BETHEL OLENTANGY PSYCHOLOGICAL SERVICES
An Association of Independent Practitioners
4949 Olentangy River Road Columbus, OH 43214
Phone: (614) 451-6606 / Text: (614) 450-2927
admin@bethelolentangy.com

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: *(*Fee is per appointment)*

First 3 sessions, Intake (53-60 minutes)	$ 290.00	/session
Established Patient, Individual (53-60 minutes - insurance claims)	$ 250.00	
Established Patient, Individual (38-52 minutes)	$ 190.00	
Family or couples therapy (45 minutes)	$ 205.00	
Established Patient, Individual (16-37 minutes)	$ 125.00	
Missed appointments (see Cancellation Policy)	$ 190.00	
Psychological Testing (per 45-minute session)	$ 205.00	
(Fees are based on time spent in administration, scoring, interpretation, and write-up time.)	$ 6.00	/minute
Assessment forms for diagnostic evaluations (forms priced up to; not billable to insurance)	$ 15.00	/form
Diagnostic Evaluation Reports (i.e., ADHD; not billable to insurance)	$ 300.00	/report
Phone calls, emails, and/or review of documents longer than 5 minutes (to client, family, another healthcare provider)	$ 5.00	/minute
Phone calls, emails, and or/review of documents for any court-related matters	$ 7.00	/minute
Letters, formal reports, travel time for "out-of-office" services	$ 7.00	/minute
Testifying in court, depositions and court-related work including travel time	$ 400.00	/hour
(Payable in full in advance including if subpoenaed, or called by another party)		
Executive coaching, consulting, mediation (not billable to insurance)	$ 270.00	
Group	$ 60.00	/ meeting
Dialectical Behavior Therapy (DBT) Skills Group		
Understanding Your Relationship with Food: Group Therapy for Successful Lifestyle Change		

Billing:

- Payment is expected at the time of services rendered. A valid form of payment on file is required for all patients.
- 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/one business day is required for appointment cancellations. Cancellations given with less than 24-hour notice and no-shows for appointments are subject to a fee of $190 (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.
- Group Therapy: 24-hour notice/one business day is required for appointment cancellations. Cancellations given with less than 24-hour notice and no-shows are subject to a fee of $60.00.

_____ **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 Association, 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.

Appointment Reminders:

Clients will receive automated appointment reminders via email, as a courtesy, from a third-party system. Clients are ultimately responsible for maintaining their appointments.

Policies for Support Group

- Dialectical Behavior Therapy (DBT) Skills Group
- Understanding Your Relationship with Food: Group Therapy for Successful Lifestyle Change

Cancellation Policy for Support Group:

- 24-hour notice/one business day is required for appointment cancellations. Cancellations given with less than 24-hour notice and no-shows are subject to a fee of $60.00.

ADHD Evaluation Overview:

An ADHD evaluation with our office involves meeting with a provider for a minimum of three (3) sessions. The first one (1) to three (3) sessions are intake interview sessions (to gather information and to determine which assessments are best suited to make a diagnosis); once the evaluation has been completed, you will meet with the provider for a feedback session to review the results, diagnosis (if applicable), and potential recommendations. This evaluation does include some out-of-pocket costs, which are not billable to your insurance company. These fees include roughly $300.00 for the report written by your provider, as well as the assessment materials, which generally cost between $45.00-$150.00. These fees would be in addition to the fees for the intake and feedback sessions.

Patient Information

Patient Name _____ Date of Birth _____

Home Address _____ City _____ Zip _____

Parent/Guardian Information:

Name _____ Date of Birth _____

Relationship to Patient _____

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 _____

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

Patient Name: _____ Patient DOB: _____

Please select the items that are of concern to you from the options below:

