The Atrium
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Phone: 215-550-1818
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www.buckscountyanxietycenter.com

Intake Form and Policies

Contact Information:

Name:

Address:

Telephone:	Home:	Ok to leave detailed message: YES NO
	Cell:	Ok to leave detailed message: YES NO
	Work:	Ok to leave detailed message: YES NO

E-mail:

Date of birth:

Marital status:

Number of children, gender, ages:

Occupation: Current job:

Emergency Contact:
Name: Phone number:
Relationship to you:
This information is requested in the event of a psychiatric emergency. No information will be given to anyone about your treatment status or appointments without your expressed permission.

Payment:
You may pay for sessions by cash, credit card, or check.

All checks should be made out to **Bucks County Anxiety Center.** There is a $30 fee for any returned checks.

You may carry a balance for **one week**. Any balances that are not paid within a week will be automatically charged to your credit card. **By filling out the information below, you acknowledge that any outstanding balances will be automatically charged to your credit card.**

Card type:

Name on card:

Card number:

Security code:

Expiration date:

Signature:

_____Please charge all sessions directly to this credit card (Your Initials:)

Referral Source:

How did you hear about this practice?

Doctor OT PT Psychiatrist Psychologist/Social Worker Google Psychology Today

Other:

Working with your therapist (please use the back or attach another page if you need more space)

- What brings you in to work with me?
- What is your history with this issue?
- What are your goals?
- How will you know when you have achieved these goals?
- What challenges do you anticipate?
- What kind of supports do you have in place?
- What are some important things you want me to know about you?

Medical Information

Primary care physician:

Primary care physician's phone number:

Date of last physical:

Have you been diagnosed with any medical conditions? Please list all and date of diagnosis.

Have you ever been diagnosed with any mental health conditions? Please list all and date of diagnosis.

Medications you are currently taking (include reason for taking them, dose, and frequency):

Other specialists you are working with (e.g., PT, OT, alternative medicine, psychiatrist, pain management):

Specialist #1:

Name:

Address:

Phone number:

May I contact this specialist to let them know we are working together? Yes No

Specialist #2:

Name:

Address:

Phone number:

May I contact this specialist to let them know we are working together? Yes No

Medical Information Continued

Are you currently taking any medications for a mental health issue? Yes No

If yes, please list name of medication, dose, frequency, and reason you are taking it:

Name of doctor prescribing the medication:

This doctor is a: General Practitioner Psychiatrist Other____________________

Have you ever been hospitalized for psychiatric reasons? Yes No

If yes, please list dates, length of hospitalization, and reasons for admission:

Educational Information (for children and adolescents only):

Current Grade:

Current School:

Academic Strengths:

Academic Struggles:

Does the child have an IEP and/or 504 in place? If so, why? What accommodations are in place? Use back if needed or bring a copy of the IEP/504.

Did the mother experience any complications during pregnancy?

Was this child born at term? If no, gestational age at birth:

Did the child reach all of their developmental milestones on time?

What is the child/teen's overall temperament and personality? What are they like?

How does this child/teen cope with stress?

How stressful is this child/teen's life?

What is the greatest cause of stress for this child/teen at this time?

How are this child/teen's relationships with their:

1) Family:

2) Friends:

3) Class/School mates:

4) Teachers/Coaches:

STATEMENT OF POLICIES

1) Psychotherapy services:

Working with a psychotherapist can result in a number of benefits. Psychotherapy and coaching require your active participation, honesty, and openness. During psychotherapy or coaching, remembering or talking about unpleasant events, feelings or thoughts can result in uncomfortable feelings such as anger, sadness, worry, fear, etc. The psychotherapist may challenge your thoughts, behaviors, assumptions, and responses. As a result, you may feel angry, scared, or disappointed. Attempting to resolve issues that brought you into the practice may result in changes that were not originally intended. For example, you may experience changes in feelings, behaviors, employment, substance abuse, schooling, housing, or relationships. Sometimes, a decision that is positive for one family member is viewed negatively by another family member. Change will sometimes be quick and easy, but it is usually slow and frustrating. There is no guarantee that psychotherapy or coaching will lead to the intended result. If you have questions about the methods used by your psychotherapist, discuss them whenever they arise. If your doubts persist, you always have the option of getting a second opinion. Every effort will be made to facilitate a smooth transition should you choose to see another mental health professional. You will be asked to leave the practice if you do not comply with the practice policies or treat the psychotherapist in a way that is disrespectful.

2) Fees and payments:

Regular sessions are 45-50 minutes in length. Fees are for this time period. Variations from this time (e.g., two sessions in one week, a longer session) will be billed accordingly. Fees are set up at the beginning of treatment. Your fee will not be increased during your first year. You will always be informed at least a month in advance of any fee increases.

Payment is due at the beginning of each session and is payable by cash, check, or credit card. Checks are to be made out to **Bucks County Anxiety Center.** There is a $30 fee for returned checks.

You may only carry a balance for one week. Balances older than one week will be automatically billed to your credit card. Future sessions will not be scheduled unless all balances are paid in full.

