CLIENT INFORMATION – COUPLES or FAMILY

Date: _____

Name :_____Date of Birth:_____
Address:_____
City:_____State:_____Zip:_____
Phone: Cell:_____Ok to leave message? voice_____text _____
Work:_____Ok to leave message? _____
Home:_____Ok to leave message? _____
Email Address:_____Ok to leave message? _____

Name :_____Date of Birth:_____
Address:_____
City:_____State:_____Zip:_____
Phone: Cell:_____Ok to leave message? voice_____text _____
Work:_____Ok to leave message? _____
Home:_____Ok to leave message? _____
Email Address:_____Ok to leave message? _____

For Family therapy

Name	Age	Gender	Relationship

Payment Information

Self Pay ❑ Yes
Insurance ❑ Yes if so who will we file under: _____
Magellan Yale Health ❑ Yes Blue Cross/Blue Shield ❑ Yes
Out of network insurance company _____
Insurance company: _____
Policyholder's employer _____
Insurance ID# _____

Patient Name: _____

Therapy goals

What is the main reason you're seeking therapy now?

_____

_____

_____

What do you most want to see improve?

_____

_____

What do you hope to gain from therapy overall?

_____

_____

Knowing that therapy involves different styles, overall what are you looking for in your therapy? You might say "not at all" "a little" "some" "very much" or whatever describes it for you.

___Just help getting through this immediate situation or decision
___Communication skills
___Longstanding relationship patterns
___Sexual difficulties

___Anything else?_____

Legal Issues

Are you currently involved with or do you plan to become involved in any legal or other proceedings (ex. law suits or workers compensation suits) for which you would plan to use documentation of your psychotherapy? ❑ No ❑ Yes
Explain:

_____

_____

Patient Name: _____

Health and Treatment History

Psychiatrist, APRN or other current Mental Health Providers:

_____

_____

Current medications: (please include dose if known and prescribing doctor)

_____

_____

_____

Medical conditions that you or your doctor believe may be related to stress or cause you psychological distress:

_____

_____

Other significant health conditions or surgery:

_____

_____

Past Mental Health or Chemical Dependency Hospitalization or Intensive Outpatient Treatment

Who Year type where how long was it helpful?

_____

_____

Current or Prior outpatient treatment including psychotherapy and medication:

Who Year type provider how long was it helpful?

_____

_____

_____

_____

Have you ever done any type of psychological testing or assessment? ❑ No ❑ Yes

If yes, when and for what purpose?_____

_____

Patient Name: _____

Signature Pages

Documents detailing office and payment policy, HIPPA Patient Notification of Privacy Rights are available online for reading, downloading, or printing at www.kathryngwhite.com or you can ask Dr White for a paper copy.

Payment/Insurance Agreements & Authorization

I accept responsibility for payment of charges for services rendered to me. If I choose to use insurance I authorize Dr White to bill my insurance provider for psychological services rendered on my behalf. If Dr White is an out of network provider to my plan, I am personally responsible for the payment of all charges not covered. If she is in my network, I'm responsible for my plan's deductible and co-payment.

I understand that, as a courtesy, Dr White or her representative will file insurance claims for the services provided, including out of network plans. However, this does not release me of my responsibility for payment of the charges for services.

I further understand and agree that a collection agency and/or the courts may be used in the event of a delinquent payment, and I realize that such action could require that the doctor release to the collection agency, attorneys, and/or the courts, information which identifies the parties involved, gives the patient diagnoses, and describes the dates and nature of the charges, as well as all other information contained on any claim filed.

If I am using insurance, I understand that securing benefits under my insurance plan will require that the Dr White provide the plan management with confidential patient information, including diagnosis and the dates and type of service rendered. Further, I understand that for utilization review and other claims review purposes, it may sometimes be necessary for the doctor to provide the plan management with additional information concerning case history, presenting problems, treatment plans, prognosis, and medical record. I fully and freely consent to the release of any and all such patient information as is necessary for the processing and review of health care claims made on my behalf. This consent shall remain in effect until all claims have been fully processed and all review procedures completed.

Signature_____

I understand that my insurance company will not reimburse for missed appointments and agree that I will be charged for and required to **pay for missed appointments not cancelled at least 24 hours in advance**

Signature_____

Patient Name: _____

Self Pay Agreement

Only for people not using insurance:
For personal reasons I decided to engage Dr. White's services and self-pay for all services rendered, and not to file for insurance reimbursement.

Signature_____

I understand and agree that I will be charged for and required to **pay for missed appointments not cancelled at least 24 hours in advance.**

Signature_____

Informed Consent to Care Your

Psychiatric and psychological care like other things in life offer no absolute guarantee of success and there are limitations to any form of care offered a patient. Since such limitations are always a function of the particular problem in question, I invite you to discuss your treatment plan with me. . Your signature acknowledges that you have seen have seen the document outlining Dr White's office policies and the parameters of care and acknowledges your informed consent for care.

Signature_____

Signature_____

Patient Notification of Privacy Rights

The Health Insurance Portability and Accountability Act (HIPAA) provides patient protections related to the electronic transmission of data, the keeping and use of patient records and storage and access to health care records. All health care providers are now required to provide patients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.
By law, I am required to secure your signature indicating you have received this Patient Notification of Privacy Rights Document.

Signature_____Date_____