☐	Alcohol or drug abuse	☐	Loneliness or homesickness
☐	Anxiety, fears, or worries	☐	Military combat or war zone experiences
☐	Anger management (angry, irritable, hostile feelings)	☐	Parental alcohol/drug use
☐	Attention/focus issues	☐	Physical attack
☐	Body image concern	☐	Physical stress (headaches, stomach pains, muscle tension)
☐	Childhood abuse (physical/sexual)	☐	Procrastination and/or getting motivated
☐	Compulsions	☐	Racial identity concerns
☐	Chronic illness (diagnosis for self or loved one)	☐	Relationship with friend/roommate
☐	Decision about career or academic future	☐	Relationship with parents/family
☐	Depression	☐	Relationship with romantic partner
☐	Domestic violence and/or intimate partner violence	☐	Self-esteem or self-confidence
☐	Emotional abuse in past or present relationship	☐	Sexual issue
☐	Emotional eating	☐	Sexual violence (unwanted sexual experience, rape, sexual assault, abuse)
☐	Ending relationship or divorce	☐	Shyness or being assertive
☐	Experiencing Discrimination	☐	Sleep problems
☐	Family of origin issue	☐	Suicidal feelings/behavior, self-harm, or cutting
☐	Gay/Lesbian/Bisexual/Transgender concerns	☐	Test anxiety, speech, or performance anxiety
☐	General interpersonal problem	☐	Weight management issues or eating disorder
☐	Grief	☐	Work stress
☐	Legal issues		

Additional information you would like your provider to know:

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MEDICATIONS

Name: _____ Patient DOB: _____

Please include all medications you are currently taking.

Medication Name	Medication Dosage	Medication Frequency

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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.

Parent/Guardian Signature:_____ Date: _____

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Parental Rights Statement

Patient Name: _____ DOB: _____

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 check 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:

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

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COMMUNICATION POLICY

Please indicate the ways in which the office may reach you:

Email:

Yes ☐ No ☐

Text messages via administrative texting number:

Yes ☐ No ☐

- Clients may choose to communicate with the office by phone, email, or text. Confidential voicemail and HIPAA compliant email are available, so let us know if that is something that you want to utilize, otherwise the electronic communications will be in an unencrypted format. The confidentiality of electronic communications which are not encrypted cannot be guaranteed, and you acknowledge the possible lack of confidentiality when any of these methods are used and agrees to accept the risks involved.

- If you only wish to use **encrypted electronic communications**, please initial here: _____

- Psychologists and office staff do not connect or communicate with clients on any form of social media. This keeps clear and appropriate boundaries within the therapeutic relationship during therapy and afterwards, should the client decide to return to treatment at some point in the future.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

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INSURANCE

Choose one of the following options below:

☐ **I choose to self-pay for each session and NOT send claims insurance:**

If you choose to not have your therapist, send information to your insurance company, you must select this option before each session and then pay for the session in full. With this option no report of any information will be made to your insurance company about that session. Although insurance companies say that they maintain confidentiality, oftentimes they report information to a national data bank that may later affect your ability to obtain other types of insurance.

☐ **I choose to use insurance for each session. I have read and understand the following information:**

Because your therapist is a licensed mental health therapist, many health insurance plans will help you pay for therapy and other services he or she offers. Because health insurance is written by many different companies, your therapist cannot tell you what your plan covers. Please read your plan's booklet under coverage for "Outpatient Psychotherapy "or under "Treatment of Mental and Nervous Conditions." Or call your employer's benefits office to find out what you need to know. If your health insurance pays part of your therapist's fee, the practice will help you with your insurance claim forms. However, please keep some things in mind: Your therapist had no role in deciding what your insurance covers. Your employer or you (if you have individual coverage) decided which, if any, services will be covered and how much you must pay. You are responsible for checking your insurance coverage, deductibles, payment rates, co-payments, and so forth. Your insurance contract is between you and your insurance company; it is not between your therapist and the insurance company unless he or she or the practice has signed a separate agreement with that company. You are responsible for paying the fees that are agreed upon. If you ask the practice to bill a separated spouse, a relative, or an insurance company and payment is not received on time, then you agree to pay this amount. In addition, the plan may have rules, limits, and procedures that should be discussed, and your therapist may not be on one of their panels. Please bring your health insurance plan's description of services to one of the early meetings with your therapist, so that you can talk about it and decide what to do. The practice will provide information about you to your insurance company with your consent, and by signing below you agree that it may do that. If the practice or your therapist has a contract with your insurance company, then billing will be sent in accordance with the contract with that company. If your therapist or the practice is not contracted with that insurance company then you will be supplied with an invoice for your therapist's services with the standard diagnostic and procedure codes for billing purposes, the times you met, the charges, and your payments. You can use this to apply for reimbursement. By signing this form, you agree to assign any reimbursement you receive from your insurance company to the practice.

