

PATIENT INTAKE FORM

(PLEASE PRINT CLEARLY AND COMPLETED ALL PAGES)

PATIENT INFORMATION:

First Name: _____ Last Name: _____ MI: _____

Date of Birth: _____ Age: _____ Sex: _____ Social Security No.: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Home: () _____ Cell: () _____ Work: () _____

Email Address: _____

Marital Status: Single Married Divorced Widowed

Student Status: Full-Time Part-Time Nonstudent

Employment Status: Full-Time Part-Time Retired Disabled Unemployed

Employers Name: _____ Employers Address: _____

City: _____ State: _____ Zip Code: _____

EMERGENCY CONTACT (In Case of an Emergency):

Full Name: _____ Relationship: _____

Telephone Home: () _____ Cell: () _____ Work: () _____

Email Address: _____

INSURANCE INFORMATION:

Primary Insurance Company: _____

Patient's Insurance ID#: _____

Insurance Group Number: _____

Preauthorization number (if applicable): _____

RESPONSIBLE PARTY INFORMATION (only fill out if responsible party different than above)

First Name: _____ Last Name: _____ MI: _____

Relationship to Patient: Parent Legal Guardian Other _____

Date of Birth: _____ Age: _____ Sex: _____ Social Security No.: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Home: () _____ Cell: () _____ Work: () _____

Email Address: _____

Policyholder's Insurance ID#: _____

Insurance Group Number: _____

Marital Status: Single Married Divorced Widowed

Student Status: Full-Time Part-Time Nonstudent

Employment Status: Full-Time Part-Time Retired Disabled Unemployed

Employers Name: _____

Employers Address: _____ City: _____ State: _____ Zip Code: _____

REQUIRED FOR TREATMENT: PLEASE READ

To my Patients,

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

Many Psychologists and other providers have implemented a similar policy. You will be asked for a valid credit card or debit card number at the time you enter treatment. The information is held securely while your insurance company is billed and pays their portion. After that time, any remaining balance owed by you will be charged (and you will be notified first) to your card on file, and a copy of the charge will be mailed to you upon request. As well, any no show or cancelation fees (200.00) without the required 48-hour notice will be charged to your card on file (insurance does not pay for these charges), as stated in the agreement for services herein.

This will be an advantage to you, since you will no longer have to write out and mail checks. It will be an advantage to my services since it will greatly decrease the number of invoices needed to be generated. You will also receive an EOB from your insurance with charges you owe such as deductibles and copayments that are your responsibility. This will aid with any misunderstandings between you and your insurance in terms of copayments, deductibles, etc. The combination will benefit everybody in helping keep costs down, along with paying any outstanding fees for services rendered.

This in no way will compromise your ability to dispute any charge or question your insurance company's determination of payment. Please understand that it is important for you to understand your insurance.

Thank you for your understanding! (3% Fee)

Sincerely Yours,

Dr. Debra Lewis
Licensed Psychologist

I authorize Dr. Lewis to charge any outstanding balances on my account that will include charges such as copayments, deductibles, missed appointments, and or fees my insurance company does not cover for services rendered and or scheduled appointments.

Visa (__) 3 letters on back of card

Master Card (___) 3 numbers on back of card)

Account Number: _____ Exp. Date: _____

Name on card (please print): _____

Address: _____ City: _____ Zip: _____

Signature: _____ Date: _____

DR. DEBRA K LEWIS

Licensed Psychologist

Certified Addiction Therapist

PHONE (248) 202-3779

Troy, MI 48085

DR.DL125@SBCGLOBAL.NET

SERVICES AGREEMENT

This document contains information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use of and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. The law requires that I obtain your signature acknowledging that I have provided you with a copy of the document. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time.

PSYCHOLOGICAL SERVICES

Psychotherapy varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. In order for the therapy to be most successful, you will have to work on things we talk about during our sessions on your own between sessions. There are no guarantees of what you will experience, although psychotherapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. On the other hand, since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like anxiety, sadness, guilt, anger, frustration, loneliness and helplessness.

PROFESSIONAL BACKGROUND AND TRAINING

My professional training includes a Doctorate in Clinical Psychology from The Michigan School of Psychology (MiSSP) in Farmington, MI. I hold a Full License to practice as a psychologist within the state of Michigan (#6301013394). I am also an Advanced Certified Addiction Therapist in the state of Michigan. I abide by the highest standards of my professional licensure and ethics. I will be happy to discuss my professional background including additional training, education, and my extensive work experiences.

