Patricia D. Post, Ph.D.
Jodie Guth, Ph.D.
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Brenda Hollenbeck, L.P.C., L.M.F.T.
Brenda LaFleur, L.C.S.W.

PLEASE COMPLETE ALL PAPERWORK AND RETURN TO OUR OFFICE:

The Psychology Clinic
2000 Southwood Drive
Lake Charles, LA 70605

THANK YOU FOR CONTACTING OUR OFFICE

WE HAVE SET YOUR APPOINTMENT FOR:

PLEASE COMPLETE AND RETURN THE ENCLOSED FORMS TO OUR OFFICE BY:

IF WE ARE HOLDING AN APPOINMENT TIME AND DON'T RECEIVE THE FORMS 48 HOURS IN ADVANCE OF THE APPOINTMENT TIME WE'LL CANCEL YOUR APPOINTMENT. UPON RECIEIVING YOUR PAPER WORK WE'LL THEN CONTACT YOU TO RESCHEDULE.

PLEASE ARRIVE 15 MINUTES EARLY SO WE CAN MAKE COPIES OF INSURANCE CARDS.

AGREEMENT TO PAY

ONCE AN APPOINTMENT IS SCHEDULED I UNDERSTAND IT'S MY RESPONSIBILITY TO NOTIFY THE OFFICE ABOVE 24 HOURS BEFORE THE SCHEDULED APPOINTMENT TIME IF I CHOOSE TO NOT KEEP THE APPOINTMENT OR IF I NEED TO RESCHEDULE DUE TO UNFORSEEN DIFFICULTIES. I AGREE TO PAY THE NON-REFUNDABLE FEE OF $50 (LCSW/LPC) or $75 (Ph.D) IF I GIVE LESS THAN 24 HOURS NOTICE OR IF I DO NOT SHOW UP FOR MY SCHEDULED APPOINTMENT.

_____ _____

(Print Name) (Date)

_____ _____

(Signature of Responsible Party) (Date)

Assignment of Insurance Benefits
Acknowledgement of Indebtedness
& Consent to Release Information

Insured Patient: _____
(Please Print)

For services provided, I hereby irrevocably assign and transfer to The Psychology Clinic of Lake Charles, LA, my rights and interest in all benefits due under the applied insurance policy or in my rights against any third party who might be held liable for the services described in the statements rendered by the hospital.

I hereby consent that The Psychology Clinic may release information concerning the above party and furnish copies of my records if requested by the insurance company. I hereby release The Psychology Clinic from legal responsibility or liability for furnishing such records or information to the extent indicated and authorized herein. I acknowledge that the Law of the State of Louisiana controls and governs the interpretation of this agreement.

I understand that I am personally and directly responsible for all bills submitted by The Psychology Clinic for professional services rendered to me and that I have the primary duty and obligation to pay my doctor for these services, notwithstanding any contract that I may have with any third party, such as an insurance company, employer, union or the government.

_____ _____ _____
Date Signature Relationship to Patient

Person Responsible for Payment

I understand that I am personally and directly responsible for all bills submitted by The Psychology Clinic of Lake Charles for professional services rendered to me and that I have the primary duty and obligation to pay my doctor for these services, notwithstanding any contract that I may have with any third party, such as an insurance company, employer, union or the government.

I hereby stipulate and agree to pay all cost of collections or attorney fees and court fees should it become necessary to resort to court action or turn my account over to a collection agency.