Policy Information

Please provide the following information so the office can send claims to your insurance company:

Insurance Company:_____

Name of Policy Holder:_____ Policy Holder Date of Birth:_____

ID Number:_____ Group Number:_____

If you are NOT the policy holder and you want to utilize your insurance, permission is given to this office to discuss insurance matters with the policy holder, and to send claims to the insurance company. Information available to the policy holder could include dates of service, diagnosis codes, and names of providers.

Parent/Guardian Signature:_____ Date:_____

Printed Name:_____

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Informed Consent to *Telepsychology* (i.e., Videoconferencing) Services

1. I understand that I must be a new or established client receiving services at Bethel Olentangy Psychological Services (BOPS) in order to be considered for Telepsychology sessions. BOPS will conduct initial assessments via videoconference only when the psychologist decides that it is appropriate for the patient.

2. I understand that BOPS is making use of Telepsychology sessions to address the needs for service, and to protect both patients and staff during possible quarantines and/or safety concerns related to Coronavirus. I understand that face to face sessions will resume on a regular basis once the Coronavirus is resolved. I understand that there are potential benefits and risks of telepsychology and video-conferencing (eg limits to patient confidentiality) that differ from in-person sessions.

3. I understand that, in order to participate in Telepsychology sessions, I will need access to a secure, reliable internet connection on a computer or mobile device in a private setting. I will be responsible for making sure that the camera and microphone on my device are accessible to the Doxy platform used for Telepsychology sessions. I know that I can request a "set-up" trial with my psychologist to be sure the technology works prior to my scheduled session.

4. I understand that, in order to participate in a Telepsychology session, I must be physically located in the state of Ohio at the time of the session.

5. I understand that it will be my responsibility to assure privacy for myself during the session, and to inform my psychologist of a) my location, b) any other persons in the room with me during a session, and c) a way that I can be reached by my therapist if we lose the internet connection. I understand that my therapist will be conferencing with me from a private room and will maintain my confidentiality.

6. I understand, in the event of technology failure during session, my psychologist and I might have to revert to a telephone session.

7. I understand that my psychologist may choose not to offer Telepsychology sessions with me, or to cease conducting such sessions, if the therapist deems such sessions to be inappropriate for my circumstances for any reason.

8. I understand that typical session fees, as listed in the general BOPS Informed Consent to Treatment document, will apply to Telepsychology sessions. If I am using insurance to pay for sessions, claims will be submitted to my insurance company as usual. Every attempt will be made to assure in advance that my insurance company will reimburse for Telepsychology sessions, but in the event that my insurance company subsequently denies the claims, I understand that I will be responsible for the fees myself. I understand that I must have a credit card on file in advance of a Telepsychology session.

9. I understand that all other elements of the general BOPS Informed Consent to Treatment document still apply, in addition to these specifications for Telepsychology sessions.

Patient Name: _____

Legal Guardian Name (if applicable) and relationship to patient: _____

Patient home address: _____

Emergency Contact name and phone number: _____

Address and Phone Number of Nearest Police Department to Residence: _____

Address and Phone Number of Nearest Emergency Services to Residence: _____

I understand that if I might hurt myself or others, or feel that telepsychology is no longer meeting my needs, I will either discuss this with my psychologist immediately, or I will go to the nearest Emergency Room and/or call the police department to be transported to the Emergency Room.

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

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Patient Name:_____ Patient Date of Birth:_____

The ***cardholder*** agrees to the use of the credit card number (listed below) for fees associated with appointments for the above-named client at the office of Bethel Olentangy Psychological Services. The cardholder understands this may include fees for missed appointments and other fees that are not billable to insurance. This agreement is binding until written notice canceling the agreement is received by the office. Termination will not be effective for previously incurred charges. If there are any changes in the information below, I agree to update the practice immediately.

Credit Card Information	
Card Type: Visa ☐ Mastercard ☐ Discover ☐ American Express ☐ HSA ☐	
Credit Card Number:	Expires:
Name of Cardholder:	CVV Code:

_____ _____
Cardholder Signature Date

_____ _____
Patient Signature Date
(If applicable and if patient is not the cardholder)

FOR OFFICE USE ONLY
Clinician:
Form reviewed by office staff:
Patient is under 18: