

**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 (Under 18)

**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

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 \_\_\_\_\_ \$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 \_\_\_\_\_

**Parent/Guardian Information:**

Name \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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.*

Parent/Guardian 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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**CONSENT FORM**

Permission is hereby granted to the clinicians of Bethel Olentangy Psychological Services to provide outpatient mental health services as necessary to diagnose, treat, and care for the needs of

\_\_\_\_\_ who is a minor and under the care of his/her parent or legal guardian.  
*(child's name)*

I understand that the therapist and I, the parent/guardian, will clarify how and/or what information will be conveyed about my child. I understand that under some circumstances confidentiality may be crucial for my child to establish a therapeutic relationship.

I have read this consent form and I certify that I understand its contents.

Signed:

\_\_\_\_\_  
Parent/Guardian

Date: \_\_\_\_\_

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**Parental Rights Statement**

Child's Name: \_\_\_\_\_

*It is our policy at Bethel Olentangy Psychological Services to attempt to engage all parental figures in their child's treatment unless parental rights have been terminated. Additionally, parents may have access to view and/or request copies of child's treatment record.*

Please initial next to the most appropriate statement regarding the status of the child's parents:

\_\_\_\_\_ The child lives with both biological parents in the same home.

\_\_\_\_\_ The child's parents are divorced, separated, or were never married.

*In this situation the parent who did not bring the child to treatment will be contacted to make them aware of the child's participation in treatment at Bethel Olentangy Psychological Services to include them in the treatment process.*

\_\_\_\_\_ The child's parents are not together and the child's other parent's parental rights have been terminated.

*If parental rights have been terminated, it is the responsibility of the parent who is seeking treatment for the child to provide documentation reflecting termination of parental rights. Please attach a copy of the court document that verifies the termination of parental rights of the other party.*

\_\_\_\_\_ The child lives with adoptive parent/s. Please attach a copy of supporting documentation regarding the adoption.

\_\_\_\_\_ The child is in the custody of a non-parent (Foster Care, Kinship Care, etc.). Please attach supporting documentation regarding custody.

**Please provide the following information for the parent who did not bring the child to treatment:**

Parent/Guardian Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Email Address \_\_\_\_\_ Employer \_\_\_\_\_

**OR**

\_\_\_\_\_ I hereby certify that I do not know the name/location of the parent who did not initiate treatment for this child.

**I agree that the information provided is accurate:**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

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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: \_\_\_\_\_

*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