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: We welcome you to our office, and would like to take this opportunity to answer some of your questions and clarify procedures.

Appointments & Fees:

-First 1 to 3 appointments (50 minutes)----------$255.00
-Individual (45 minutes)----------$170.00
-Individual (53 minutes or more)----------$230.00
-Family or couples therapy (45 minutes)----------$185.00
-Missed Appointments (see cancellation policy, page 2)----------$170.00
-l/2 session, 20-22 minutes (scheduled only)---------- $ 105.00
-Psychological testing (per 45 min. period)----------$185.00
(Fees are based on time spent in administration, scoring, interpretation, and write-up time. Ask your therapist about these fees.)
-Assessment forms for evaluations ----------$6.00 per minute--$15.00/per form
-Phone calls longer than 5 minutes are billed at the regular therapy rate ($4.00/minute).
-Letters, formal reports, travel time for "out-of-office" services will also be charged at (per 45 min. period)----------$185.00
-Testifying in court, depositions and court-related work including travel time is payable in full in advance (including if subpoenaed, even if called by another party) ----------$370.00/hr
- Executive coaching, consulting, mediation (not billable to insurance)---------$250.00/50-55 minutes

Billing: Payment is expected at the time of service for your portion of the co-pay, deductible, or payment in full if you are not using insurance for services provided. Your prompt payment allows us to keep our fees to you as low as possible. Many insurance companies pay 50-90% of the cost of psychotherapy and psychological testing, **after** your deductible is met. We bill your insurance company as a courtesy service to you, but it is your responsibility to make sure that your bill is paid in full to us. If you anticipate any problems in paying your bill, you should discuss this with us as soon as possible to make a payment plan and to minimize any misunderstandings.

Please note that there is a **$45 service charge for all returned checks.**

Also, balances older than 30 days may be subject to a l.5%/month (18%/year) finance charge, and in cases of payment default, you will be charged for any collection fees we may incur, with a minimum of an additional $25.00 fee.

Please note that it is your responsibility to know your benefits, and that it is your responsibility to pay us. We generally try to verify your insurance before you come in, but occasionally insurance companies give us erroneous information. When this happens, you agree that you are still ultimately responsible for payment in full to us. While we will do all that we can to assist you in filing your claims and seeing that proper payment is made, you are ultimately responsible for knowing your policy and for full payment of your bill. We strongly suggest that you verify your insurance benefits and know if you have any maximum eligible payments per therapy session or per year. Disputes with your insurance company are between you and them.

_____ **PLEASE INITIAL** after reading to signify agreement

Cancellations: If you need to cancel or change an appointment, be sure to give us at least **24 hour notice (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 to allow time to fill the appointment)**, otherwise you will be charged the **full fee--$170** for the appointment time reserved. Insurance companies will **not** pay this fee, so we urge you to give proper notice when canceling, for your benefit and ours. This allows us to offer your time to other patients waiting. If you are unable to give 24 hour notice, call us as soon as possible. If we are able to fill your appointment on short notice, we may be able to waive the fee. We almost always have patients waiting for times, so when you cancel giving us 24 hours notice we are able to give that time to someone else. A message left on the answering machine is sufficient if the office staff is unavailable.

Emergencies and After Hours: We have Voice Mail for your messages when we are not here. We will get back to you as soon as possible; when you call in the evening or on the weekends, it will generally be the next business day before we can return your call.
In the event of an emergency, there will be a phone number on the answering machine where you can usually reach a psychologist sooner. Please use this phone number **only in emergencies or crises.**
If for some reason you are unable to reach one of us, please get in touch with Riverside Hospital Emergency Services (614-566-5321), where there are 24-hour emergency service counselors on duty, or call 9-1-1.
If you are feeling suicidal, or that you might hurt someone else, do not hesitate to **use one of the emergency resources immediately**!

The process of therapy: If you are entering therapy for the first time, you may have some questions about how things will proceed. We will start by learning what brings you in, what your concerns are, and what you wish to work on in therapy. We will ask you about your life history, your current situation, and set goals together to guide our therapy work. Provided that both you and your therapist feel comfortable with one another, your work in therapy can now proceed. We will then work on exploring your feelings and thoughts, try out new behaviors, thoughts, handle your emotions differently, and work to gain new insights. When you feel that you have accomplished your goals, it is useful to spend a session reviewing the goals and looking at how you can continue to make progress on your own. This is an important time for you to evaluate how therapy has been helpful to you, and for the psychologist to make some additional suggestions as well. It is important to utilize the goals you mutually set with your doctor to periodically review your progress in therapy and to evaluate the process. It is your right to discontinue treatment at any time. It is the psychologist's ethical responsibility to end the relationship when it is reasonably clear that the client is not benefitting from treatment.

