



Phoenix Associates, Inc.

Phoenix Associates, Inc.  
2200 Lake Ave Suite 260  
Fort Wayne, IN 48605  
260.424.0411  
[www.phoenixassociates.net](http://www.phoenixassociates.net)

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## Client Information

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Client Name	Sex	Date of Birth
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Client Address

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City	State	Zip
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Preferred Contact Number	Alternate Number
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Referral Source

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## Guarantor Information (Person Responsible for Payment)

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Guarantor Name	Relationship to Client
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Address

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City	State	Zip
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Home Phone	Cell Phone
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Employer	Occupation
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## Primary Insurance Information

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Insurance Company

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Insured's name	Relationship to Client
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Date of Birth

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Insured's Identification #	Group #
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Insured's Employer

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## Secondary Insurance Information

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Insurance Company

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Insured's name	Relationship to Client
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Date of Birth

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Insured's Identification #	Group #
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Insured's Employer

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**List names and ages of others living in your home.**

<b>Name</b>	<b>Age</b>	<b>Relationship to Client</b>
<b>Name</b>	<b>Age</b>	<b>Relationship to Client</b>
<b>Name</b>	<b>Age</b>	<b>Relationship to Client</b>
<b>Name</b>	<b>Age</b>	<b>Relationship to Client</b>
<b>Name</b>	<b>Age</b>	<b>Relationship to Client</b>
<b>Name</b>	<b>Age</b>	<b>Relationship to Client</b>

**CONSENT FOR MENTAL HEALTH SERVICES**

I, the undersigned, agree and consent to participate in the mental health services offered and provided by Phoenix Associates, Inc., a mental health provider or psychologist, as defined in Indiana law.

I understand that I am consenting and agreeing only to those mental health services that the above named provider is qualified to provide within:

- a) The scope of the provider's license, certification, and training; or
- b) The scope of license, certification, and training of those mental health providers directly supervising services received by the patient.

**Signature of Client/Parent/Legal Guardian** \_\_\_\_\_

**Relationship (if other than client)** \_\_\_\_\_

**Witness** \_\_\_\_\_ **Date** \_\_\_\_\_

**(Must be over 18)**

## Financial Policy

In order to prevent misunderstandings, we request that you read and sign the following financial policy.

### Payment at Time of Service

Payment is expected at the time of services unless prior arrangements have been made. We accept cash, money orders, checks, and VISA/MasterCard/Discover. (Collecting our fees at the time of service helps to contain the cost of care.)

Please remember that our services are rendered and charged to the client and not the insurance company. Your insurance company has an obligation to you, but not to us. The person responsible for payment of the account is the client, or the person (parent or custodian) bringing the client in for care. Even if another party is legally responsible for medical care of the client, as in divorce cases or auto accidents, the client, or person (parent or custodian) bringing the patient in for care is still responsible for the charges incurred. We will assist in filing with your insurance company or billing a third party, but you have ultimate responsibility for payment.

### Insurance

Our services may not be covered under the terms of your insurance policy. Please contact your insurance company regarding covered services. Some plans require pre-authorization or the referral of a primary care physician. It is your responsibility to understand your plan requirements and to obtain any necessary authorization or referrals. We will be happy to assist you, but again, the ultimate responsibility for payment is yours.

I understand that late cancellation and no-show fees may not be billed to insurance, and I am personally responsible for the payment.

I have read and understand the Financial Policy above and I agree to its terms.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Relationship** (if other than client)

### AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Phoenix Associates, Inc. to release any information acquired in the course of the client's examination or treatment, which is necessary to process insurance or third party payer claims.

\_\_\_\_\_  
**Signature**

### AUTHORIZATION TO PAY BENEFITS

I hereby authorize payment directly to Phoenix Associates, Inc. of the benefits, if any, otherwise payable to me for services rendered by Phoenix. I understand that I am financially responsible for non-covered services.

\_\_\_\_\_  
**Signature**

**PLEASE HAVE INSURANCE CARDS READY TO BE COPIED**



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## Office Policies

All co-pays and payments must be paid in the month of the service. If you require payment assistance please talk to the office staff to arrange a payment plan. If the account becomes delinquent it may be sent to collections.

