BETHEL OLENTANGY PSYCHOLOGICAL SERVICES
An Association of Independent Practitioners
4949 Olentangy River Road
Columbus, OH 43214
Phone: (614) 451-6606
Fax: (614) 451-2923

Client Information

To Our Clients:

Welcome to our office. Enclosed you will find information regarding fees, billing practices, office policies, and other procedures. If you have additional questions or concerns that are not addressed within this packet, please ask your therapist or the administrative staff.

Appointments and Fees:

First 1 to 3 appointments (50 minutes)	$265.00
*(*Fee is per appointment)*	
Individual (45 minutes)	$180.00
Individual (53 minutes or more)	$240.00
Family or couples therapy (45 minutes)	$195.00
Missed Appointments (see cancellation policy, page 2)	$180.00
l/2 session, 20-22 minutes (scheduled only)	$115.00
Psychological testing (per 45 min. period)	$195.00
(Fees are based on time spent in administration, scoring, interpretation, and write-up time.)	
Assessment forms for evaluations	$4.00/min, $15.00/form
Phone calls longer than 5 minutes	$4.00/minute
Letters, formal reports, travel time for "out-of-office" services (per 45 min)	$4.00/minute
Testifying in court, depositions and court-related work including travel time is payable in full in advance including if subpoenaed, or called by another party	$380/hr
Executive coaching, consulting, mediation (not billable to insurance)	$260.00

Billing:

- Payment is expected at the time of services rendered.
- Our office verifies insurance benefits and bills insurance companies as a courtesy to the client. Benefit verification is not a guarantee of coverage or reimbursement. It is ultimately the client's responsibility to know their policy and for payment in full for any portion of services that insurance does not cover.
- Please note that there is a $45 service charge for all returned checks.

Cancellation Policy:

- 24-hour notice is required for appointment cancellations. Cancellations given with less than 24-hour notice and no-shows for appointments are subject to a fee of $180 (not billable to insurance).
- Monday appointments must be cancelled by noon on Friday and appointments scheduled for the day after a holiday must be cancelled by noon the previous business day

_____ **INITIAL** indicating policy/procedure agreement

After Business Hours/Emergencies:

- Voicemails left after business hours, on the weekends or during holidays will be returned the following business day.
- For situations that cannot wait until the office reopens, phone numbers for on-call psychologists are provided in the office voicemail message.
- If the situation is life threatening call 911 or proceed to the nearest emergency room.

Confidentiality:

- Information disclosed during therapy sessions is confidential and will not be released without the client's permission. Exceptions to this include the following:
  - The client is actively suicidal.
  - The client is threatening to harm another person.

  In these instances, the therapist is legally bound to protect the client and other parties and therefore confidentiality may have to be broken.
- Treatment information will be released to the client's insurance company in order to pay for services rendered.
- Confidentiality for teenagers and children will be discussed to clarify their rights and the rights of the parents.
- Confidentiality for couples and families can be discussed with the therapist.
- A General Release of Information form may be signed for the therapist to communicate with other family members, medical professionals or other persons of the clients choosing.

Health Insurance Portability and Accountability Act (HIPAA):

This office practices and complies with all policies and procedures occurring under the HIPPA guidelines. A copy of the HIPPA policies is available to the client upon request.

Ethics and Professional Standards:

As psychologists licensed by the State of Ohio and as members of the Ohio and the American Psychological Associations, we agree to abide by and uphold the most responsible ethical and professional standards possible. We accept responsibility for the consequences of our acts and make every effort to protect the welfare of our clients and to ensure that our services are used appropriately.

Release of Liability:

The client releases the therapist from liability of their psychological counseling/care within one week of a missed appointment or upon canceling an appointment without rescheduling.

Returning Clients:

- Clients absent from therapy for longer than 3 months are considered a returning client and will be billed as a new client.
- Clients absent from therapy for longer than 1 years' time will need to complete updated paperwork.
- Clients with existing balances wanting to return to the practice will not be able to schedule until payment is made in full.

Professional Referrals:

Our office sends Thank You cards for referrals from professional sources (other medical professionals etc.). If you prefer not to have our office send a Thank You card, please let the front desk staff know.

_____ **INITIAL** indicating policy/procedure agreement

Patient Information

Patient Name _____ Date of Birth____/____/____

Social Security Number_____ Race/Ethnicity _____

Home Address_____ City_____Zip _____

Cell Phone _____ Home Phone _____Work Phone _____

Email Address _____Employer _____

Emergency Contact _____ Relationship _____

Home Address_____ City_____Zip _____

Cell Phone _____ Home Phone _____Work Phone _____

By signing below, I agree to the following:

- ✓ *I have read, understand and agree to the office policies and procedures of Bethel Olentangy Psychological Services as outlined above.*
- ✓ *I acknowledge and understand that the treating psychologist as an independent contractor is solely and legally responsible for my treatment and care.*
- ✓ *I have read or received a copy of the HIPAA Notice Form.*

Client Signature _____ Date _____

Whom may we thank for referring you to our office? _____

May we contact them with a thank you note? (please circle) YES NO

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Presenting Concerns Questionnaire

Client Name: _____ Date of Intake: _____

Please read this checklist and select the items that are of concern to you.

