birthdate: (MM/DD/YY) Sex: / / ☐ M ☐ F
Patient's Address: (No., Street)	Patient's Social Security Number:
City , State, Zip Code:	Telephone: Work ( ) Home ( ) Cell: ( )
Patient Status: **Single** ☐ **Married** ☐ **Other** ☐ **Employed** ☐ **Full-Time Student** ☐ **Part-Time Student** ☐	Is Patient's Condition Related to: a: Employment? Current or Previous Yes ☐ No ☐ b. Auto accident? c. Other accident? Yes ☐ No ☐ Yes ☐ No ☐

Insurance Information:

Insured's Name: (Last Name, First Name, Middle Initial)	Insured's ID Number:
Insured's Address: (No., Street)	Insured's Social Security Number:
City, State, Zip Code:	Insured's Date of Birth: MM/DD/YY:
Employer Name:	Patient Relationship to Insured: Self ☐ Spouse ☐ Child ☐ Other☐
Address: (No., Street) _____ City, State, Zip Code	Telephone: Work ( ) Home ( ) Cell: ( )
Responsible Party: (If different from Insured)	Relationship to Patient:
Address: _____ City, State, Zip Code:	Telephone: Work ( ) Home ( ) Cell: ( )
Primary Insurance Company: (Name)	**Secondary Insurance Company:** (Name)
Identification Number:	Identification Number:
Group Number:	Group Number:
Insurance Plan: (Type of coverage)	Insurance Plan: (Type of Coverage)
Insurance Address:	Insurance Address:
Insurance Phone Number:	Insurance Phone Number:
Who Referred you to this office:	Have you previously had therapy at Spectrum? If yes, who did you see?
Primary Care Physician – Name & Telephone Number:	

Spectrum Psychotherapy Centers, LLC℠

CLIENT'S INFORMED CONSENT TO TREATMENT

I have chosen to receive treatment from _____. I understand that my choice is voluntary and that I may terminate therapy at any time.

I understand that there is no assurance that I will improve, and that during the course of therapy, issues may be discussed that may be upsetting in nature but are necessary to resolve my difficulties.

I understand that confidentiality of records will be held and released in accordance with state laws regarding confidentiality of such records.

I understand that state and local law require the reporting of all cases in which there is abuse of a minor child. I also understand that my therapist is required to report all cases in which there is a danger to self or others.

I understand that there may be other circumstances in which the law requires that my therapist disclose confidential information.

I understand that my therapist may be required to disclose information about me to managed care companies for the purpose of claims processing, authorizing continued treatment, coordination of care, quality assurance and utilization review. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered, and that this consent will expire one year after the date signed below, or one year after all claims for treatment have been paid.

I understand that if my therapist has not heard from me in sixty (60) days, I will no longer be considered a client.

I have read and understand the above.

_____ _____

Signature of Client Date

_____ _____

Signature of Parent, Guardian, Conservator Date
Or Authorized Representative (if required)

_____ _____

Signature of Witness Date

Spectrum Psychotherapy Centers, LLC℠

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS FORM

☒ I authorize the physicians and/or clinicians to provide from their records any information including substance abuse or any other confidential information requested by my insurance company, Medicare, Medicaid, Champus, or other Third Party payors, in connection with payment for any incurred charges. I also authorize the physician and/or clinician to provide information from my medical record to any utilization and/or quality review organization affiliates with my insurer for use in utilization management.

☒ I agree to pay all charges incurred by me. I assign my insurance benefits to which I may be entitled to the physician and/or clinician providing the services. I understand that I am responsible for any charges not covered by this agreement.

☒ I permit disclosure of my Protected Health Information via electronic transmission, including e-mail and/or internet, for purposes of treatment, payment, or healthcare operations. I understand that there is a possibility, although remote, that electronically transmitted information can be intercepted. I also understand that my clinician will comply with HIPAA requirements to safeguard and secure any information transmitted in this form.

Name of Patient: _____ **Date:** _____

Person responsible for payment: _____

Signature of Patient: _____

(Parent or guardian if patient is a minor)

Date: _____

Spectrum Psychotherapy Centers, LLC℠

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that, with my consent, this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the healthcare providers involved
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and provider certification

I understand that, except in certain cases, my protected health information will not be released without my written authorization.

I have read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that you have the right to change your privacy practices from time to time and that I may contact you at any time to obtain the most current copy of the *Notices of Privacy Practices*.

I understand that I may request a copy of this Notice.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand that you are not required to agree to my request, but if you do agree, then you are bound to abide by such restrictions.

Name _____

Relationship to Patient _____

Signature _____ Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

OFFICE POLICY AND PROCEDURES AGREEMENT

This guide to office policies and procedures provides answers to questions about fees, appointments, insurance, confidentiality, and other issues related to services provided. In addition, it describes the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI). HIPAA 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 Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. If you have any further questions or concerns, please feel free to discuss them with me.

