

Cymbria Hess, IMFT
Anderson Hills Psychotherapy

CLIENT INFORMATION SHEET

Welcome to Anderson Hills Psychotherapy

Benefits and Risks

Psychotherapy has both benefits and risks. Treatment is based on the needs of the particular individual, couple or family. We encourage you to discuss your treatment plan and progress with your therapist at any time. Psychotherapy is a cooperative effort that involves open and honest communication between client and therapist. Benefits of therapy may include personal growth; family and/or relationship enhancement; and improvements in mood, behavior, thinking, and work or academic functioning. Risks sometimes include, but are not limited to worsening of mood, behavior and/or family functioning. Difficult feelings and issues may need to be experienced and addressed. Your doctor may need to add or adjust medication. Adjunctive treatments or programs may be recommended. If you should decide to terminate treatment at any point in the therapy or assessment process, we will be glad to help facilitate a referral somewhere else.

Confidentiality

Issues discussed during the course of individual psychotherapy are generally confidential by law. The confidentiality of any information from you is vigorously protected. Exceptions to confidentiality are legally required in cases of potential harm to oneself or others, child or elder neglect or abuse, and in cases where a court subpoena may require the release of confidential material. We urge you not to sign a blanket release of information without first discussing it with you provider. Some insurance companies require treatment plans or clinical information before they will pay for treatment. You have a right to pay for your treatment yourself if you do not want any clinical information released to insurance companies. We make every effort possible to release only the required information to your insurance companies avoiding intimate details as much as possible.

Telephone Contact

We are usually not immediately available by telephone. While in session, we do not return phone calls. We make every effort to return calls on days we are in the office with the exception of holidays and weekends. Please leave time frames when you are most likely to be available and we will do our best to return your call then. If your call is urgent, please specify this on the voice mail system. *If you have privacy block please temporarily remove it so we may return your call.*

Emergencies

If a mental health related emergency occurs, you are advised to go to an emergency room, as you would do with any other health emergency. Someone will evaluate the person in crisis at the emergency room who will then decide an appropriate course of action. Please request the emergency room staff to notify your provider here. If you will be using insurance, it may be advisable to contact the insurance company to ask which hospitals are covered by your plan.

Cancellations or Missed Appointments

We request the courtesy of 24-hours notice if you need to cancel an appointment. Your appointment time is specifically reserved for you and is not readily reassigned to others. Cancellations less than 24 hours may be billed directly to you. Missed appointments will be charged FULL FEE. Insurance companies will not reimburse you for these charges.

Financial & Billing Policies are addressed separately. Written HIPPA policies and procedures are available upon request.

Please do not hesitate to speak with us if you have any questions or concerns about these policies or your treatment. It is our goal that your treatment with Anderson Hills Psychotherapy exceeds your expectations.

YOUR SIGNATURE ON THE "CLIENT INTAKE DATA" (page 2) FORM INDICATES YOUR UNDERSTANDING AND ACCEPTANCE OF THESE POLICIES. Please retain this for your records. Thank you!

Anderson Hills Psychotherapy: Client Intake Data

Patient Name _____ Sex: M or F _____ Date of Birth _____
 Billing Address _____

Street _____ City _____ State _____ Zip Code _____
 Phone (H) (____) _____ (W) (____) _____ Social Security # _____
 Cell (____) _____ Pager (____) _____ Email _____

Is it OK to call and leave messages at any of the above numbers and email? Yes No Preferred Place to call:
 If no, how may we contact you? _____

Responsible Party (if patient is a minor) _____ Relationship to patient _____
 Patient's Employer/School _____ Full-time or Part-time _____
 Employer/School Address _____
 Street _____ City _____ State _____ Zip Code _____

Primary Care Physician _____ Address _____
 Phone (____) _____ Who referred you? _____
 May we thank them for the referral? Yes No

PRIMARY INSURANCE INFORMATION

Policy Holder's Name _____ Sex: M or F _____ Date of Birth _____

Policy Holder Address _____
 Street _____ City _____ State _____ Zip Code _____

Employer _____ Work Phone (____) _____

Employer Address _____
 Street _____ City _____ State _____ Zip Code _____

INSURANCE COMPANY

MENTAL HEALTH ADMINISTRATOR

Address to send claims _____
 Phone (800) _____

Policy Holder's Social Security # _____ Policy # _____ Group # _____

Authorization # _____ for _____ sessions. Effective date range _____ to _____

Medicare # _____ Part B Effective Date _____ Primary _____ Secondary _____

Worker's Compensation Claim # _____ Injury Date _____

Are you covered by any other insurance carrier? Yes No If YES, please complete secondary insurance section below.

SECONDARY INSURANCE INFORMATION

Policy Holder Name _____ Date of Birth _____
 Employer _____ Work Phone (____) _____

INSURANCE COMPANY

MENTAL HEALTH ADMINISTRATOR

Address to send claims: _____
 Phone (800) if available (____) _____

Policy Holder's Social Security _____ Policy # _____ Group _____

STATEMENT OF UNDERSTANDING: I have read and understand the *Client Information Sheet* and give informed consent. The signature below indicates your acceptance of liability for any balance due and the understanding that an outside billing service is being used to manage your account. If insurance is to be used, the signature below also authorizes release of any medical information requested by the insurer (dates of service, services rendered, and diagnosis) in order to process insurance claims and authorizes payment of medical benefits directly to the provider.

Signature _____ Date _____

FOR OFFICE USE: Dx: _____ Provider: CH,IMFT 7-6-09 ahp
 Financial Notes:

Cymbria L. Hess, MA, IMFT, LICDC
Anderson Hills Psychotherapy
cymbria@ahpsych.com www.cymbriahess.com
513-233-0020 ext 1

Billing Information & Fee Schedule

The purpose of providing this written information is to clarify the financial aspects of therapy. Payment for services is an important part of any professional relationship. This is even more so in therapy; as one treatment goal is to have clear relationships including clarification of each person's duties and obligations. Please see me if you have questions or concerns about these policies.

