Sumer Statler Aeed

Licensed Psychologist

This information will help me to better understand your goals and concerns. If you have any concerns regarding a question please leave it blank to discuss it in person.

All information provided will be held in strict confidence.

PATIENT INFORMATION

Full Name _____ Date of Birth _____

Street Address _____

City/State/Zip _____

Home Phone _____ Work/Cell Phone _____

Is it ok to leave a message on your phone? Yes ____ No _____

Email address (optional) _____

Referred By _____

Occupation/Profession _____

Relationship Status _____

Any prior counseling or inpatient services? Yes _____ No _____

Who shall be responsible for payment?

Self ____ Insurance ___ Family ____ Other _____

If you would like our office to provide insurance billing please

provide the following information.

_____	_____	_____
Name of Insurance Company	Primary Insured Person	Date of Birth

_____	_____
Insured's ID Number	Insured's Group Number

_____	_____
Address for Claims	City/State/Zip

_____

Provider or Customer Service Phone Number

I hereby authorize the release of information necessary to file or substantiate claims with my insurance company. I understand that I am responsible for any amounts due on my account in full, whether covered by insurance of not.

_____	_____
Signature of Client	Date

Name of Primary Doctor _____

Name of Psychiatrist if applicable _____

Current Medications Taken

Name	Dose	Prescribed to Treat
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

On a scale of 1-10 (10 highest) what is your current level of physical well-being?

On a scale of 1-10 (10 highest) what is your current level of emotional well-being?

Please describe briefly what brings you to therapy?

_____

_____

_____

_____

What do you hope to achieve? What are your goals and expectations?

_____

_____

_____

_____

Client Rights

Therapy is for your benefit so please ask questions about any techniques or procedures and be informed of any potential risks involved in treatment. You have the right to have an established set of goals to be regularly reviewed. You have the right to stop treatment at any time without any moral or legal obligations. If you would like a referral to another therapist may be provided at any time.

You have the right to confidential treatment. No information about your therapy shall be released without your written permission. This confidentiality is protected by law; however there are several exceptions to this of which you should be aware including:

1. If you are a danger to yourself or others.
2. If you describe a situation in which there is reason to suspect child or elder abuse or neglect.
3. Adolescents under 18 may only receive therapy with the written consent of their parent/guardians. The parent/guardians have the right to all information presented to the therapist. However, therapists often encourage parent/guardians to respect their children's privacy to aid in the therapeutic process.
4. In the event of a court order.
5. From time to time I may consult with other professionals regarding case management, every effort is made to protect your privacy and anonymity.

When an insurance company requests information other than on the claims form, this office shall provide only a summary with your written permission. Copies of progress notes shall not be released. Most if not all insurance companies require a diagnosis be provided in order to pay for services.

If any psychological tests are administered you have a right to a summary of the results. The actual test records remain the property of the therapist.

Should we be on your insurance panel our office is happy to provide the convenience of billing your insurance directly, however, you are ultimately responsible for all charges in the cases of denial of benefits, co-pays, or co-insurance amounts. Collection costs may be charged on outstanding balances past 90 days.

Sessions are 50 minutes in length. Our office has a cancellation policy of 24 hours. You will be charged for appointments not cancelled or rescheduled within 24 hours except in the case of family illness or emergencies. Insurance companies do not reimburse for missed appointments. With your permission we shall place you credit card on file to cover any late cancellations or missed appointments.

Credit Card # _____ Expiration _____

Billing Zip Code _____ CCV Code _____

Your signature below indicates that you have read and understood your rights described above:

_____ _____

Signature Date