Services Offered

The psychotherapy services I provide are designed to help you with the problems for which you sought help. They may include individual, couples, family, group therapy, or psychological testing. If I think you might benefit from medication, I can arrange for you to see a psychiatrist who will evaluate your need for medication. Consultation with other professionals, schools, and/or the courts may also be necessary for your treatment.

Appointments

Except in rare emergencies, I will see you at the time scheduled. Because this time is set aside for you, it is important that you keep this appointment. If circumstances arise that make it necessary for you to cancel an appointment, I ask that you give at least 48 hrs (business days) notice. THE FULL HOURLY FEE WILL BE CHARGED FOR ALL APPOINTMENTS MISSED WITHOUT 48 HOUR (BUSINESS DAYS) NOTICE. You will be responsible for the full fee yourself, as most insurance companies will not reimburse for missed sessions.

Fees and Billing Procedures

The fee for the initial evaluation for you and/or your family is _____. Subsequent sessions will be charged at _____ per hour. Your insurance co-pay is _____, subject to verification. Services not covered by insurance such as missed appointments, telephone sessions, reports, school visits, report writing, and other consultations, are solely your responsibility. These services are billed at the hourly rate.

FEES OR CO-PAYMENTS ARE PAYABLE IN FULL AT EACH VISIT. Payments for missed appointments are due with the regular fee at the next visit. Insurance companies usually require a co-payment, or sometimes they pay only a portion of your fees up to a certain limit per calendar year. It is your responsibility to pay the co-payment or deductible not covered by your insurance. If you are having difficulty paying your bill, please let me know and we can discuss a payment arrangement. If you fail to make payments and your account becomes past due, this matter may be referred to a collection agency.

a. **Divorced Parents:** In the case of divorced parents, the parent who initiates therapy for a child is the party responsible for payment. The parents involved should work out shared financial arrangements.
b. **Reports:** If I am required to write a report for the court, all fees for report writing must be paid in full before the reports will be sent. Fees will also be charged for other types of reports or evaluations sent to schools, attorneys, or other government agencies.
c. **Telephone sessions:** A telephone session occurs when you or I have a conversation of a therapeutic, problem-solving, or information-exchanging nature. Short phone calls (under 10 minutes) are not considered sessions. Lengthy calls will be charged as a session prorated on my hourly rate. Insurance companies do not reimburse for telephone sessions.

Health Care Insurance
Most health insurance policies cover the services of licensed mental health professionals. Please read your policy carefully and be aware of the benefits and payment limits involved. If you are a member of a managed care program for which I am a provider, you will be responsible for following the rules of your plan, for example, getting a referral from your primary care physician or authorization prior to the first session. I will complete the necessary paperwork and file the forms with your insurer.

Emergencies
If you have an emergency, call the office, which is served by a 24-hour answering service or voicemail and state clearly that your call is an emergency. Your call will be returned as soon as possible.

Confidentiality
Psychological services are best provided in an atmosphere of trust. You expect me to be honest with you about your problems and progress; I expect you to be honest with me about your expectations for therapy, your compliance with medication if relevant, and any barriers to therapy. Because trust is so important, all therapy is confidential. The law protects the privacy of all communications between a patient and a therapist. Without your consent, I cannot release any information about you except in situations noted below. The law calls this information Protected Health Information (PHI). In order to properly provide services to you, I may need to disclose PHI for a variety of reasons. **Your signature on this Agreement provides consent for those disclosures, as follows:**

- **Treatment**: At some point, I may need to share of disclose information with others who are also treating you in order to coordinate services. For example, I may feel it is helpful to contact your personal physician or a facility where you are receiving or have received treatment.
- **Payment:** I may disclose information to bill your insurance or others to be paid for the treatment we provide. This information may include diagnosis, type and length of treatment, and your progress.
- **Health Care Operations:** If an oversight agency requests information about my practice, I may be required to disclose information for these purposes. I will make every effort to protect your identity in these cases.
- To release information for other than purposes of treatment, payment, or health care operations, I must obtain a **specific written authorization** from you to do so.

ALTHOUGH YOUR SIGNATURE ON THIS AGREEMENT IMPLIES GENERAL CONSENT TO THE ABOVE DISCLOSURES, IT IS OUR POLICY TO OBTAIN SPECIFIC WRITTEN PERMISSION TO RELEASE INFORMATION WHENEVER POSSIBLE.