SESSIONS/PROFESSIONAL FEES

I typically conduct 45-minute sessions on a weekly basis, although there are situations in which more or less frequent sessions are warranted. Once an appointment is scheduled, you will be expected to pay for it unless you provide 48 hours notices of cancellation. If I am able to offer another appointment in the same week, I will. If I offer another appointment and you miss both appointments, you will be responsible for two sessions. In addition to weekly sessions, I reserve the right to change for other professional services you may need, including report writing and time spent performing any other services you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, including preparation and transportation cost, even if I am called to testify by another party.

TELEPHONE CONTACT

Due to my work schedule, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call on the

same day you place it. This may not always include weekends or holidays. If you have an emergency that cannot reasonably wait until the end of the business day, you are urged to call 911 or contact the nearest emergency room.

LIMITS OF CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meet certain legal requirements imposed by HIPAA. These are situations that require that you provide written, advance consent.

Your signature on this Agreement provides consent for those activities as follows:

- Disclosures required by health insurance carriers to collect fees.
- If a patient threatens to harm him/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can provide protection. There are some situations where I am permitted or required to disclose information without either your consent or Authorization:
 - If you are involved in a court proceeding and a request is made for information concerning my professional services, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your written authorization or a court order. If you are involved in, or contemplating, litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
 - If a government agency is requesting the information for health oversight activities.
 - If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
 - If a patient files a worker's compensation claim, and I am providing treatment related to the claim, I must, upon appropriate request, furnish copies of all psychological reports and bills.

There are some situations in which I am *legally obligated* to take action, and which I believe are necessary, to attempt to protect others from harm. I may have to reveal some information about a patient's treatment. In my practice, such situations are unusual. These are the types of situations in which I am *legally obligated* to break confidentiality:

- If I have reason to believe that a child has been abused, the law requires that I file a report with the appropriate governmental agency.
- If I have reasonable cause to believe that a disabled adult or elder person has had a physical injury or injuries inflicted upon such disabled adult or elder person, other than by accidental means, or has been neglected or exploited, I must report this suspected abuse.
- If I determine that a patient presents a serious danger of violence to another, I may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the patient.

If such a situation arises, I will make every effort to fully discuss it with you **before** taking any action and will limit my disclosure to what is necessary.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep two sets of professional records. One set constitutes your **clinical record**. It includes information about your reasons for seeking therapy, a description of the ways in which your problems impact your life, your diagnosis, the goals we have set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports

that have been sent to anyone, including reports to your insurance carrier. In addition, I also keep a set of psychotherapy notes. These notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of **psychotherapy notes** vary from patient to patient, they can include the contents of our conversations, my analysis of those conversations, and how they impact your therapy.

They may also contain particularly sensitive information that you may reveal to me that is not required to be included in your clinical record, and information supplied to me confidentially by others.

Your psychotherapy notes are kept separate from your clinical record. Your psychotherapy notes are not available to you, and cannot be sent to anyone else, including insurance companies, without your written, signed authorization. Insurance companies cannot require your authorization as a condition of coverage, and they cannot penalize you in any way for your refusal to provide them.

MINORS AND PARENTS

Patients under 18 years of age, who are not emancipated, and their parents, should be aware that the law allows parents to examine their child's treatment records unless I believe that doing so would endanger the child. Because privacy in psychotherapy is often crucial to successful progress particularly with teenagers, it is sometimes my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment I will provide them with only general information about the progress of the child's treatment, and his/her attendance of sessions. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization, unless I feel that child is in danger or is a danger to someone else. In those cases, I will notify the parent of my concern. Before giving parents any information, I will discuss the matter with the child, if possible.

BILLING AND PAYMENTS

You will be expected to pay your portion of each session that is not covered by insurance at the time of service. If your account has not been paid for more than 60 days, and arrangements for payment have not been agreed upon, I have the option of using legal means to secure payment. This may involve hiring a collection agency which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his or her name, the nature of the services provided, and the amount due. If legal action becomes necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

If you have a health insurance policy, you should also be aware that your health insurance company requires that I provide it with information relevant to the services I provide to you. A clinical diagnosis will be required for reimbursement. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire **clinical record**. In such situations, I will make every effort to release only the minimum information about you that is necessary for payment of the claim. This information will become part of the insurance company's files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands.

By signing this Agreement, you agree that I can provide requested information to your carrier.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

SIGNATURE _____

DATE _____