Dipoto Counseling Group

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9 Victory Drive, Suite 3, Liberty, MO 64068
Phone 816-268-8501 Fax 816-452-5700

CLIENT INFORMATION FORM

Full Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____
(Street) (City) (State) (Zip code)

Marital Status: _____ Date married (if applicable): _____

Employer: _____ Occupation: _____

Home phone: _____ Work phone: _____

Cell phone: _____ Social Security #: ___-___-___.

Referred to Practice By: _____

Address: _____ Phone: _____

To (re)schedule or confirm appointments, where may I call?

Home: Yes ↑ No ↑ **Work:** Yes ↑ No ↑ **Cell:** Yes ↑No ↑

May I leave a message on the answering machine? Yes No ↑

May I leave a message with someone at this number? Yes No ↑

Please list any restrictions: _____

***Whom may I contact in case of an emergency*?**

Name: _____ Relationship: _____

Phone: _____ Alternate phone: _____

Please complete the following:

In the space below, please briefly describe the reason(s) for seeking services:

_____

_____

_____

When did this problem begin?: _____

Have you ever had previous counseling or psychotherapy? Yes No ↑

If "yes," by whom and when? _____

Reason for treatment? _____

Are you currently taking any psychotropic medication (e.g. antidepressants, anti-anxiety, etc.)?

Yes ↑ No ↑ *If yes, list medication(s) and current dosage(s):* _____

_____

Name of Psychiatrist: _____ Phone: _____

Allergies to food or drug?: _____ _____

Have you ever been psychiatrically hospitalized? Yes ↑ No ↑ *If so, when and where?*

_____

Have you ever made a suicide attempt/gesture? Yes ↑ No ↑ *If so, please explain:*

_____

Please use the scale below to indicate your current level of distress with the following items:

	No Concern	**Some**	**Moderate**	**Urgent**
Feelings over a recent loss/death	0	1	2	3
Relationship with friends /family	0	1	2	3
Relationship with romantic partner	0	1	2	3
Sexual concerns	0	1	2	3
Sexual orientation	0	1	2	3
Survivor of abuse	0	1	2	3
Racial/ethnic issues	0	1	2	3
Low self-esteem	0	1	2	3
Loneliness	0	1	2	3
Depression	0	1	2	3
Anxiety	0	1	2	3
Fears/worries	0	1	2	3
Sleep problems	0	1	2	3
Eating problems	0	1	2	3
Body image concerns	0	1	2	3
Problems with alcohol/drugs	0	1	2	3
Losing contact with reality	0	1	2	3
Suicidal feelings/behaviors	0	1	2	3

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FINANCIAL POLICY

Thank you for choosing us as your mental health care provider. In order to reduce confusion and misunderstanding between our clients and this practice, we have adopted the following financial policy. We are dedicated to providing the best possible care and personal service to you and regard your complete understanding of our financial policies as essential element of your care and treatment. If you have any questions or concerns, please discuss them with your therapist. Please initial A - I and sign prior to receiving any treatment from our providers.

Upon arrival, please sign in at the front desk and notify us of any changes in your insurance or contact information.
(A)_____ Please understand that payment of your bill is considered a part of your treatment. Insurance is a contract between you and your insurance company. **It is your responsibility to know and understand your insurance policy benefits**. We are not always a party to this contract. We will not become involved in disputes between you and your insurance regarding deductibles, copayments, covered charges, secondary insurance or other matters regarding reimbursement.

Insurance and Fee Policy

(B)_____As a courtesy, we will verify, pre-certify and submit your insurance claim to a primary and secondary insurance plan. Your benefits, costs and co-payments as they pertain to your treatment will be discussed with you. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other insurance. Any amount that your insurance company will not be paying is due from you at the time services are rendered. We do not balance bill on insurance plans in which we are participating or contracted providers. You are responsible for providing this office with copies of your insurance card(s) or any changes with your insurance or coverage prior to being seen by one of our providers. Failure to do so may result in a denial of your claim making you financially responsible for your session(s).

(C)____ If you do not have insurance, full payment is due at the time-of-service. Unaccompanied minors will be denied service unless charges have been preauthorized to an approved credit card or payment is received at time of service.

