Associated Therapists, Inc.

5762 Bolsa Ave, Ste. 107 Huntington Beach, CA 92649
5212 Katella Ave., Ste. 104, Los Alamitos, CA 90720
235 E. Broadway Suite 1040 Long Beach, CA 90802
Phone: (714) 898-0362 ÅFax: (714) 893-3267

NEW CLIENT INFORMATION

PATIENT'S NAME: _____ **TODAY'S DATE:** _____

DATE OF BIRTH: _____ **AGE:** _____ **SEX:** _____ **MARITAL STATUS:** _____

HOME ADDRESS: _____ **CITY / STATE / ZIP:** _____

HOME PHONE: (____) _____ **BUSINESS PHONE: (____)** _____

CELL PAGER: _____ **PATIENT SOCIAL SECURITY:** _____

STUDENT STATUS: Non Student Full Time Part Time Unknown EMAIL: _____
REFERRED BY: _____ **ADDRESS** :_____

CITY / STATE / ZIP: _____ **PHONE:** _____ **FAX:** _____

What is the Relationship of Person Filling Out This Form to the Patient:

Person financially responsible for payment of services and / or subscriber of the primary insurance plan:
SUBSCRIBER: **SOCIAL SECURITY NUMBER:**

HOME ADDRESS: _____ **CITY / STATE / ZIP:** _____

HOME PHONE: (____) _____ **BUSINESS PHONE: (____)** _____

OCCUPATION / TITLE: _____ **EMPLOYED BY:** _____

SUBSCRIBER DATE OF BIRTH: _____ **POLICY ID NUMBER:** _____

INSURANCE COMPANY: _____ **PLAN NAME / GROUP NUMBER:** _____

INSURANCE ADDRESS: _____ **ADDRESS LINE 2:** _____

CITY / STATE / ZIP: _____ **PHONE NUMBER:** _____

FAX PHONE NUMBER: _____ **IPA / HMO NAME:** _____

SUBSCRIBER RELATIONSHIP TO PATIENT: Self Parent Spouse Dependent Other

EMPLOYMENT: Full Time Part Time Not Employed Unknown Retired Retired Date: _____

Below For Office Use Only:

Provider Name: _____ Code: _____ AT Number: _____

Services : Individual Family Testing Group Medication Other _____CPT _____ Co Pay: _____
Diagnosis: Code: _____ Description: _____ DSM-4 or ICD-9 Office: _____

Diagnosis: Code: _____ Description: _____ DSM-4 or ICD

THERAPISTS: PLEASE ATTACH COPY OF AUTHORIZATION AND INSURANCE CARD TO THIS FORM

Associated Therapists, Inc.

5762 Bolsa Ave., Ste 107 Huntington Beach, CA 92649
5212 Katella Ave., Ste.. 104, Los Alamitos, CA 90720
110 West Ocean Blvd., Ste. 18 Long Beach, CA 90802
Telephone: (714) 898-0362 z Fax: (714) 893-3267

Office Policies And General Information Agreement To Provide Mental Health Services

Associated Therapists, Inc. and its employees provide administrative support such as referrals, client and insurance billing, office space, clerical services, and voice messaging to the professional staff. Associated Therapists, Inc. and its employees do not engage in professional mental health practice. Each physician, nurse or therapist is an independent individual performing their professional service in a private practice as governed and licensed by the State of California.

CONFIDENTIALITY

All written or spoken material from any and all sessions, including psychological testing, will be considered confidential unless:

1. the patient authorizes release of information with his / her signature.
2. the patient presents a physical danger to self.
3. the patient presents a danger to others.
4. child / elder abuse / neglect are suspected.

In the latter two cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

It is understood that cases are sometimes discussed among professionals for educational, consultation and / or research purposes. In addition, in couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members.

Health Insurance: Disclosure of confidential information may be required by your health insurance carrier or HMOs, PPOs, MCOs, or EAPs in order to process the claims. This office or your therapist has no control or knowledge over what insurance companies do with the information submitted or who has access to this information.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to matters which may be of a confidential nature, **it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc....), neither you (client's) nor your attorney's, nor anyone else acting on your behalf will call on your therapist or agents of this office to testify in court or at any other proceedings, nor will a disclosure of the psychotherapy records be requested.**

MEDIATION AND ARBITRATION

All disputes arising out of or in relation to this agreement to provide psychological/psychiatric/mental health services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement between you and your therapist. The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement shall be submitted to and settled by binding arbitration in Orange or Los Angeles Counties in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, your therapist and Associated Therapists, Inc. can use legal means (court, collection agency, etc....) to obtain payment. The prevailing party in arbitration or collection proceeding shall be entitled to recover a reasonable sum as and for attorney fees. In the case of arbitration, that sum will be determined by the arbitrator.

 Client / Guardian Initials: _____

CONSENT FOR TREATMENT

I authorize and request that my therapist(s) at Associated Therapist, Inc. carry out psychological examinations, treatments, and / or diagnostic procedures which now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

TERMINATION

If at any point your therapist determines that he / she is not able to provide the exact services you require, he / she will discuss this with you and, if appropriate, will terminate treatment. In such a case, you will receive a number of referrals which may be of help to you. If you request and authorize in writing, your therapist will talk to the provider of your choice in order to help with the transition. If at any time you want another professional's opinion or want to consult with another therapist, your therapist will assist you in finding someone qualified, and if he / she has your written consent, will provide him / her with the essential information. You have the right to terminate therapy at any time.

If you choose to do so, your therapist will provide you with names of other professionals whose services your might prefer.