_____ _____
Date Signature

In order to control our costs of billing, office visits are to be paid at the time the service is rendered. Insurance Information

INSURANCE:

Clinician: _____ **Appointment Date:** _____

Patient Name: _____ **DOB:** _____ **SSN:** _____

Patient Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: (_____) _____ Alternate Phone: (_____) _____

Insurance Company:_____ Phone: (_____)_____

Subscriber ID: _____ Group No: _____

Subscriber's Name: _____ DOB: _____ SSN: _____-_____-_____

Subscriber's Address: _____ City, State, Zip: _____

Phone: (_____) _____ Alternate Phone: (_____) _____

Employer:_____

OFFICE USE ONLY

Effective Date:_____

Co-Pay/Co-Insurance: _____

Deductible:_____ Deductible Met?:_____

No. of Visits:_____

Authorization:_____

Out of Pocket _____

Psychological Testing Covered the Same?_____

Mail Claims To:

_____

_____

_____

The Psychology Clinic
2000 Southwood Drive
Lake Charles, LA 70605

Privacy Consent

I understand that as a condition to my receiving treatment at The Psychology Clinic, The Psychology Clinic may use or disclose my protected health information for the purpose of 1) providing treatment and 2) obtaining payment for treatment, and 3) as necessary for the operations of The Psychology Clinic. These uses and disclosures are explained more fully in the Notice of Privacy Practices, which has been provided to me and which I have had the opportunity to review.

I understand that the privacy practices described in the Notice of Privacy Practices may be revised in the future, and that I have a right to request from The Psychology Clinic a copy of any revised Notice.

_____

Name **Date**

_____

Witness **Date**

the Psychology clinic

CHILD/ADOLESCENT INTAKE FORM

Please provide the following information and answer the questions. Information you provide here is protected as confidential information. Please fill out this form and bring it to your first session.

Today's Date: _____

Child's Name: _____ Age: _____ DOB: _____ Sex: _____

School: _____ Grade: _____ Teacher: _____

Parent Information

Circle: Father Step Father Foster Father Other: _____(please explain)

Name: _____ Employer: _____

DOB: _____ Age: _____ SS#_____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Home #:_____ Work #:_____ Cell #: _____

Circle: Mother Step Mother Foster Mother Other: _____(please explain)

Name: _____ Employer: _____

DOB: _____ Age: _____ SS#_____-_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Home #:_____ Work #:_____ Cell #: _____

Emergency Contact: _____Phone #:_____

Emergency Contact's Relationship to Child: _____

Who referred your child to my practice? Please provide agency/professional's name & tel #: _____

_____

May I contact the agency/person to thank them for referring you? Yes No Please initial:_____

May I obtain additional information from this person re: your child? Yes No Please initial:_____

What is the main reason(s) you're seeking help for your child? (Include how long he/she's had these symptoms or problems): _____

_____

_____

_____

What are your hopes regarding your child's assessment/therapy? _____

_____

_____

HEALTH & MENTAL HEALTH INFORMATION

Does your child currently have any medical problems? If so, please describe: _____

_____

_____

Has your child ever been treated for any of the following? If so please circle and describe: Head injury or loss of consciousness, frequent ear infections, tubes placed, hearing or vision problems, headaches, meningitis, seizures, asthma, elevated lead levels, slow/fast growth, allergies, cancer, surgeries, any other conditions: _____

_____

_____

Has your child previously seen a therapist or psychiatrist? If so, what year? Who did he/she see and for what reason? About how many meetings did your child have? Was the experience helpful or not? How so? _____

_____

_____

Has your child ever been hospitalized for medical or mental illness? If so, list when, where & reason:

_____

_____

Please list your child's current prescription medications with dosage (psychiatric and general health):

_____

_____

Please list any previous psychiatric medications (with dosage and dates): _____

_____

Who is your child's primary care physician? _____

Who is your child's psychiatrist (if applicable)? _____

When was your child's last complete physical exam (mo/year)? _____

Parents are (choose one): Married Separated Divorced Living Together

If separated or divorced, how old was your child when the separation occurred? _____

Child lives with (choose one): Both parents Mother Father Other

Who has legal custody? _____

Please describe the current visitation/custody arrangements (if any) and type of communication with child's other parent: _____

YOUR CHILD'S FAMILY	BIOLOGICAL MOTHER	BIOLOGICAL FATHER
Current age, or If deceased date, age, & cause of death		
Country of Origin		
Occupation		
Religious/Spiritual Affiliation (if any)		
Highest grade completed		
Any history of the following (please circle)	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse

Siblings

Please list your child's brothers and sisters in the order of birth (including adopted or step siblings).

First name	Biological, Adopted or Step	Current Age	School grade?	Male/ Female	Lives with you? (Yes/No)	Any medical, social or academic problems (please list for each)?

FAMILY MENTAL HEALTH HISTORY

In the section below identify if any members of your family and extended family have a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please circle		List Family Member(s)
Anxiety (general)	Yes	No	
Obsessive Compulsive Behavior	Yes	No	
Depression	Yes	No	
Suicide Attempts	Yes	No	
Bipolar/Manic Depressive	Yes	No	
Alcoholism	Yes	No	
Substance Abuse	Yes	No	
Domestic Violence	Yes	No	
Eating Disorders	Yes	No	
Obesity	Yes	No	
Schizophrenia	Yes	No	
Counseling or Psychotherapy	Yes	No	
Psychiatric Hospitalizations	Yes	No	

YOUR CHILD'S DEVELOPMENTAL HISTORY

Pregnancy and Birth: Mother used during pregnancy: alcohol _____ drugs _____ cigarettes _____

Delivery: Normal___Breech____Cesarean____Full-term____ Premature____if premature,# of weeks____

Medications used during pregnancy? Please list: _____

Length of pregnancy?_____Weeks Age of mother at birth: _____ Birth weight: _____

Were there any complications during delivery? If so, please describe: _____

_____

Developmental Milestones and Early Development

At what age did your child do the following (indicate approximate month or year of age for each):

Walk Alone _____First Words_____First Phrases_____

Toilet trained? Yes No Approximate age completed? _____

Enjoyed cuddling? Yes No Fussy, Irritable? Yes No More active than other babies? Yes No

If your child has siblings, was development different in any way? Explain:_____

YOUR CHILD'S SCHOOL, HOME, SOCIAL & PERSONAL FUNCTIONING

School/Academics

Your child's current grade? _____ Has he/she ever repeated a grade? Yes No If so, which? _____

School name: _____Public or Private (circle one)?

Previous school attended? _____

What preschool experience did your child have? _____

Were any problems detected in your child's kindergarten screening? Yes No If so, please explain:

_____

Is your child in a regular classroom? Yes No Does your child have an IEP ? Yes No

Does your child receive 504 accommodations? Yes No

Has your child ever received tutoring? Yes No If so, please explain: _____

What are your child's typical grades? _____

(Reports and standardized test score information may be helpful)

What are your child's strongest and weakest points academically? _____

_____

Are you satisfied with your child's educational program? Yes No Please explain: _____

_____

Home/Family Life

What are 5 things that you enjoy most about your child? _____

_____

What are some activities you engage in as a family? _____

Does your child participate in any religious or faith-based group? _____

Does your child listen and obey instructions 75% of the time? Yes No

What are your discipline techniques? _____

What are your strengths personally and as a parent? _____

What are some of your areas of needed growth? _____

What are your child's strengths (things he/she is good at)? _____

Social and Community Engagement

What are your child's favorite activities or hobbies? _____

In what extracurricular/community activities is he/she involved? _____

How does your child get along with other children? _____

Who are some of your child's closest friends (first name)_____

Your Child's Symptoms or Problems

How much are each of the following areas currently a problem for your child?

	Not at all	**A little**	**Somewhat**	**Considerably**	**Terribly**
	1	**2**	**3**	**4**	**5**
Anxiety	1	2	3	4	5
Physical Problems	1	2	3	4	5
Sleep Problems	1	2	3	4	5
Depression	1	2	3	4	5
Eating Disorder	1	2	3	4	5
Parent-Child Conflicts	1	2	3	4	5
Sibling Conflicts	1	2	3	4	5
Social Relationships	1	2	3	4	5
School Problems	1	2	3	4	5
Sexual Problems	1	2	3	4	5
Spiritual/religious	1	2	3	4	5
Legal problems	1	2	3	4	5
Abuse (physical, emotional, sexual)	1	2	3	4	5

