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 and 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.

****

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. _____

****

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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. _____

AN ADDITIONAL NOTE REGARDING YOUR INSURANCE COVERAGE

While we at Medical Psychology Associates will do our best to help you understand what aspects of your mental health treatment your health insurance will and will not cover, please be aware that knowledge of your benefits is ultimately your responsibility. There are some employers who renew or change healthcare coverage mid-year, rather than with the start/end of the calendar year. Regardless of when you policy renews or changes, it is your responsibility to inform your provider of this and to provide our clinic with a copy of the new insurance card in a timely manner. There are certain policies that require preauthorization for mental health services that must be completed prior to the psychotherapy session. You can contact the behavioral health branch of your insurance carrier to obtain this information. Additionally, beginning in 2016, more policies are emerging that require referral by a primary care provider for services. Most of these policies are managed by **United Healthcare**, and **Referral Required** is indicated on the front of the card. This referral *must* be in place prior to the session in order for you to be able to utilize your insurance benefits.

Please initial below:

I understand that it is my responsibility to provide any new/change of insurance information to my psychologist/psychotherapist at least one week prior to any psychotherapy session that I would like to have covered under this insurance. I understand that I am responsible, in full, for any charges denied by the insurance carrier if information regarding my new coverage is not provided in this time frame. _____

I understand that I am responsible for knowing whether a referral from my primary care provider is required by my insurance carrier and for obtaining this authorization if necessary. I understand I am responsible for any charges not covered by the insurance if I do not obtain this authorization. _____

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FINANCIAL POLICY AND CREDIT CARD AUTHORIZATION

If your account accumulates an outstanding balance that is over 30 days past due, the following process can occur; your balance will be due on the first of the month following receipt of your most recent account statement. If we do not receive payment on the first of the month, we will provide you with a notice on your next account statement that your account is past due and that more serious action may be taken to collect any outstanding balance. If payment is not received within the next month, we will bill your credit card thereafter.

_____ Master Card _____ Visa _____ Discover _____ Debit _____ HSA/FlexSpend

Card Number: _____

Exp. Date: _____ CSC_____

Name of Cardholder: _____

I, _____, authorize Medical Psychology Associates to bill my credit card, as mentioned in the above terms, or as determined by alternate agreement by both parties. Cardholder acknowledges receipt of goods and/or services and agrees to perform the obligations set forth in the Cardholder's agreement with the Issuer.

_____ _____
Cardholder's Signature Date

Additional family members covered by this agreement:_____

NEUROPSYCHOLOGICAL/PSYCHOLOGICAL EVALUATIONS

Payment due is expected at the time of service; amount of payment expected is dependent upon your insurance coverage, which may include an office copay, coinsurance, and/or high deductible plan. Unless it has been determined that your insurance will cover 100% of the charges for the evaluation, a payment in the amount of $100/hour of testing (typically average 6 hours) will be collected before the neuropsychological/psychological testing begins. Report will be released when payment has been received in full or an agreed upon payment plan is arranged.

Although we do our best to accurately verify your insurance benefits, there may be times we receive incorrect information from the insurance company or the insurance company denies payment based upon medical necessity, you remain ultimately responsible for paying the bill for services rendered. Any overpayment will be refunded to you within 30 days of the final payment received from your insurance company.