STONEBURNER & ASSOCIATES, LLC

A Practice of Independent Mental Health Professionals

CLIENT INFORMATION SHEET FOR PSYCHIATRIC SERVICES

For Staff Use:	**Checklist:**
Assigned Psychiatrist: ASHA	HIPAA_____
Case #: _____	All Intake Date Completed ___
Case opened by initials: _____	All Signatures Obtained ___

Initial Information **Today's Date: _____**

Client Name: _____ _____ _____
First Middle Last

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Pager: _____

Cellular: _____ Fax: _____ Email:_____

Birthdate: _____ Sex: _____ Social Security #: _____

Marital Status: _____ Spouse's Name: _____

Parent(s)/Guardian(s) if patient is a minor:_____

Responsible Party Information: **If the client is not financially responsible for payment of services, please complete the following information concerning the responsible Party.**

Responsible Party First Name: _____ Last Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Birthdate: _____

Relationship to Client: Parent(s) ____ Guardian _____ Spouse _____

Home Phone: _____ Work Phone: _____ Cellular: _____

Messages can be left at (Check all that apply):

_____Home voice mail _____Cell phone voice mail _____Work voice mail _____US Mail

Who Referred You To This Office? Court _____ Agency _____ Other _____

Name _____ Position _____

Address _____ Phone _____

Primary Care Physician Name: _____

Physician Street Address: _____ City: _____

State: _____ Zip: _____ Physician Phone: _____

Fee Policy for Psychiatric Services

The professional staff of sole proprietors at Stoneburner and Associates, LLC (hereinafter referred to collectively as 'management') are committed to providing caring and professional mental health care to all of our clients/patients. As part of the delivery of mental health services, a financial policy has been established and clarified to state clearly the obligations of management and of clients/patients.

The person designated by the patient/parent/guardian as the Person Responsible for Payment of Accounts is required to sign the Fee Policy that explains the fees and collection policies of the management company relative to the psychiatric practice.

Without exception, the Person Responsible for Payment will be financially responsible for payment of fees in full to the psychiatrist AT THE TIME OF SERVICE.

Should the Party Responsible for payment fail to pay fees the account after 90 days, the account is subject to collections.

While payment is due at the time of service, the patient/parent/guardian may choose to submit a claim for reimbursement to the company that insures the patient/client. A receipt will be provided to the patient/parent/guardian at the time of service and payment with all the information required for insurance reimbursement should the insured's policy provide for such reimbursement. The patient/parent/guardian is responsible for any requirement prior to sessions with the psychiatrist for obtaining pre-certification or pre-authorization if required by their health insurance carrier to receive reimbursement. Neither the psychiatrist nor management shall in any way be responsible for submittal of such insurance claims nor for the third-party reimbursement beyond providing appropriate verification of the service and payment to the patient/parent/guardian for their use in obtaining insurance reimbursement.

Missed appointments or cancellations less than 24 hours prior to the appointment are charged at rate equal to the full rate for services that were scheduled with the psychiatrist. Payment of such fees for missed appointments or cancellations will be due in full 10 days from the date of the appointment missed or late cancellation.

There is normally no charge for telephone consultations with clients and with other professionals if such phone contacts are 15 minutes or less in duration. Telephone calls exceeding 15 minutes, will be prorated at the psychiatrist's standard hourly rate.

Payments will be accepted from the Person Responsible for Payment by check, cash or charge cards, including VISA and MASTERCARD. Clients using charge cards may utilize the cards as charge cards or debit cards.

The psychiatrist can answer any questions regarding the financial policies as stated above.

I have read, understand and agree with the provisions of the above-stated Fee Policy:

Signature of Person Responsible for Payment of Account Date

Signature of Co-responsible Party of Payment of Account Date

Witness' Signature Date

STONEBURNER & ASSOCIATES, LLC

Consent for Treatment

For adults receiving services:

I hereby give my consent to receive treatment and related services from the designated professional(s) providing services to me at Stoneburner & Associates, LLC. I understand that this consent is for the duration of the services to be provided.

_____
Client Name (please print)

_____ _____
Client Signature Date

_____ _____
Witness Signature Date

If patient is a minor, the parent or guardian should sign this statement:

I hereby give my consent as parent or guardian for the following individual to receive treatment and related services from the designated professional(s) providing services at Stoneburner & Associates, LLC. I understand that this consent is for the duration of the services to be provided.

_____
Client Name (please print)

_____
Parent or Guardian Name (please print)

_____ _____
Parent or Guardian Signature Date

_____ _____
Witness Signature Date

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Acknowledgement of Receipt of Privacy Practices

This is to acknowledge my receipt of the Stoneburner & Associates, LLC, *Notices of Privacy Practices* (effective April 14, 2003) on the date below.

_____ _____

Date Signature of Patient or Personal Representative

_____ _____

Witness Patient's Name (please print)

_____

Name of Personal Representative (If applicable)

_____

Description of Representative's Authority to Act for Patient (e.g., Legal Guardian)

STATEMENT OF UNDERSTANDING CONFIDENTIALITY

Confidentiality is one of the essential elements of the counseling relationship. Your clinician is committed to maintaining confidentiality except in cases where intervention is a professional or legal mandate, including the following:

1. Any threat to harm yourself or others, including murder, suicide, and assault.
2. Any reports of actual or suspected child abuse, endangerment or neglect.
3. Any reports, actual or suspected, of abuse of the elderly.
4. Clinician is court ordered to testify.

Your clinician may discuss cases with professional colleagues, without use of names, as deemed necessary.

For adults receiving services:

I have read, understood, and agree with the limits of confidentiality. I hereby give my consent for treatment.

_____
Client Name (please print)

_____ _____
Client Signature Date

_____ _____
Witness Signature Date

If patient is a minor, the parent or guardian should sign this statement:

I have read, understood, and agree with the limits of confidentiality. I hereby give my consent as parent or guardian for the following individual to receive treatment.

_____
Client Name (Please print)

_____
Parent or Guardian Name (please print)

_____ _____
Parent or Guardian Signature Date

_____ _____
Witness Signature Date

Crisis Response Plan

When thinking about suicide or otherwise feel that I am in a crisis situation, I agree to do the following:

1. Try to identify what is upsetting me, then write out and review more reasonable responses to my suicidal or other harmful thoughts, including thoughts about others, the future, and myself.

2. Do things that help me feel better for about 30 minutes, including listening to music, having tea, going for a walk.

3. If I do not feel better, I will contact a family member or a friend to discuss the matter.

4. I can call my therapist and/or psychiatrist.

5. If the thoughts continue, get specific and I find myself preparing to do something to harm myself, I will call the Emergency Number, which is 614-276-2273, the Netcare Access 24 hour hotline and/or go to the Emergency Room of the nearest hospital closest to me.

_____ (Patient Signature)