There are some situations where I am permitted or required to disclose information without either 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 law. I cannot provide any information without your (or your legal representative's) written authorization, or 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.
- 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, furnish all treatment reports to the patient's employer and to the patient or his/her attorney.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reason to suspect or believe that a child under 18 years of age (1) has been abused or neglected, (2) has had non-accidental physical injury, or injury which is at variance with the history given of such injury, inflicted upon such child, or (3) is placed at imminent risk of serious harm, then I must report this suspicion or belief to the appropriate authority, usually the Commissioner of Children and Families. Once such a report is filed, I may be required to provide additional information.
- If I have reason to believe or suspect that an elderly or disabled or incompetent individual has been abused, I may have to report this to the appropriate authority. Once such a report is filed, I may be required to provide additional information.
- If I believe that a patient presents an imminent risk of personal injury to another identifiable individual, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. I may also have to take protective action if another's property is endangered.
- If a patient presents an imminent risk of personal injury to him/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to only what is necessary. You have a right to request a list of these disclosures.

Patient Rights

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

Minors and Parents

Patients under 16 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records unless I decide that such access is likely to injure the child. (There are some circumstances in which I can provide treatment for not more than 6 sessions to a child under 16 without parental consent or notification, but the requirements for such nonconsensual treatment are complicated and can be discussed on request.) Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's consent, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

I have read this agreement and understand its terms. I agree to comply with these policies.

I acknowledge that I have read and understand the HIPAA Privacy Notice described above.

Print Name _____

_____ _____

Signature Date

OFFICE USE ONLY

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Date:	Initials:	Reason:

Spectrum Psychotherapy Centers, LLC℠

Consent for Treatment of Minors

Minor's Name _____

Date of Birth _____

Therapist (s) _____

This is to certify that I give permission to _____
(Name of Therapist)

for treatment of my child.

This treatment may include individual, couple, family or group psychotherapy, and testing.

This treatment may also include referrals to other appropriate State and County or other professionals.

_____ _____
Signature of Parent/Guardian **Date**

_____
Printed Name of Parent/Guardian

_____
Street Address

_____
City/State/Zip

_____
Phone

_____
Witness/Title

INTAKE AND HISTORY FORM FOR CHILDREN AND ADOLESCENTS

PLEASE FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE

CHILD

1. Child's name:_____Sex_____Birthdate_____

2. Address:_____Phone_____
   Street City State Zip code

3. Natural_____Adopted_____if yes, at age_____Foster_____if yes, at age_____

4. Who referred you?_____

5. Reason for referral:_____

_____

FAMILY Members (full, adoptive, foster, half, etc.)

Brothers and sisters

First name - Last name	Sex	Birthdate Mo. Day. Yr.	Age	School Grade/ Occupation	Relationship to child (full, step, adoptive, half foster)	Address if different from above
1.						
2.						
3.						
4.						
5.						
6.						

List all others living in the home:
Name_____Relationship_____Age_____

1._____

2._____

3._____

BIRTH MOTHER

Name _____Age_____

Date of Birth _____Place_____

Address_____

_____

Religion _____Race_____

Education_____

Occupation_____

Hours/Shift_____

Employer(s)_____

Address_____

_____Phone:_____

Marital Status (circle, date) Married_____

Separated _____Divorced_____

Widowed _____Never Married_____

Previous Marriages (dates)

_____

Children from Previous Marriage_____

_____

BIRTH FATHER

Name _____Age_____

Date of Birth _____Place_____

Address_____

_____

Religion _____Race_____

Education_____

Occupation_____

Hours/Shift_____

Employer(s)_____

Address_____

_____Phone:_____

Marital Status (circle, date) Married_____

Separated _____Divorced_____

Widowed _____Never Married_____

Previous Marriages (dates)

_____

Children from Previous Marriage_____

_____

STEPMOTHER/FOSTER MOTHER

/ADOPTIVE MOTHER/GUARDIAN

Name _____Age_____

Date of Birth _____Place_____

Address_____

_____

Religion _____Race_____

Education_____

Occupation_____

Hours/Shift_____

Employer(s)_____

Address_____

_____Phone:_____

Marital Status (circle, date) Married_____

Separated _____Divorced_____

Widowed _____Never Married_____

Previous Marriages (dates)

_____

Children from Previous Marriage_____

_____

STEPFATHER/FOSTER FATHER

/ADOPTIVE FATHER/GUARDIAN

Name _____Age_____

Date of Birth _____Place_____

Address_____

_____

Religion _____Race_____

Education_____

Occupation_____

Hours/Shift_____

Employer(s)_____

Address_____

_____Phone:_____

Marital Status (circle, date) Married_____

Separated _____Divorced_____

Widowed _____Never Married_____

Previous Marriages (dates)

_____

Children from Previous Marriage_____

_____

How long has family lived in present home?_____

Single family house_____ Two family house_____Apartment_____

Does family plan to move within next year? _____If yes, where?_____

Languages spoken in home:_____

If more than one, which language is spoken most often?_____

FAMILY AND SOCIAL HISTORY - MEDICAL AND DEVELOPMENTAL HISTORY

1. Child's doctor: Name_____ Address_____
2. Other doctor: Name:_____Title:_____
   Address_____
3. Place of Birth: City_____State_____