	Depression		Parental alcohol/drug use
	Suicidal feelings/behavior, Self-harm, or Cutting		Childhood physical abuse or Sexual abuse
	Anxiety, Fears, or Worries		Domestic violence or Intimate partner violence
	Physical stress (Headaches, Stomach pains, Muscle tension)		Physical attack (Mugged, beaten up, Shot, Stabbed, Threatened with a weapon)
	Sleep problems		Emotional abuse in past or present relationship
	Body image concern		Sexual violence (Unwanted sexual experience, Rape, sexually assaulted, Abused by intimate partner)
	Irritable, Angry, or Hostile feelings		Military combat or War zone experiences
	Self-esteem or Self-confidence		Learned that self or loved one was diagnosed with a threatening/chronic illness
	Loneliness or Homesickness		Gay/Lesbian/Bisexual/Transgender concerns
	Compulsions (e.g. Collecting things, Cleaning, Shopping, Gambling, Porn, Internet, Sexual)		Experiencing Discrimination
	Alcohol or Drug abuse		Racial identity concerns
	Shyness or Being assertive		Decision about career or academic future
	General interpersonal problem		Legal issues
	Relationship with friend/roommate		Family of origin issue
	Relationship with romantic partner		Work stress
	Loss of significant person or Grief		Procrastination or Getting motivated
	Ended relationship or Divorce		Test anxiety, Speech or Performance anxiety
	Sexual issue		Specific issue to discuss with therapist
	Weight management issues or Eating disorder		Emotional eating
	Relationship with parents/family		Other:

Psychologist's Initials: _____

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General Release of Information for Primary Care Physician

Client Name:_____ Date of Birth: _____

We find that it can frequently be useful for your physician to know that you are involved in counseling/therapy, particularly if there is a need for medication. Many managed care companies now request that we have contact with the primary care physician. You have the right to decide whether your physician knows about your treatment or not, and your treatment records are protected by confidentiality laws (42 CRF Part 2): We will not release any information without your written consent.

In accordance with Federal Regulation 42 CFR, Part 2, I hereby authorize:

_____
(Psychologist Name)

To exchange applicable information with my physician ☐

To exchange information if medication is needed ☐

Physician Information:

Name: _____

Address: _____

Phone: _____ Fax: _____

Client Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Relationship (if client is a minor):_____

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INSURANCE

Listed below is some information regarding the risks of using health insurance to pay for services. This information is provided so you (the client) can make an informed decision about whether to utilize insurance. Please feel free to discuss with your therapist before deciding.

- ✓ The therapist is required to provide detailed reports and notes to insurance companies if requested, resulting in loss of confidentiality
- ✓ Information is shared between insurance companies which could affect applying for coverage elsewhere in the future.
- ✓ A psychological diagnosis can impact the ability to get health or life insurance coverage in the future due to treatment records being logged with the Medical Information Bureau.

Health Insurance Claim Form Signature. *Check one of the boxes below*. This is needed to bill your insurance company, if you plan on using your insurance benefits.

I understand the benefits and the possible risk of using my health insurance, and I have made the following decision:

_____ I choose to utilize my insurance benefits, and I authorize this office to release whatever information is needed to assure benefits and process claims. I authorize payment of medical benefits to this physician or supplier of services.

OR

_____I choose to self-pay for my therapy services.

_____ _____
Signature Date

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Social Media and Email Communications Policy

It is our practice's policy that psychologists and office staff do not connect or communicate with current or former clients on any form of social media (e.g. Facebook, Linked In, Twitter, Snapchat or other social media). This policy keeps boundaries clear between the professional relationship at the office and the personal lives outside of the work setting. This also maintains appropriate boundaries within the therapeutic relationship during therapy and afterwards, particularly should the client decide to return to treatment at some point in the future.

In general, the best way to contact your psychologist is by calling the office. Confidential voice-mail is available in the event that the office is either closed or phone lines are busy. On occasion, clients request to e-mail the office. The confidentiality of e-mail cannot be guaranteed, and the client acknowledges the lack of confidentiality when choosing to e-mail their therapist.

We DO send reminder notices, with your permission, via text message and email; however, as noted above, email is not a secure or always confidential method of communicating, and thus we need you to initial below if you wish to utilize this as a means of communication.

Please check below the way in which our office can reach you, with your permission, and with your understanding and acceptance that it may not be totally secure, and sign below.

The office may reach me by email to remind me of appointments, and I may choose to contact my psychologist via email on occasion.

Yes_____ No_____

_____ _____
Signature Date

Updated: 3/21/2019