The Atrium
4 Terry Drive, Suite 11, Newtown, PA 18940
Phone: 215-550-1818
e-mail: admin@buckscountyanxietycenter.com
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:

- All payment is due at your session. Patients may not carry a balance.
- You may pay for sessions by cash, credit card, or check.
- Make checks out to **Bucks County Anxiety Center.** There is a $30 fee for returned checks.
- Phone sessions are pre-billed.

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:

Patient Signature Printed Name - Patient

_____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 see (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 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_____

- Are you currently taken any supplements, essential oils, or herbal remedies? Yes No
- If yes, please list what you are taking, dose, frequency, and reason you are taking it:

- Have you ever been hospitalized for psychiatric reasons? Yes No
- If yes, please list dates, length of hospitalization, and reasons for admission:

- Are you currently being treated for any medical conditions? Yes No
- If yes, please list condition, treatment, and impact on your daily functioning. Use the back of this page or add an extra form if needed. Please attach any articles you want your therapist to read.

- **Recreational Drugs Use**
    - What are you using? (this includes pills of any kind)
    - How often?
    - Are you hiding this from anyone?
    - Who do you use with?
    - Do you ever use alone? If so, when?
    - How does drug use help you?

- **Alcohol Use**
    - How many times a week are you drinking?
    - What do you drink?
    - Are you hiding this from anyone?
    - Do you ever drink alone?
        - If yes, when?
    - How does drinking help you?

High Risk Activities:

Please indicate if you've ever done any of these activities, how often, and whether it's happening now or happened in the past.

Activity	How often	Currently Doing This	Did this in the past
Driving while drunk/high			
Operating a boat or any other kind of machine while drunk or high			
Exchanging money for sex			
Selling drugs or pills			
Buying drugs or pills			
Gambling			
Having unprotected sex			
Stealing money or things			

Background Information:

Have you every been arrested? If yes, for what?

Have you ever spent time in prison? If yes, for what?

Have you ever been fired from a job due to illegal behavior? If yes, on what grounds?

Have you ever been investigated by Child Protective Services? If yes:

When:

Reason:

Outcome:

Developmental and Educational Information

- Must be filled out for all children and teens.
- Please complete if you are a young adult (up to age 25) who has ever been diagnosed with ADHD, a learning difference, Asperger's, sensory processing disorders, or any issue impacting your ability to make it through school easily and/or make friends.

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? Please bring in a copy of the IEP, 504, and any psychological or educational testing results.

Did the mother experience any complications during pregnancy?

Was this child born at term?

If no:

- Gestational age at birth:
- Amount of time in NICU:
- Trouble with temperature regulation, eating, digestion, breathing, heart rate, etc.:

Developmental and Educational Information:

Did the child reach all their developmental milestones on time? If no, please explain.

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

How does this child/teen cope with stress?

What is the greatest cause of stress for this child/teen right now?

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

- Family:
- Friends:
- Class/School mates:
- Teachers/Coaches:

BUCKS COUNTY ANXIETY CENTER STATEMENT OF POLICIES

Please read through each policy. Sign at the bottom of each policy to indicate you've read it and understand it.

If the patient is over the age of 18, only the patient needs to sign. If the patient is over the age of 18 but parents are paying for services, providing insurance coverage, or involved in any way, parent and patient need to sign.

1) Psychotherapy services:

Working with a psychotherapist can result in several 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, sad, or disappointed.

Attempting to resolve issues that brought you into therapy may result in changes in your life that you were not planning on originally. For example, you may experience changes in feelings, behaviors, employment, substance use or 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.

Sometimes, seeing an outpatient therapist once a week is not enough to really help you if you are experiencing a very high level of anxiety or depression. Your psychotherapist will let you know as soon as possible if you need a higher level of care and will work with a treatment center to transfer your case. If you are struggling with another mental health condition that is impacting your life or health, we may refer you to another treatment program so that you can get a handle on that issue first. Examples include active eating disorders and addictions.

There is no guarantee that psychotherapy or coaching will lead to the result you want. There are many factors involved and your psychotherapist will explain these as needed. If you have questions about the methods used by your psychotherapist, discuss them whenever they come up.

If your doubts continue, you always have the option of getting a second opinion. Every effort will be made to help you make a smooth transition if 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 any member of our team in a way that is disrespectful. This applies to your family members as well. We reserve the right to refer you to another therapy practice if we feel we're not a good fit for you or your family.

****Please sign indicating you understand this policy:**

Signature - Patient

Signature - Parent/Guardian

Printed Name - Patient

Printed Name - Parent/Guardian

2) Fees and payments:

Regular sessions are 45 minutes long. 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. You will always be informed at least two weeks in advance of any fee increases.

Coaching and consulting sessions may run longer than 45 minutes. You will receive specific information about the length of your meetings and the fees charged for those services.

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 cannot carry a balance.

If you are in crisis, your therapist will work with you to come up with an immediate plan to keep you safe.

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 your confidential information.

Your psychotherapist may also charge for other professional services you may need and will let you know 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

****Please sign indicating you understand this policy:**

Signature - Patient

Signature - Parent/Guardian

Printed Name - Patient

Printed Name - Parent/Guardian

3) Meeting times and cancellation policy:

We have a strict cancellation policy out of fairness to our all our staff and patients. Unlike other doctors or providers, we do not double book a slot.

Once an appointment has been scheduled, that time is reserved for you which means we can't give it to anyone else.

You must provide 24 hours' notice or you will be charged the cost of your therapist's full out of pocket session fee.

Often, appointments can be rescheduled for the same week. This is not always possible. If you cannot reschedule within the same week, you will be charged.

Phone sessions in place of in-person sessions are always available.

****Please sign indicating you understand this policy:**

Signature - Patient Printed Name - Patient Signature - Parent/Guardian Printed - Parent/Guardian

4) Insurance:

Some therapists in the practice are credentialed with insurance companies while other therapists are not.

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.

When you use insurance, your diagnoses are recorded in central data bases that can be accessed by different companies and agencies. A mental health diagnosis may impact your ability to obtain security clearances for work or purchase life, health, or disability insurance. If you are concerned about this, we recommend you pay out of pocket and not submit your receipt.

If you are paying out of pocket, receipts can be issued for sessions that have been paid in full so that you can submit them to your insurance company. Many of our patients who pay out of pocket are reimbursed 50-80% of what they paid their therapist. Please check with your insurance to see what your plan will reimburse you for seeing an out of network provider.

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.

****Please sign indicating you understand this policy:**

Signature - Patient Printed Name - Patient Signature - Parent/Guardian Printed - Parent/Guardian

4) Psychotherapist availability and emergencies:

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.

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.

Emergencies:

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

If you are in the ER for observation and/or are admitted to a facility or program, please sign consent with the hospital or facility so that they can contact your therapist as soon as possible.

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

****Please sign indicating you understand this policy:**

Signature - Patient | Printed Name - Patient | Signature - Parent/Guardian | Printed - Parent/Guardian

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 (including the emergency contact listed on this form), 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.

****Please sign indicating you understand this policy:**

Signature - Patient Printed Name - Patient Signature - Parent/Guardian Printed - Parent/Guardian

6) Duty to Report and/or Warn:

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. **We do not need your consent or authorization to release information about you in the following 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.

****Please sign indicating you understand this policy:**

Signature - Patient Printed Name - Patient Signature - Parent/Guardian Printed - Parent/Guardian

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:

Printed Name - Patient

Parent/Guardian Signature: Date:

Printed Name - Parent/Guardian

Bucks County Anxiety Center

2019 Payment Policy Update

Dear Patients,

Thank you very much for the opportunity to work with you and your families. We're incredibly honored to be part of your lives. We strive to provide the best possible experience for anyone coming to see us.

In order to address changes in insurance laws and the increasing number of high deductible plans, we're changing how and when we bill our patients.

Please read this update and sign at the end indicating you understand our new policies.

<u>We want to let you know about changes to our payment policy that will go into effect immediately:</u>

- We no longer allow patients to carry a balance, even for a week. Instead, we are collecting at point of service.
    - Fees and co-pays must be paid at the beginning of session.
    - If you can't make payment, session will be cancelled. Since your therapist held that slot, it will be considered a late cancelation and you will be charged the full cost of your therapist's out of pocket fee. That means your insurance company will not reimburse any part of that cost.
    - If you're in crisis, you and your therapist will develop a plan immediately to address that issue and keep you safe.

- If you have any changes to your insurance, it is your responsibility to let us know.
    - If we receive a rejection notice indicating you're no longer covered by the plan we have on record, you will be charged the full out-of-pocket fee for any session the insurance company didn't cover.
    - You will be charged the full out-of-pocket fee until you resolve any issues with your new insurance plan.
    - We will provide you with the appropriate invoices so that you can resolve any issues with your insurance company.

- We will be charging your deductible up front.
    - It is important that you notify us if you have a deductible since it can take a month or more to receive any notice from your plan. This could leave you with a balance of several hundred dollars before we could schedule another session.
    - If you have a deductible or co-insurance, we will charge an estimated amount based on contracted rates with your insurance company.

- Our practice reserves the right to not accept returning patients who ended therapy with us with an unpaid balance.
    - Under certain conditions, we will consider resuming sessions if the balance due is paid in full and the patient pre-pays for sessions going forward.

- In general, it can take most insurance companies up to **60 business days** (i.e., 3 months) to resolve billing issues. As a result, you may receive an invoice for hundreds of dollars that cover multiple sessions over several months.
    - The more proactive you can be regarding your plan and coverage, the less likely you will have to deal with this kind of situation.

Thank you very much for cooperating with our updated policies. Please let us know if you have any questions.

All the best,

Dr. Levy and the staff of Bucks County Anxiety Center

*****Please sign indicating you understand this policy:**

Patient's Signature: **Date:**

Patient's Printed Name:

Parent's Signature: **Date:**

Parent's Printed Name:

****If the patient is over the age of 18 but parents are paying for therapy, providing insurance coverage, or involved in any way, parents and patient have to sign.**