DUAL RELATIONSHIPS

Therapy never involves sexual or business relationships nor does it involve any other dual relationship that impairs your therapist's objectivity, clinical judgement, therapeutic effectiveness or can be exploitive in nature.

RELEASE OF INFORMATION

I authorize the release of information for claims, certification / case management, and other purposes related to the benefits of my Health Plan.

NOTICE OF PRIVACY PRACTICES

A notice of privacy practices in compliance with the Health Insurance Portability and Accountability Act (HIPAA), describing how information about you may be used and disclosed and how you can get access to this information is provided to you. Please review it carefully. I have received the Notice of Privacy Practices. I have been provided an opportunity to review it.

I understand and agree to all of the above information.

_____

PRINTED Patient (or Parent / Guardian) Name

_____ _____

SIGNATURE Patient (or Parent / Guardian) Date

Associated Therapists, Inc.

5762 Bolsa Ave., Ste 107 Huntington Beach, CA 92649
5212 Katella Ave., Ste.. 104, Los Alamitos, CA 90720
110 West Ocean Blvd., Ste. 18 Long Beach, CA 90802
Telephone: (714) 898-0362 z Fax: (714) 893-3267

FEE SCHEDULE

4/15/10

PROFESSIONAL FEES**:**

Initial Therapy Visit	$185.00 hr
Individual Psychotherapy, Family Therapy or Marital Counseling	$150.00 hr
Medication Evaluation	$ 200.00 hr
Medication Management (30 min)	$145.00 hr
Medication Management (15 min)	$ 95.00 hr
Psychological Testing	$150.00 hr
Test Scoring and Interpretation	$150.00 hr
Integrated Visual and Auditory Perception Test (IVA) - Test for ADHD	$ 95.00
Report / Document Preparation	$150.00 hr
Group Psychotherapy	$ 65.00 hr
Telephone Therapy / Consultation - charged per 15 minutes	$ 37.50
Professional Consultation (Doctor, Lawyer, etc.)	$150.00 hr
Behavioral Training	$ 50.00 hr
Hospital Visit (Including Psychological Testing)	$200.00 hr
School, IEP or Home Visit (Time + Travel)	$150.00 hr
Educational / Vocational Therapy	$100.00 hr
Educational Classes	**Price Per Class**

ADMINISTRATIVE FEES:

Returned Check	$ 15.00
Document Copy Services	$ 15.00 + **15 cents / copy**

Most therapists operate as independent professionals within our practice. Your therapist may have fees for some or all services that differ from those above. Your therapist is responsible for negotiating your fees. If you have any questions or concerns, discuss them with your therapist.

Remember it is your responsibility to understand exactly the charges for the services you receive and which services are covered by your insurance. If you have any doubt, or if you do not understand the charge for a recommended service, ask your therapist or one of our office personnel.

If a recommended service will present a financial hardship for you or your family, you may request a reduction in the fee. Requests for fee reductions are examined on a case-by-case basis. Family income and expenses are considered in determining allowable reductions in fees. If you feel that a reduction is warranted for you, ask your therapist.

If you have any questions about any of the information contained in the FEE AGREEMENT or the FEE SCHEDULE, ask for answers before you sign.

 Client / Guardian Initials: _____

FEE AGREEMENT

We know that unexpected medical costs are one of the most common sources of stress on individuals and families. Associated Therapists attempts at all times to keep that stress to a minimum by keeping our fees as low as possible. **Please read the attached fee schedule carefully**. If you have any questions about the fee schedule, please ask your therapist or one of the office personnel. If you are paying part or all of your fees with insurance, be aware that most insurance carriers place limitations of the types of service for which they will pay. Your therapist may recommend a service or you may request a service which is not covered by insurance, in which case you will pay the entire fee. When a given service is recommended to you or if you request a service or procedure, make certain that it is clear to you whether or not your insurance will pay. If you are in doubt ask our office personnel to check for you.

All fees are to be paid at the time of service. A fee of one and one half percent per month (18% per year) may be added monthly to all outstanding accounts in excess of thirty days.

Certain health insurance plans have pre-arranged contracted fee arrangements that are different than the amounts quoted. Upon verification of your eligibility and benefits, your insurance carrier will be billed for you and your therapist will be paid directly by the carrier. **The patient will be responsible for any applicable deductibles and co-payments at the time of service.** If you are not eligible at the time services are rendered or if your insurance carrier does not authorize the services, you are responsible for payment of the quoted fees or the rate negotiated with your insurance carrier, whichever applies.

CANCELED / MISSED APPOINTMENTS

Sessions normally are scheduled for 50 minutes. Group sessions are scheduled for approximately 90 minutes. A scheduled appointment means that time is reserved only for you. If an appointment is missed or canceled with less than 24 hours notice, the patient will be billed as determined by each therapist. This charge can not be billed to your insurance plan.

DELINQUENT ACCOUNTS

If accounts become delinquent (past 30 days) our office will begin collection procedures. We will attempt to contact you directly. If your account remains delinquent (past 90 days) an outside collection agency may be used and / or small claims court action taken. In such cases, non clinical information (as given on the New Client Information form) may be released to assist in the collection of the amount due. Patient will be responsible for all court and legal fees incurred if above action is necessary.

If any of the above provisions are not satisfactory please make alternative arrangements prior to or during your first therapy appointment. Please sign to indicate that you have carefully read and agree to the above conditions.

_____

Print Client Name

_____ _____

Signature of Person Financially Responsible and Date

Therapist Signature and Date