Payment or co-payment is required at the time of service. Payment is accepted in the form of cash, checks, or money orders. Credit card payments can also be completed via my website and Paypal. Please pay for each session before its end. I have found that this arrangement helps us stay focused on our goals, and works best. I suggest you make out your check (or prepare other form of payment) before each session begins to ensure that our time is used for therapy rather than business details. Payments not received within 10 days of the session will be assessed an additional service billing fee of \$15. Payment envelopes can be provided when needed. Any returned checks are assessed a fee equivalent to what the bank charges me.

My billing service, **AF Comprehensive Billing Services**, will manage your account including the billing of any insurance claims. **Please contact AF Comprehensive Billing Services at (513) 304-9245 with any/all questions regarding your billing statements or account.** Also, keep us aware of any changes in address or insurance policies status so that we may keep accurate contact records and properly process insurance claims.

Insurance Billings: Your insurance contract is between you and your company. I had no role in deciding what your insurance covers. Your employer decided which, if any, services will be covered and how much you (and I) will be paid. I will be required to provide (sometimes detailed) information about you to your insurance company. Your signature below provides consent for the disclosure of that information. Should you wish to review any required insurance forms or content with you I will do so upon request. I may send this information by mail or by fax. While I do my best to maintain the privacy of your records, once it is transmitted to a third party I can not be held liable for how they manage your private information.

You are responsible for knowing your insurance coverage, deductibles, payment rates, co-payments, and so forth. You—not your insurance company or any other person or company - are responsible for paying your dates of service fees. *We cannot rely on insurance compliance for payment.* Please determine if your insurance requires you, the patient, to obtain authorization prior to initiating treatment. If charges are denied due to an oversight on your part, you will be responsible for the charges. We will bill insurance each session, and when necessary, re-bill insurance up to three times when claims are seemingly erroneously denied. However, after three unsuccessful attempts to collect from insurance, payment will default to you directly. You may then pursue insurance reimbursement on your own. We will provide "how to" information should that need arise. We work hard to secure insurance reimbursements but can not wait indefinitely for insurance plan compliance.

My current regular fees are as follows:

Initial Session: To obtain background information, perform diagnostic assessment and plan of care. Also covers the additional clerical time to establish you as a new patient. Rate: \$150.00

Psychotherapy & Consultation: 45-50 minutes of contact time for individuals (adult, adolescents, and children), families and couples. Rate: \$125.00.

Extended sessions with a time of 100 minutes may be available, only when scheduled in advance, for a fee of \$185.00. Please be aware that insurance will generally not financially cover that type of session.

Legal Work, Other Services & Correspondence: Any legal case involvement (preparation, letters or reports to the court, phone calls, depositions or court testimony includes billable travel costs) whether under subpoena or not, are billable at an increased rate. Rate: \$175.00 per 45 minutes, in fifteen-minute increments.

All other out of office services (such as hospital visits, consultations with other therapists, and school visits) and any requests for letters will be billed at the regular hourly rate of \$125.00. Some services may require payment in advance.

Telephone consultations: I believe that telephone consultations (emergency or otherwise) may be suitable or even needed at times in our therapy. When this occurs I will charge you our regular fee, prorated over the time needed if it exceeds 5-10 minutes. If I need to have long telephone conferences with other professionals as part of your treatment, you will be billed for these at the same rate as for regular therapy services. If you are concerned about all this, please be sure to discuss it with me in advance so we can set a policy that is comfortable for both of us. Of course, there is no charge for calls about appointments or similar business.

Missed appointment fees: 24-hour cancellation notice is required so that others may have access to that appointment time. *Please do call if you cannot attend your session.* There is no charge for appointments that are canceled with a courtesy of 24-hour notice. Appointments not canceled (“no shows”) 24 hours prior will be charged at the full session fee of \$125.00; this applies to all clients. Sessions canceled with less than 24 hours notice will be billed \$50.00. Insurance cannot be utilized for any of these charges. This fee will be due at the time of your next session. You may leave a message on my confidential voice mail at 233-0020, ext. 1 with appointment concerns or rescheduling needs. The voice mail system time and date stamps all messages. Or I may be contacted via email cymbria@ahpsych.com (do not use your full name for confidentiality protection-identify yourself with first name, last initial & appt time/date). Three “no show” missed appointments, without payment, may result in the termination of our treatment agreement.

If you think you may have trouble paying your bills on time, please discuss this with me. I will also raise the matter with you so we can arrive at a solution. If your unpaid balance reaches or exceeds \$400, I will notify you by mail. If it then remains unpaid, I must stop therapy with you. Fees that continue unpaid (after insurance has covered their portion) will be turned over to small-claims court or a collection service. A finance charge of up to 10% may be added to any accounts that accrue past 90 days to cover the cost of account maintenance.

I will assume that our agreed-upon fee-paying relationship will continue as long as I provide services to you. I will assume this until you tell me in person, by telephone, or by certified mail that you wish to end it. You have a responsibility to pay for any services you receive before you end the relationship. If there is any problem with my charges, my billing, your insurance, or any other money-related point, please bring it to my attention. I will do the same with you. Such problems can interfere greatly with our work. They must be worked out openly and quickly. You will be given advance notice if my fees should change.

Your signature below indicates your understanding, acceptance of financial responsibility and agreement with this policy. PLEASE SIGN ONE COPY FOR YOUR CHART AND KEEP ONE FOR YOUR RECORDS.

Name _____ Date _____