If your account has not been paid for more than 60 days, the practice has the option of using legal means to secure payment. This may involve a collection agency or going through small claims court which will require the practice to disclose otherwise confidential information.

Your psychotherapist may also charge for other professional services you may need, and will let you know verbally what the fee will be before providing the service. You will not be charged for any non-therapy or non-coaching service without your knowledge or approval ahead of time.

You will be charged for between session phone calls lasting longer than 15 minutes on the following basis: 15-30 minutes: $50 30-45 minutes: $100

3) Meeting times and cancellation policy:

Once an appointment has been scheduled, that time is reserved for you. You must provide 24 hours notice or you will be billed in full. Often times, appointments can be rescheduled for the same week. This is not always possible. Phone sessions in place of in-person sessions are always available.

4) Insurance:

The therapists in the practice are credentialed with different insurance carriers. If you are paying out of pocket, receipts can be issued for sessions that have been paid in full so that you can access your out of network benefits. If you are using your insurance benefits, you are responsible for all balances that are not paid by your plan including co-pays, co-insurance, and any rejected claims.

Please contact your insurance company as soon as possible to verify your benefits and avoid any unpleasant billing surprises later on. Not all psychological diagnoses are considered "reimbursable" by all managed care companies. It is illegal to alter a diagnosis to fit the guidelines of a particular insurance company.

Career coaching sessions are usually not covered by insurance companies. Please contact your insurance company and/or employer if you have any questions regarding your benefits for this service.

4) Psychotherapist availability:

You may leave a voicemail message 24/7. You may also e-mail at any time. Calls and e-mails regarding scheduling issues will be returned during normal business hours, Monday-Friday 9-5pm. Urgent calls will be returned as soon as possible, and always within 24 hours.

IN AN EMERGENCY (I.E., YOU NEED TO SPEAK WITH SOMEONE RIGHT AWAY BECAUSE YOU ARE EXPERIENCING SEVERE EMOTIONAL DISTRESS) YOU MUST GO TO THE EMERGENCY ROOM OR CALL 911

NEVER USE E-MAIL TO COMMUNICATE WITH YOUR THERAPIST DURING AN EMERGENCY

Confidentiality of e-mail, cell phone, texts, and faxes: With your permission, your psychotherapist will communicate with you via cell phone, text, and e-mail. These means of communication are not 100% secure. If this is a concern to you, please be as brief as possible when sending an e-mail, texting, or leaving a voice mail.

5) Confidentiality and limits on confidentiality:

The law protects the privacy of all communication between a client and a psychotherapist. In most situations, the psychotherapist can only release information if you sign a consent form.

Your signature on this Agreement provides consent for these activities:

- Obtaining the appropriate kind and level of help if you threaten to harm yourself. This can involve contacting 911, a family member, and/or others who can help provide protection.
- Consulting with other mental health or medical professionals regarding your situation. During these consults, every precaution is taken to protect your identity. The other professionals are also

legally obligated to keep the information confidential. If you do not object, your psychotherapist will not inform you of these consults unless they feel it is important to your work together.

- E-mailing you regarding new services.
- Disclosing required information to a collection agency to collect overdue fees.
- Disclosing Personal Health Information to managed care companies regarding a claim you submitted.
- Disclosing Personal Health Information to managed care companies for the purpose of payment.

There are situations in which the psychotherapist is permitted or required by law to disclose information without either your consent or authorization:

- If you are involved in a legal proceeding and the psychotherapist is served with a court order for information regarding your diagnosis and treatment.
- If a government agency requests information for health oversight activities.
- If you file a lawsuit or complaint against the psychotherapist or practice, the psychotherapist may disclose information about you as part of their defense.
- If the psychotherapist is being compensated for providing treatment as a result of a worker's compensation claim that you filed. Upon the appropriate request, the psychotherapist will need to provide information for utilization review purposes.

In situations in which the psychotherapist believes it is necessary to attempt to protect others from harm, the psychotherapist may need to reveal information about you and your treatment. Your consent or authorization to release information is not needed in these situations:

- Psychologists and Social Workers are considered mandated reporters of child and elder abuse. If there is reason to suspect child or elder abuse and/or neglect, the psychologist/social worker is mandated to file a report with the police and/or the necessary protective agencies. Once a report is filed, the psychologist/social worker may be required to provide additional information.
- If a client communicates a threat of physical violence against an identifiable third person (or the community) and the client has the apparent intent and ability to carry out that threat in the near future, the psychologist/social worker has to take protective actions. These actions include notifying the potential victim (or, if the victim is a minor, his/her parents and the county Department of Social Services), contacting the police, and/or seeking psychiatric hospitalization for the client.

Client Consent:

I have read this document outlining practice policies regarding services, payment, insurance, meeting times, cancellations, psychotherapist availability, and privacy. I understand them and agree to comply with all of the policies and procedures described in this document.

Patient name: Signature:

Parent/guardian name: Signature:

Date:

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I hereby acknowledge that I can print off a copy of Bucks County Anxiety Center's Privacy Practices from the website. In addition, I hereby consent to the use and disclosure of mine and/or my child's personal health information for the purposes of treatment, payment, and health care operations.

Patient Signature: Date:

Parent/Guardian Signature: Date: