



**IN CASE OF EMERGENCY NOTIFY (if other than above)**

NAME: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

**INSURANCE COVERAGE**

PRIMARY INSURANCE

INSURED NAME: \_\_\_\_\_ PLAN NUMBER: \_\_\_\_\_

INSURED'S DATE OF BIRTH: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

INSURANCE COMPANY NAME: \_\_\_\_\_

INSURANCE COMPANY ADDRESS: \_\_\_\_\_

INSURANCE COMPANY PHONE NUMBER: \_\_\_\_\_

HAVE YOU PRECERTIFIED ANY VISITS? Y N UNSURE

SECONDARY INSURANCE (IF ANY)

INSURED NAME: \_\_\_\_\_ PLAN NUMBER: \_\_\_\_\_

INSURED'S DATE OF BIRTH: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

INSURANCE COMPANY NAME: \_\_\_\_\_

INSURANCE COMPANY ADDRESS: \_\_\_\_\_

INSURANCE COMPANY PHONE NUMBER: \_\_\_\_\_

HAVE YOU PRECERTIFIED ANY VISITS? Y N UNSURE

**PAYMENT AGREEMENT**

I AGREE TO THE FOLLOWING PAYMENT PLAN TO COVER MY PORTION OF THE CHARGES:

\_\_\_\_\_ I DO NOT HAVE INSURANCE AND WILL PAY IN FULL AT THE TIME OF SERVICE.

\_\_\_\_\_ I WILL FILE MY OWN INSURANCE AND WILL PAY IN FULL AT THE TIME OF SERVICE.

\_\_\_\_\_ PLEASE FILE MY INSURANCE. I WILL PAY MY COST SHARE AT THE TIME OF SERVICE.

I UNDERSTAND THAT IF PROBLEMS ARISE IN GETTING PAYMENTS FROM MY INSURANCE COMPANY, IT WILL BE MY RESPONSIBILITY TO PAY THE BILL AND SETTLE WITH THE CARRIER UNLESS THE PROVIDER HAS OTHERWISE CONTRACTED WITH YOUR CARRIER. I AGREE TO PAY OFF ANY BALANCE ON MY ACCOUNT WITHIN 90 DAYS UNLESS I HAVE MADE OTHER ARRANGEMENTS. I UNDERSTAND THAT MY ACCOUNT MAY BE SENT TO A COLLECTION AGENCY IF I DO NOT PAY MY BILL ACCORDING TO THIS DOCUMENT. IF USE OF A COLLECTION AGENCY IS NECESSARY YOU WILL BE CHARGED A 6% INTEREST FEE ON THE BALANCE IN ADDITION TO A \$15 COLLECTIONS FEE.

\_\_\_\_\_ RESPONSIBLE PARTY SIGNATURE

\_\_\_\_\_ DATE

## MENTAL HEALTH DISCLOSURE FORMS

### **Limits of Confidentiality Statement**

All information between the practitioner and the patient is held strictly confidentially. There are legal exceptions to this:

1. The patient authorizes a release of information with a signature.
2. The patient's mental condition becomes an issue in a lawsuit.
3. The patient presents as a physical danger to self (Johnson v County of Los Angeles, 1983).
4. The patient presents as a danger to others (Tarasoff v Regents of University of California, 1967).
5. Child or Elder abuse and/or neglect is suspected (Welfare and Institution and/or Penal Codes).

In the latter two cases, the practitioner is required by law to inform potential victims and legal authorities so that protective measures can be taken. All written and spoken material from any and all sessions is confidential unless written permission is given to release all or part of the information to a specified person, persons, or agency. If group therapy is utilized as part of the treatment, details of the group discussion are not to be discussed outside of the counseling sessions.

**Initial here:** \_\_\_\_\_

### **Release of Information:**

I authorize release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation, and professional communication. If I am an insured client, I further authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan.

**Initial here:** \_\_\_\_\_

### **Emergency Access:**

A covering practitioner or I am available after hours to handle **emergencies**. By calling the main office number during after hours, you will be instructed how to contact the on-call practitioner. You may be charged for telephone consultation in excess of 5 minutes.

**Initial here:** \_\_\_\_\_

### **Financial Terms: Insurance Coverage and Copayments**

N/A

You are responsible for obtaining prior authorization for treatment from your insurance carrier. We will bill your insurance, however, you are responsible for co-payment amounts and deductibles as set by your benefit plan. Missed appointments are not covered by your insurance and the charges associated with them are your responsibility.

Copayment amounts are set by your benefit plan. These payments are due and payable at each appointment. Service fees are as follows (unless otherwise negotiated with your insurance plan):

**Initial Visit: \$150/ 50 minutes**

**Individual Therapy : \$125/ 50 minutes**

**Family Therapy: \$150/ 50 minutes**

**Psychological Testing: \$175/ hour**

**Letter or Report Preparation: \$125/ hour**

**Legal Testimony: \$200/ hour**

At any time during treatment, should you become ineligible for insurance coverage, you must notify the practitioner and understand that I will become responsible for 100% of the service charges.

**Initial here:** \_\_\_\_\_

**Cancellation and Missed Appointment Policy**

Scheduled appointment times are reserved especially for you. If an appointment is missed or canceled with less than 24 hours notice, you may be billed according to the scheduled fee and instructions of your benefit plan. Repeated “no-show” appointments could result in referring you back to the insurance company or referring doctor for referral to another practitioner. Your insurance company can not be billed for fees associated with missed or canceled appointments. Our fee for missed appointments is \$40.00.

Initial here: \_\_\_\_\_

**Appeals and Grievances for insured Clients**

I acknowledge my right to request reconsideration (an Appeal) in the case that outpatient care is not certified. I understand that I can request an Appeal directly through my Health Plan and that I risk nothing in exercising this right. I also understand that I may submit a Grievance to my Practitioner at any time to register a complaint about my care or I may send the complaint directly to my Health Plan.

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**Consent for Treatment**

I authorize and request my practitioner to carry out psychological and/or psychiatric exams, treatment and/or diagnostic procedures, which now, or during the course of my treatment become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me.

\_\_\_\_\_ Client Signature \_\_\_\_\_ Date

**Consent for Treatment for Child or Dependent**

I am the legal guardian or legal representative of the patient and on the patient’s behalf legally authorize the practitioner to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

\_\_\_\_\_ Patient Name

\_\_\_\_\_ Patient Social Security number

\_\_\_\_\_ Signature of legal guardian/representative

\_\_\_\_\_ Date

\_\_\_\_\_ Relationship to Patient

## **Notes or Questions for Dr. Larsen**