

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) _____ \$235.00

*(*Fee is per appointment)*

Individual (45 minutes) _____ \$180.00

Individual (53 minutes or more – insurance claims) _____ \$240.00

Family or couples therapy (45 minutes) _____ \$195.00

Missed Appointments (see cancellation policy, page 2) _____ \$180.00

1/2 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 _____ \$6.00/min,

\$15.00/form

Phone calls longer than 5 minutes _____ \$6.00/minute

Letters, formal reports, travel time for "out-of-office" services (per 45 min) _____ \$6.00/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.

_____ **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 _____

Professional Referrals:

Our office sends Thank You cards for referrals from professional sources (other medical professionals etc.). Please indicate below who referred you to our office and if you consent to sending that referral source a Thank You card.

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

May we contact them with a thank you note? 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 CFR 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: _____

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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, E-Mail and Text Message 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. Clients may choose to communicate with the office via text message or e-mail. The confidentiality of text messages and e-mail cannot be guaranteed, and the client acknowledges the lack of confidentiality when choosing to communicate using these methods.

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.

Please mark preferences below:

	YES	NO
The office may contact me via text message.		
The office may send text message reminders for appointments.		
The office may contact me via e-mail.		

Client Signature

Date