FIRST APPOINTMENT ORIENTATION

Thank you for choosing me for your behavioral healthcare services. I recognize you have many choices and I appreciate your trust in me. I appreciate your downloading and completing the paperwork prior to your fist session. Completing the paperwork allows me the opportunity to spend a greater amount of time on clinical rather than administrative issues.

Some things to keep in mind:

- ✓ Please ensure you call your insurance company prior to the first appointment to get pre-authorized and bring your authorization number, if given to you by your insurance company.
- ✓ Remember, you can download and print, review, or ask for a complete set of Privacy Policies, Client's Rights, and Therapist Disclosure Statement.
- ✓ I will review and answer any questions about this paperwork or other matters.
- ✓ Please bring your insurance card.
- ✓ I will need information about your copayment and/or deductible. If you do not know this information, please contact your insurance company and ask for an explanation of benefit coverage for mental/behavioral health issues.
- ✓ I will need your primary care physician's telephone number.
- ✓ If you have seen a counselor or psychiatrist within the last two years, I will need a telephone number to contact them.
- ✓ It is very helpful for the therapy process if you bring a list of goals for therapy. This will help you and your therapist make better use of the first session.

GOALS FOR THERAPY, PLEASE LIST.

CLIENT INFORMATION

NAME:_____

ADDRESS:_____
street city state zip

BIRTH DATE:_____ AGE:_____ GENDER: ____ MALE ____ FEMALE

SOCIAL SECURITY #:_____

RELATIONSHIP STATUS: ____ MARRIED ____ SEPARATED ____ SINGLE
____ DIVORCED ____ COHAB. ____ CHILD

I AGREE TO PAY MY CO-PAY OF _____ AT THE BEGINNING OF EACH SESSION
IF I AM SELF PAYING, I WILL PAY _____ AT THE BEGINNING OF EACH SESSION
WHOM SHOULD I THANK FOR THE REFERRAL? _____

CONTACT INFORMATION

HOME PHONE:_____ BEST TIME TO CALL:_____
Can we leave a message?_____
WORK PHONE:_____ MAY WE CALL YOU IN CONFIDENCE AT WORK:_____
Can we leave a message?_____
PARENT TO CONTACT IF PATIENT IS CHILD: _____

INSURANCE INFORMATION

Primary

NAME OF INSURED (if different than patient) :_____
ADDRESS OF INSURED (if different than patient): _____

GENDER: ____ MALE ____ FEMALE BIRTHDATE:_____ SS#: _____
INSURANCE COMPANY:_____ PHONE: _____
ADDRESS: _____

MEMBER ID# _____ GROUP NUMBER:_____
INSURED'S EMPLOYER:_____ STATUS: EMPLOYED TERMINATED LOA
AUTHORIZATION # _____ INSURANCE TYPE: HMO PPO OTHER DEDUCTIBLE: _____

Secondary Insurance (if any)

NAME OF INSURED (if different than patient) :_____
ADDRESS OF INSURED (if different than patient): _____

GENDER: ____ MALE ____ FEMALE BIRTHDATE:_____ SS#: _____
INSURANCE COMPANY:_____ PHONE: _____
ADDRESS: _____

MEMBER ID# _____ GROUP NUMBER:_____
INSURED'S EMPLOYER:_____ STATUS: EMPLOYED TERMINATED LOA
AUTHORIZATION # _____ INSURANCE TYPE: HMO PPO OTHER DEDUCTIBLE: _____

WHO WOULD YOU LIKE NOTIFIED IN CASE OF EMERGENCY?

NAME:_____ RELATIONSHIP TO YOU:_____
ADDRESS:_____
HOME PHONE:_____ WORK PHONE: _____

Signature of Responsible Party: ____

AGREEMENTS AND DISCLOSURES

(for all participants or guardians over 18 years of age)

AGREEMENTS

1. I authorize Stuart Rayner to contact the referral source for treatment, payment, or health care operations, **understanding that personal information will need to be released to my insurance company or the company that manages my benefits**.

2. I authorize Stuart Rayner to bill my insurance/managed care company for the psychotherapy. He may need to disclose clinical information necessary to process all claims.

3. I authorize _____ to make payment directly to
(insurance/managed care company)
Stuart Rayner for the benefit specified and otherwise payable to me, but not to exceed the usual and customary charges for the services.

4. I understand that regardless of any insurance benefits, that I am fully responsible for the payment of all fees for services rendered.

5. I authorize Stuart Rayner to mail any correspondence regarding my treatment, satisfaction with treatment, updates about my treatment and educational programs during and after the completion of my treatment to my home mailing address.

_____ yes _____ no

6. I want my primary care physician to be notified of my treatment?

_____ yes _____ no

DISCLOSURES

I understand Stuart Rayner cannot be held responsible for being unable to access me due to telephone devices that may block calls, my use of a pager system in which I cannot be directly reached, any form of caller identification**, or any type of device that does not allow my therapist to make direct telephone contact with me.**

I understand that Stuart Rayner is active as a volunteer with a Disaster Relief Team, and may have to leave for up to two weeks, with little notice. Stuart Rayner will make arrangements for you to be notified of any pending absence, and when necessary, alternate clinical arrangements will be made.

FINANCIALS

1. My usual and customary rate for providing direct face-to-face psychotherapy services is $120.00 per hour.
2. You will be billed **$55 for not giving a minimum of 24 hours notification** of cancellation. This outstanding balance must be paid or resolved (at Stuart Rayner's discretion) prior to additional psychotherapy services being delivered.
3. You will be billed $40 for a returned check.
4. You will be billed for non covered and non routine services such as extended telephone consultation, crisis intervention, report writing, extended care coordination with other providers at a rate of $2.50 per minute. You will be informed of events involving additional billing prior to the event.

4. Any legal reporting, consultation, or coordination is billed at a rate of $3.50 per minute.

SIGNATURE:_____ DATE:_____

Medical Information – Please complete for all participants in therapy:

Name	Last 2 years Major medical events	Current medications Prescribed and OTC	Dosage	List Allergies

Family Physician: _____ Phone: _____

Psychiatrist: _____ Phone: _____

Pediatrician Name: _____ Phone: _____

Tobacco Use: Cigarettes ____ Chewing ____ Other ____ How much _____

Who: _____

Alcohol and Drug Use:

Who? Type? Amount? Frequency?

Family history of alcohol/drug use, mental health, physical conditions:
Member: History: