

MEDICAL PSYCHOLOGY ASSOCIATES

6110 N. Port Washington Road, Glendale, WI 53217
6520 W. Layton Avenue, Suite 206, Greenfield, WI 53220
Phone: 414-962-1000 Fax: 414-963-6866

INTAKE FORM

Client's Name: _____ Today's Date: _____

Date of Birth: ____/____/____ Age ____ Male ____ Female ____

Address: _____ City: _____

State: _____ Zip Code: _____ Social Security Number: _____

Home Phone: _____ Cell Phone: _____

Email Address _____

May we contact you by email? _____ May we contact you by Cell Phone? _____

Education: _____ Occupation: _____

Employer: _____ Work Phone: _____

Marital Status: _____ Spouse's/Partner's Name: _____

Children's Names and Ages: _____

Who referred you or how did you find us? _____

Parent's Names (if client is a minor): Mother _____ Father _____

Signature of Responsible Party: _____ Date: _____

Emergency Contact Person _____ Phone # _____

INSURANCE INFORMATION

Policy Holder (if other than Client) _____

Date of Birth _____ Social Security # _____

FOR THERAPIST USE ONLY:

Therapist Name: _____ Billing Code _____

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HEALTH ASSESSMENT

NAME: _____ DOB: _____

Please briefly describe your reason for seeking services with our clinic:

Have you seen a psychotherapist, counselor, psychologist, or psychiatrist in the past?

(Yes/No) _____ When? _____

Name of past mental health provider _____

What City? _____

Are you under the care of a psychiatrist? Please indicate name and phone number:

Please list any past or ongoing health problems of significance:

List any medications (including dose) you are now taking:

Name of primary care physician: _____

Date last examined by your physician (month/year): _____

Please list any hospitalizations (dates and reasons):

Client signature _____ Date _____

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INFORMED CONSENT

Thank you for choosing to receive services from Medical Psychology Associates. In keeping with the State Statute section 51.61 and HSS 94, we are required to inform you of your rights when seeking treatment at our clinic. Our clinic is designed to provide psychotherapy, family counseling, lifestyle counseling, and psychological diagnostic services for children and adults. These services are beneficial only to the extent that the clients(s) are actively participating with the staff in the delivery of service. It is our belief that the psychologist and client(s) together design and implement the treatment program.

- 1) The benefits from psychotherapy may include, but are not limited to, being better able to meet your needs, improve communication skills, more satisfying intimate relationships, and better understanding of your personal goals and values.
- 2) Psychotherapy is conducted in individual, family, couples, or group sessions with a psychologist for purposes of determining and resolving problems or concerns.
- 3) Psychotherapy may include the risk of remembering unpleasant events and can arouse intense emotions of sadness, fear, and anger. Feelings of anxiety, depression, frustration, loneliness, or helplessness may also be aroused.
- 4) The psychologist may suggest alternative treatment modes and will make referrals when appropriate or necessary.
- 5) If you forego psychotherapy, it is possible your problems may not be resolved, or may become worse than they are at the present time.
- 6) This informed consent will be in effect until such time that you are discharged from treatment either by mutual agreement with your psychologist, your own decision, or your psychologist's clinical decision that services with another provider or agency are more appropriate for your treatment needs.
- 7) You have a right to withdraw this informed consent at any time. Your request must be in writing.

Confidentiality and Denial of Rights

Information discussed with a psychologist is confidential and will not be discussed without your release of that information. However, Wisconsin Law requires that psychologists break this confidentiality under the following conditions: 1) when there is a court order to do so, 2) there is a serious threat of harm to oneself (suicide) or harm to another person (homicide), or 3) if a child or older adult (over the age of 60) is being endangered through abuse or neglect.

As your psychologist, there are times I may find it necessary to consult with other professional colleagues about your treatment. Should it be useful or necessary for me to do so, I will not present any information that would allow you to be personally identified without your consent.

Insurers sometimes require the release of certain information before they will authorize payment. In such instances, only the minimum information required for reimbursement will be released.

Printed Name: _____ Relationship (if other than client) _____

Signature: _____ Date: _____

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FINANCIAL POLICY

FEE PAYMENTS: Please understand that when you come for psychological services, you and your psychologist automatically contract with one another. While we will do our best to assist you in verifying insurance coverage, it is ultimately your responsibility to understand your benefits. Any charges not covered by your insurance company are your responsibility. This includes deductibles, co-pays, lapses in coverage, any private pay arrangements agreed upon between you and your psychologist, or any charges not covered by your insurance company for other reasons determined by your insurance after services are rendered.

***PSYCHOTHERAPY FEES - PSYCHOLOGIST – Ph.D, Psy.D**

\$265/Hour - Initial Intake Consultation \$175/ Psychotherapy - 45 Minutes \$215/ Psychotherapy - 60 minutes

***PROFESSIONAL COUNSELOR MA, MSW, LPC or SOCIAL WORKER FEES**

\$240/Hour - Initial Intake Consultation \$150/ Psychotherapy - 45 Minutes \$190/ Psychotherapy - 60 minutes

***NEUROPSYCHOLOGICAL ASSESSMENT/PSYCHOLOGICAL ASSESSMENT WITH TESTING:**

\$250/ Hour - Psychological Evaluation with Testing \$250/Hour for Neuropsychological Fees

*If your psychologist is an in-network provider she/he has agreed to accept the contracted rate with your insurance company.

FINANCIAL POLICY

(Continued from Page 4)

I understand payments are due 30 days from the date of the statement. After three consecutive months, failure to make payment in full, or to make payment arrangements with our office, will result in your account being turned over for collections. If this occurs, a 25% collection charge will be added to your bill.

Please initial here _____

ADDITIONAL PRORATED CHARGES MAY BE INCURRED FOR THE FOLLOWING: Phone calls of duration made by client or relatives, preparation of reports, letters, or handout materials, and consultation with collateral personnel (e.g., physicians, other service providers, legal counsel).

By signing this form I understand and agree to these terms for Medical Psychology Associates to release such information as may be requested by my insurance company for the purpose of billing or coverage clarification and any benefits or payments for treatment received are assigned directly to Medical Psychology Associates.

Signature of Responsible Party

Date

Please initial the following:

I understand that any no shows, or a cancellation after 12:00 noon on the day prior to the scheduled appointment, will be billed at the rate of \$80. I also understand that insurance companies will not cover these charges and I am therefore responsible for this payment. _____

I understand that I am responsible for any charges not covered by my insurance company including deductibles, co-pays, and lapses in insurance coverage. _____

Please initial the following ONLY IF YOU ELECT TO DECLINE INSURANCE BENEFITS

I am choosing **NOT** to use my insurance benefits to cover services. _____

I understand payment is due at time of service. _____