FULL PAYMENT IS DUE AT TIME OF SERVICE. IT IS NOT OUR POLICY TO BILL
WE ACCEPT CASH, CHECK, OR ALL MAJOR CREDIT CARDS

24-Hour Cancellation Policy

(D)_____You will be charged for every scheduled appointment unless you cancel at least **24 hours** in advance. Late cancellation or no shows will be billed at the rate of $50.00. Insurance carriers will not pay for no shows or cancellation charges, those will be your responsibility.

Appointment Reminder

(E)_____ We will make a courtesy reminder call 48 hours prior to your scheduled appointment. Ultimately, keeping scheduled appointments is your responsibility.

Credit Card Payment

(F)_____ You may choose to keep your credit card on file with this office to simplify the billing process and ensure that any fees are easily billed at the time of service. Payment is also accepted over the phone or on our website: www.dipotocounselinggroup.com

Returned Checks

(G)_____There is a fee of $15.00 for any check returned unpaid by your bank. If your bank returns a check as unpaid, you will be placed on a cash or credit card only basis, as we will no longer accept checks from you.

Paperwork

(H)_____There are times when you may need paperwork completed by one of our providers. There is a fee for filling out forms and reports. The fees vary according to the document(s) needed. Paperwork and forms can take up to 10 business days to be completed.

Divorce

(I)____If you have been or are now involved in divorce, please understand that, legally, we are not a part of the divorce and are not bound to any divorce decree issued by a court of law. The person that presents themselves or a minor child for treatment is responsible for payment of the medical bill. If your divorce decree states that your ex-spouse is to pay any portion of the medical bills, then you must pay us at the time of service and then seek payment from your ex-spouse per the terms of your divorce decree.

_____ _____
Signature of Patient or Responsible Party Date

_____
Print name of patient

Dipoto Counseling Group

Patient Name: _____

Authorization of Payment

Please choose **ONE** of the following:

1. **I am a private pay client**. I will be responsible for payment in full at the time each service is rendered.

   _____ _____
   Initials **Date**

2. **I authorize payment of benefits to *Dipoto Counseling Group*** for services rendered. I further authorize the release to my insurance company of any medical or other information necessary to process my insurance claims. I understand that I am responsible for all balances not paid by my insurance company, including, but not limited to deductibles, coinsurance, and co-pays.

   _____ _____
   Initials **Date**

EAP (Employee Assistance Program) Policy

I understand that if I am entitled to benefits through an Employee Assistance Program, I must present the billing information and the authorization number for that benefit at my first appointment. If, during the course of my treatment, I find out that I was entitled to an EAP benefit that I was unaware of, Dipoto Counseling will begin billing my EAP with the next session, provided I have obtained an authorization, and regardless of the beginning date of that authorization.

_____ _____
Initials **Date**

This section does not need to be completed if you Registered Online, if so please skip to signature section:

Primary Insurance Information*:*

Name of Policy Holder: _____ Relation to client:_____

Date of Birth: _____ Social Security #_____

Insurance Company: _____ Telephone #_____

Policy/Member #_____ Group#_____

Is there another Insurance Provider? Yes No *If so, please list additional insurance information:*

Insurance Company: _____ Policy Holder Name: _____

Policy/Member #:_____ Group # _____ Policy Holder Date of Birth:_____

I have read and understand all of the above policies.

_____ _____
Signature Date

_____ _____
Print Your Full Name Date of Birth

Dipoto Counseling Group

Treatment Contract and Patient's Rights

Patient: _____

I, _____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at Dipoto Counseling Group hereby referred as the Practice. Further, I consent to have treatment provided by a psychologist, social worker, or counselor. The rights, risks and benefits associated with the treatment have been explained to me, as well as, alternative forms of treatment that are available. I understand that the therapy may be discontinued at any time by either party. The practice encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Patient's Rights notification and certify that I have read and understand its content.

Non-Voluntary Discharge from Treatment: A client may be terminated from the Practice non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the office, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with the Group Director or request to re-apply for services at a later date.

Client Notice of Confidentiality: The confidentiality of patient records maintained by the Practice is protected by Federal and/or State law and regulations. Generally, the Practice may not say to a person outside the Practice that a patient receives services or disclose any information identifying a patient as an alcohol or drug abuser unless: 1) the patient consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the Practice, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is the Practice's duty to warn any potential victim, when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not private health information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original.

I consent to treatment and agree to abide by the above stated policies and agreements with Dipoto Counseling Group.

_____ _____

Signature of Client/Legal Guardian Date

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

_____ _____

Clinician Date