Psychological testing: Sometimes psychological testing is needed to gain clarity regarding important aspects of your personality and/or current psychological status. Such assessment is often very cost effective in treatment planning. Fees for the assessment are based upon the number and nature of tests given. Your psychologist will inform you of these costs at the time the testing is recommended, and once assessment is completed, your psychologist will discuss the findings with you.

Confidentiality: Everything that takes place in psychotherapy is confidential, and may not be released without your express written permission. There are two exceptions to this; if you become actively suicidal or are thinking of hurting someone else, and if you are involved in child or elder abuse. We are legally bound to protect you and the other parties, and confidentiality may have to be broken. If you have insurance that uses managed care, treatment information must be released to them in order for your insurance to pay for services rendered to you. We may ask you to sign a release of information form so that we may communicate with your other doctors, previous therapists, or family members. You have the right to refuse to sign these forms if you so choose. Finally, confidentiality for teenagers and children will be discussed during the first session to clarify rights of the child/teen and the parents. Additionally, confidentiality for couples and families should be discussed with your therapist.

_____**PLEASE INITIAL** after reading to signify agreement to policies/procedures.

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. If you are unhappy with your services here, it is especially important that you try your best to communicate with us the sources of your dissatisfaction. You may do this in writing if you feel uncomfortable speaking to your therapist, the office manager (if it is a billing issue), or Dr. Orcutt. If we do not reach an agreeable solution and you need help finding additional or alternate assistance, we will do our best to help you locate a more suitable referral or therapy resource. Since therapists generally agree that it is not in the client's best interest to be receiving similar services from two professionals at the same time, should you wish to contract with another therapist for services, it is important that you indicate your desire to make a change.

Release of Liability: If you fail to show for an appointment, we will try to contact you during that appt. time at the number you have provided. If we do not hear from you within one week of the missed appointment, you have released us of all liability for your psychological counseling/care. Also, if you cancel an appointment without rescheduling, you release us from liability for your psychological care/counseling. You are welcome to reschedule at any time, provided any past balances, including no show fees, are paid. Of course there are extenuating circumstances, such as an extended vacation, family emergency, unforeseen business trip, etc. In such cases, please contact us as soon as possible to keep us informed.

Questions: If during the course of your therapy you have any questions about the nature of your therapy (i.e. goals, procedures, etc.) or about fees, please ask. This issue is even more important on matters which you fear might be embarrassing to either yourself or us--you are encouraged to go ahead and bring such matters up for consideration since dealing with such matters is often an important part of your treatment.

_____ **PLEASE INITIAL** after reading to signify agreement

Patient Information (CHILD)
Patient Name _____DOB: ___/___/___

Social Sec. # _____

Home Address _____City _____ZIP _____

Parent/Guardian Information

Name _____Relationship to Patient _____

Home# _____ Cell#_____ Work#_____

Email address_____
Can we use your email for appointment reminders? yes_____no_____

Your Employer_____

Spouse/Partner/Significant Other Name_____

Work#_____ Cell# _____

Emergency contact_____Relationship_____

Address_____ City_____ Zip_____
Phone#_____

Whom may we thank for referring you to us? _____

Please note: We often send our professional sources letters to thank them for referring you to our office. If, a doctor, lawyer, etc. referred you; we generally send them a brief note or Thank you card letting them know you were seen in our office. Do we have your permission to do this with your referral source? **Yes**___ **No** ___

I have read and/or have received a copy of the HIPAA Notice Form _____
SIGNATURE

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. If I do not pay this balance within 30 days of being billed, I understand that a 1.5%/ month (18%/year) interest charge may be added to my account until the balance is paid in full. If I do not pay this balance or arrange a payment plan, I understand that I may be turned over to a collection agency and I will be billed for any subsequent collection charges, including a minimum charge of $25.00. I have read and understand the office policies on the previous pages. I certify this information is true and correct to the best of my knowledge, and I will notify you of any changes in my health insurance or the above information as soon as possible. I agree to abide by the cancellation policy as well.

PARENT/GUARDIAN SIGNATURE: _____

I understand that my psychologist, as an independent contractor, is solely legally responsible for my treatment and care.