### Insurance

We will make every reasonable effort to obtain authorization, file insurance claims and secure payment for our services on your behalf as a courtesy; however, the client not the insurance company is ultimately responsible for payment. We recommend that you contact your insurance company to verify eligibility and benefits prior to the first date of service. In the event that your insurance denies the claim because authorization was not obtained, the service is not a covered benefit of your plan, the therapist is not a covered provider for your policy, we were not informed of changes to your plan or for any other reason beyond our control, the client will be responsible for payment.

### No show or Late Cancellation OR Returned Check Fee

- It is the responsibility of the client to pay \$25.00 for the No Show or Late Cancellation appointments within the same month it occurred. Charging a no show or late cancellation fees are at the discretion of the therapist.
- It is also the client responsibility to pay the \$25.00 returned check fee. It has become necessary for us to implement the policy.
- If there are three (3) no shows any future appointments will be cancelled and there will be no rescheduling unless the therapist advises us otherwise.

**I have read and understand this notice:**

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



## Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The following Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. The following also describes your rights to access and control your protected health information.

- *Protected Health Information* is information about yourself that may identify you and that relates to your past, present, or future health conditions and related health care services.
- *Treatment* is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist or treatment provider.
- *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

We are required by federal law to abide by the terms of this Notice. The terms of this notice may change at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a copy of any revised Notice of Privacy Practices. Uses of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. Your PHI may be disclosed without authorization in the following circumstances:

- *Child Abuse* –If your therapist believes that a child is a victim of child abuse or neglect, s/he must report this belief to the appropriate authorities.
- *Adult and Domestic Abuse* –If your therapist believe or have reason to believe that an individual is an endangered adult, s/he must report this belief to the appropriate authorities.
- *Health Oversight Activities* –If the Indiana Attorney General's Office (who oversees complaints brought against psychologists instead of the Indiana State Psychology Board) is conducting an investigation into our practice, then we are required to disclose PHI upon receipt of a subpoena.
- *Judicial and Administrative Proceedings* -If the patient is involved in a court proceeding and a request is made for information about the professional services we provided you and/or the records thereof, such information is privileged under state law, and we will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety* -If you communicate to your therapist an actual threat of violence to cause serious injury or death against a reasonably identifiable victim or victims or if you evidence conduct or make statements indicating an imminent danger that you will use physical violence or use other means to cause serious personal injury or death to others, we may take the appropriate steps to prevent that harm from occurring. If we have reason to believe that you present an imminent, serious risk of physical harm or death to yourself; we may need to disclose information in order to protect you. In both cases, we will only disclose what we feel is the minimum amount of information necessary.
- *Worker's Compensation* -We may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard

to fault.

- You have the right to inspect and copy your protected health information. Federal law, however, prohibits your inspection or copying of the following records: psychotherapy notes, information compiled for the purpose of civil, criminal, or administrative action, as well as other protected health information that is subject to law that prohibits access.

You have the right to request a restriction of your protected health information. This means you may ask us not to disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that this information not be disclosed to family members or friends who may be involved in your care. Phoenix Associates, Inc. is not required to agree to a restriction that you may request.

You have the right to obtain a copy of this notice upon request.

You may complain to us if you believe your privacy rights have been violated. You may file a complaint by notifying the office manager, Privacy Officer for Phoenix Associates, Inc. This complaint will be kept confidential and not affect your care. You may contact the office manager at (260) 424-0411 for further information about the complaint process.

This notice was published and becomes effective as of April 14, 2003 and thereafter.

### **PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT**

Welcome to Phoenix Associates, Inc. This Agreement contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Policies and Practices to Protect the Privacy of Your Health Information for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

#### PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit, instead; it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some first impressions of what your work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with your assigned therapist. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about your therapist's procedures, you should discuss them whenever they arise. If your doubts persist, your therapist will be happy to help you set up a meeting with another mental health professional for a second opinion.