Has your child experienced any stressors (recent or during the past year) that may be contributing to his/her difficulties? Yes No

(e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, child's changes school, family moved, family financial problems, remarriage, sexual trauma, other losses)? Yes No

If yes, please describe:_____

_____

Feel free to provide any additional information on a separate page.

the Psychology clinic

For Your Information

We have prepared this form because we want you to know your rights and responsibilities as a client. Please read this information and sign at the end. Your signature documents that you have read and that you understand this information. We will be pleased to answer any questions you have regarding this or any related material.

Fees & Payment
The fee for a 45-minute first appointment intake session is $150 for a LCSW/LPC or $190 for a Ph.D.; following appointments are $100 for a Clinician or $150 for a Ph.D. per visit. There may be charges for other services such as testing, court appearances or depositions, reports, phone calls exceeding ten minutes with you or third parties (attorneys, doctors, insurance carriers, managed care reviewers). Payment is expected at the time of service.

Missed Sessions
We will try to call you to verify your appointment a day in advance. It is your responsibility, however, to call and cancel an appointment at least 24 hours in advance to avoid being billed for missing a session. Missed session fees are half of the fee for a regular visit: $50 for a LCSW/LPC and $75 Ph.D. Fees for a missed session are NOT covered by insurance.

Insurance
The charges for our services are covered to varying extents by most health insurance policies. Our billing office is happy to assist you in filing with your insurance carrier for reimbursement. Our contract for payment, however, is with the client and NOT with the client's insurance carrier.

Insurance coverage varies a great deal among different policies. We will be happy to contact your insurance carrier for you and verify your coverage. The basic questions to be answered include:

*Is there a deductible to be met?
*Are outpatient mental health benefits covered and is pre-certification necessary?
*What percentage of the fee will the insurance cover, and is there a limit on the eligible charges?
*Is there a limit on the number of sessions allowed?
*Are reviews by managed care required?
*If there is more than one insurance company, are there special rules to follow?

Clients must make full payment at the time service is rendered until the deductible has been met. Thereafter, clients must pay their co-payment amount and we will submit claims to the insurance company for the remaining amount. It is the client and NOT the insurance company who is ultimately responsible for payment.

Insurance companies require that a diagnosis be provided in order for a claim to be processed. In some cases, insurance companies will not pay for some certain diagnoses. If you have any concerns about your insurance billing, please feel free to discuss them with our staff.

Confidentiality
Any information that you reveal to your therapist is considered "privilege communication", and it is your right to have that information kept confidential. Mental health professionals are not allowed to release any information about clients without a signed "Release of Information" form that permits the transfer of specific information to a specified individual. This form is valid for one year.

There are only rare situations in which information about clients may be released with or without the client's permission. These situations are as follows:

When a child is physically abused, neglected, or sexually abused, we are required by law to contact the proper authorities (Police, State Department of Family Services).

When a client or another individual is in clear and immediate life-threatening danger as with homicide or suicide, we are required by law to take steps to insure their safety, even if it means contacting authorities without the client's permission.

In addition, there are situations in which the client is involved in civil or criminal litigation where the therapist and his/her records can be subpoenaed, particularly when the client is suing someone for damages based on emotional injury or when the client is involved in a child custody proceeding.

Emergency Coverage
Each therapist can be reached during office hours at (337)-474-2682. After ours, the phone will be transferred to an answering service that will locate either your therapist or the therapist on call for emergency situations. Please let the operator know if your call is an emergency. When your therapist is out of town, he/she will make arrangements for another therapist to cover crisis situations. In the unlikely event that your therapist and the on-call therapist cannot be reached quickly in an emergency, you may consider calling your family physician, a local hospital, or the Lake Charles Mental Health Center at (337)-475-8022

I have read, and I understand the office policy.

_____ _____
Signature Date

_____ _____
Witness Date