PARENT/GUARDIAN SIGNATURE: _____

**** IF I GIVE LESS THAN 24 HOURS NOTICE TO CANCEL AN APPOINTMENT, OR I DO NOT SHOW UP FOR A SCHEDULED APPOINTMENT, I AGREE TO PAY THE FULL $170.00 FEE, WHICH IS NOT BILLED TO INSURANCE.**

PARENT/GUARDIAN SIGNATURE:_____**Date:**_____ **Witness:** _____

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ABOUT FEES AND INSURANCE

We want to share some information with you about using insurance, so you can make an informed decision about using your insurance benefits. We find that increasingly more of our patients prefer to self-pay, and they see this as an investment in their future and their healthier and more meaningful life.

Pros- Obviously, health insurance helps to pay the bills.

Cons-

1.) Increasing loss of confidentiality can occur. If your insurance is managed care, your therapist is required to write detailed reports approximately every six visits to the managed care company, which could mean that some of your issues are logged into the insurance computer. While managed care companies generally endeavor to keep this information private, insurance companies to share information with each other, if you apply for coverage elsewhere. You need to decide whether you are comfortable with this, or if the benefits of having insurance to help pay for your services is worth this trade-off.

2.) Patients sometimes find that because of previous psychological/psychiatric diagnoses, that they are unable to get health or life insurance coverage in the future. Even if you do not tell an insurance company on your application that you have had treatment, it is logged with the Medical Information Bureau, with whom all insurance companies check. If you self-pay, then no diagnosis is filled in insurance computers, and thus there is no record of treatment outside of our office, unless you choose to share this.

3.) Many companies, before making promotion decisions regarding their employees, check health/insurance records, without your knowledge. If your employer is enlightened, they may know that therapy is a useful tool to help employees be healthier and happier in their lives. However, if you do not know this about your employer and you prefer to maintain privacy, you may wish to self-pay.

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 you to release whatever information is needed to assure benefits.
OR
*_____I choose to self-pay for my therapy services.

Please feel free to discuss this with your therapist before making your decision.

_____ _____
Signature Date

Health Insurance Claim Form Signature. *Sign in both of the boxes below*, this is needed to bill your insurance company. Only sign if you plan on using your insurance benefits.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____	13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____

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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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RELEASE OF INFORMATION FOR PRIMARY CARE PHYSICIAN

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. This release will stay in effect unless you sign to revoke it with us.

Please let us know what you would like:

I, _____, hereby authorize

_____
(Psychologist Name)

Please check one:
____ to exchange any applicable information with my physician
____ to exchange relevant information if medication is needed.
____ not to exchange information with my physician

_____	_____	_____
Print name of Patient	Date of Birth	SS#

_____	_____
Signature of Patient	Date

_____	_____
Signature of Parent/Guardian	Date

Name of Physician: _____

Address: _____

_____

Phone: _____

Fax: _____

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Social media policy for Bethel Olentangy Psychological Services

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 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.

Y. N. You may reach me by email to remind me of appointments and I may choose to contact my psychologist via email on occasion.

Signed,_____

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Authorization for General Release of Information

Client Name:_____ Date of Birth: _____

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

Bethel Olentangy Psychological Services
4949 Olentangy River Rd. Columbus, OH 43214
Phone: (614) 451-6606 / Fax (614) 451-2923

Name of person to release to / to receive from: _____
(circle one or both)
Address: _____

_____

Phone: _____ Fax: _____

for the following information: _____

_____

for the specific purpose of: _____further care _____evaluation
_____reimbursement/ins _____other

and I release all of the above named parties of any legal liability which may arise from the release of information requested.

I understand that this authorization for the release of information will automatically expire 1 year after the date on the release unless otherwise indicated below.

Reason and date of earlier expiration:_____

I also understand that this release can be revoked by me at any time and that the revocation must be signed and dated by myself.

Client Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Relationship (if client is a minor):_____

Witness:_____

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CONSENT FORM

Permission is hereby granted to the clinicians of Bethel Olentangy Psychological Services, Columbus, Ohio, to provide outpatient mental health services as may be 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 should clarify in the first session how and/or what information will be conveyed about my child/teen. I understand that under some circumstances, especially with teens, that confidentiality may be crucial for the teen to establish a therapeutic relationship.

I have read this consent form and I certify that I understand its contents as of this date and time.

Signed:

_____ Date: _____
Parent/Guardian

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Parental Rights Statement

Client (Child) 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. If this statement describes your child's situation please be advised that BOTH parents are required to have a credit card on file. We will charge each credit card 50% at each visit, unless each parent or a legal document states otherwise. Fees must be paid at each visit.

_____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:

Name: _____

Address: _____

_____

Phone: _____

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:_____