#### MEETINGS

Therapists at Phoenix Associates, Inc. normally conduct an evaluation that will last from 2 to 4 sessions. During this time, you and your therapist can decide if this therapist is the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, we will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions so the late cancellation fee is solely your responsibility.** If it is possible, we will try to find another time to reschedule the appointment that week. Please be aware that this is often very difficult to do.

### PROFESSIONAL FEES

Our hourly fee is \$110.00. In addition to weekly appointments, we charge this amount for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. If you become involved in legal proceedings that require our participation, you will be expected to pay for all of our professional time, including preparation and transportation costs, even if we are called to testify by another party. Because of the difficulty of legal involvement, we charge \$150.00 per hour for preparation and attendance at any legal proceeding.

### CONTACTING YOUR THERAPIST

Due to our work schedules, your therapist is often not immediately available by telephone. While we maintain regular hours in the office, we do not answer the phone when we are with a patient. When we are unavailable, our telephone is answered by our secretary or by our answering machine. We will make every effort to return your call on the same day you make it, with the exception of weekends and holidays and days we are not scheduled in the office. If you are difficult to reach, please inform us of some times when you will be available. In emergencies, you can try us at our home number. If you are unable to reach us and feel that you can't wait for us to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If your therapist will be unavailable for an extended time, he or she will provide you with the name of a colleague to contact, if necessary.

### LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist, licensed clinical social worker, licensed mental health counselor, and certified substance abuse counselor. In most situations, we can only release information about your treatment to others if you sign a release of information form that meets certain legal requirements imposed by IDPAA and/or Indiana law. However, in the following situations, no authorization is required:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of the patient. The other professionals are also legally bound to keep the information confidential. If you don't object, you will not be told about these consultations unless it seems important to your therapy. We will note all consultations in your Clinical Record (which is called "PID" in the Notice of Policies and Practices to Protect the Privacy of Your Health Information at Phoenix Associates, Inc.).
- You should be aware that your treatment is provided in a practice setting involving other mental health professionals and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- We also have contracts with a medical computer information technology firm, independent psychologists, practicum students, and an accounting firm. As required by IDP AA, we have a formal business associate contract with them, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If you are involved in a court proceeding and a request is made for information concerning the professional services we provided to you, such information is protected by the health professions bureau's-patient privilege law (specific to your therapist's profession: psychologist, licensed clinical social worker, licensed mental health counselor, substance abuse counselor). We cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.
- To a coroner or medical examiner, in the performance of that individual's duties.
- If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a patient's treatment. These situations are unusual in our practice.

- If we have reason to believe that a child is a victim of child abuse or neglect, the law requires that we file a report with the appropriate government agency, usually the local child protection service. Once such a report is filed, we may be required to provide additional information.
- If we have reason to believe that someone is an endangered adult, the law requires that we file a report with the appropriate government agency, usually the adult protective services unit. Once such a report is filed, we may be required to provide additional information.
- If a patient communicates an actual threat of physical violence against an identifiable victim, or evidences conduct or makes statements indicating imminent danger that the patient will use physical violence or other means to cause serious personal injury to others, we may be required to disclose information in order to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.
- If a patient communicates an imminent threat of serious physical harm to him/herself, we may be required to disclose information in order to take protective actions. These actions may include initiating hospitalization or contacting family members or others who can assist in providing protection.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit our disclosure to what is necessary. While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

### PROFESSIONAL RECORDS

The laws and standards of our professions require that we keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that that disclosure would physically endanger you and/or others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in the presence of your therapist, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, we are allowed to charge a copying fee of \$0.25 per page (and for certain other expenses). If we refuse your request for access to your records, you have a right of review, which your therapist will discuss with you upon request.

### PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of



protected health information. These rights include requesting that your therapist amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about Phoenix Associates, Inc.'s policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

### MINORS & PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes our policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, we will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. We will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

### BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, we may be willing to negotiate a fee adjustment or payment installment plan. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs may be included in the claim.

### INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, we will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested.

This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above unless prohibited by contract. Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

**YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.**

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

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

Witness: \_\_\_\_\_

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