   Hospital_____
4. Pregnancy
   a. Condition of mother during pregnancy. (illness, hospitalization, etc.)
   Explain:_____
   _____
   b. List any medication taken during pregnancy; for what reason; prescribed by:_____
   _____
   _____
5. Birth history
   a. Labor: Length:_____(if any complications, please explain)
   _____
   _____
   _____
   _____
   b. Delivery: Normal_____Breech_____Caesarean_____Transectional_____
   Full Term _____Premature _____ If premature, number of weeks_____
   c. Condition of child at birth. If any complications, please explain below. (For example, was infant given oxygen, blood transfusion, placed in an incubator, other medical treatment) _____
   _____
6. Developmental History
   a. State approximate age when your child:
   Rolled over _____Sat unsupported_____Crawled_____
   Pulled to standing position _____Walked alone_____
   Responded by smiling at you _____Made cooing noises_____
   Said first word _____Began to say "Mama and dada"_____
   Understood and followed simple directions _____Knew own name _____

Began combining words to make little sentences _____

Breast fed until _____Bottle fed until_____

Started to help with feeding _____Fed self_____

Training in urinary control started _____reasonably well trained_____

Training in bowel control started_____ reasonably well trained_____

How would you describe training: Easy_____ Difficult _____Stormy_____

Any past or present problems in bowel or urinary control: No _____Yes_____

If yes, please describe_____

7. Medical History

a. When was your child last seen by a physician?_____

b. When was last complete physical exam?_____

c. Has your child ever experienced serious illness, injury or hospitalization?_____

No_____ Yes_____ Describe and give dates_____

d. Has your child any physical handicaps or learning disabilities?_____

No_____ Yes_____Describe_____

e. Describe Present Health. Does your child have frequent illness, stress related sickness, etc.?_____

_____

f. Is your child currently taking any medications? No_____ Yes_____ Name of medication and its purpose_____

_____

Name of physician prescribing _____When was child last seen by physician for this medication? _____

g. Have there been serious illnesses or hospitalizations for any other members of your family? _____

_____

_____

8. Social History

a. How would you describe your present family situation?_____

_____

b. List family and community members that you feel have a significant relationship with your child., i.e. grandparents, and/or other relatives, day care/school staff, baby sitters._____

c. History of physical abuse with child and other family members:_____

d. Is abuse still occurring?_____

e. Has child ever lived with other than his own parents? No_____ Yes _____

f. Have any deaths occurred in immediate family since your child was born? No_____ Yes _____ Give dates and relationship to child_____

Sexual Assessment

a. Is there a family history of rape, molestation, or incest that the child is either a victim of or aware of? If so, please explain.

_____

_____

b. Has parent provided children with education in sexuality? Please explain._____

_____

c. Are there other sexual issues that affect the child?_____

_____

Drug and Alcohol History

1. Identify family members who have a past/present history of drug/alcohol involvement:

_____

_____

2. Would you describe your family as alcohol/drug dependent: Yes_____ No_____
3. Presently abusing alcohol/drugs: Yes_____ No_____
4. Recovering from alcohol/drugs: Yes_____ No _____

Previous Treatment:

1. Any previous psychological or outpatient and/or inpatient (hospitalization) psychiatric treatment? Yes_____ No _____

   Done in an outpatient or inpatient setting? Yes_____ No_____

   Therapists? _____

   Dates of treatment:_____

   Lists of outpatient/inpatient facilities where treatment occurred:_____

   _____

   Reasons for treatment :_____

   Outcome - Check one: Much improved _____ Improved _____ Same _____ Worse _____
2. Any previous testing (school psychological) No _____ Yes _____

   With whom? _____Dates:_____

   Address_____

   Reason_____
3. Please list any other professionals or agencies currently or previously involved with your child (DCF worker, minister, probation officer, etc.).

   Name:_____Address:_____

   Phone Number:_____Dates involved:_____

   Name:_____Address:_____

   Phone Number:_____Dates involved:_____
4. Drug and alcohol treatment: (Check one) Evening:_____ Inpatient:_____ Outpatient:_____

Court History

1. Please list any previous arrests, charges, conviction, current status, name of probation or parole officer, location of court, requirements of stipulation:

   _____

   _____

2. Presently involved with - Check all that apply: Youth Services:_____ Probation _____ Juvenile Court _____

School History

1. Attended nursery school? (Where and when)_____
2. Other schools? _____

   _____

3. Present school:_____Grade:_____Teacher:_____

   Address:_____

   Is child receiving services in school and with whom? Yes _____ No _____

Name:_____

   What kind?_____individual _____group

   School Psychologist/Counselor _____Phone:_____

4 Do we have your permission to contact school personnel listed above? Yes _____ No _____

_____ _____

(Signature Parent/Legal Guardian) (Date)