Patient Information

Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Work Phone _____ Ext _____

Cell Phone _____ Pager # _____

eMail Address _____

Date of Birth _____ Social Security Number _____

Marital Status _____ Gender ☐ Male ☐ Female

Employer or School _____ Employment Status _____

Referred By _____ Field 1 _____

Field 2 _____ Field 3 _____

Is the patient covered by insurance? ☐ Yes - Go to section II

☐ No - Go to section V on back page of this form

Section II - Insured Information

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

If "Patient Relationship to insured" is other than "Self" please complete the following. If patient is the insured go directly to section III.

Insured's Name _____

Address _____

Address _____

City _____ State _____ Zip _____

Phone _____ Work Phone _____

Date of Birth / / Social Security Number _____

Marital Status _____ Gender ☐ Male ☐ Female

Employer or School _____ Employment Status _____

Section III - Insurance Policy Information

☐ Medicare ☐ Medicaid ☐ ChampUS ☐ ChampVA ☐ Group Health Plan ☐ FECA ☐ Other

Insurance Company _____

Address _____

Address _____

City _____ State _____ Zip _____

Plan Name _____

Policy Number _____ Group Number _____

Is the patient covered by more than one insurance ? ☐ Yes - Please complete Section 4 - Page 2

☐ No - Please return this form to the Receptionist

(Over)

Section IV - Secondary Insurance Policy Information

☐ Medicare ☐ Medicaid ☐ ChampUS ☐ ChampVA ☐ Group Health Plan ☐ FECA ☐ Other

Insurance Company _____

Address _____

Address _____

City _____ State _____ Zip _____

Plan Name _____

Policy Number _____ Group Number _____

Section V - Billing Information

(Complete only if there is **no** insurance coverage.)

Who is responsible for charges for this patient. ☐ Patient - Please return this form to the Receptionist.

☐ Other - Please Complete the following information.

Name _____

Address _____

Address _____

City _____ State _____ Zip _____

Phone _____ Work Phone _____

Date of Birth / / Social Security Number _____

Marital Status _____ Gender ☐ Male ☐ Female

Employer or School _____ Employment Status _____

Section VI- Mental Health Authorization and Billing: If you intend to use insurance for mental health or substance abuse treatment, call the customer service number on your card and find out the specifics of your coverage. In some cases, this will involve a behavioral health provider network and a utilization management company providing any required authorization and benefit payments that is different from your insurance company. In addition, if provider services are limited to a restricted panel, you must verify that Patrick A. Quigley, Ph.D. is recognized as a member of that provider group.

The following information must be completed in order to access insurance benefits. If this section is not filled out, it is assumed insurance does not apply.

Behavioral health management company:

Name _____

Phone Number (including area code) _____

Your mental health ID # (if different from your insurance plan ID #) _____

Patient Co-pay (per Session) $_____ or % of fee patient pays $_____

Plan Deductible (if any) $_____ Deductible already paid $_____

Sessions available yearly_____

Treatment authorization number (if applicable) _____

Number of sessions authorized _____

Claims are mailed to: _____

_____

HAVE YOU HAD ANY PREVIOUS PSYCHOLOGICAL CONSULTATIONS?

☐ No ☐ Yes When: Where: Therapist:

HAVE YOU EVER BEEN HOSPITALIZED FOR PSYCHIATRIC REASONS?

☐ No ☐ Yes When: Where: Therapist:

FAMILY MEMBERS AND OTHERS NOW IN HOUSEHOLD

NAME	RELATIONSHIP	BIRTHDATE AND AGE	BIRTHPLACE	OCCUPATION	MARITAL STATUS

ORIGINAL FAMILY (Mother, Father, Brothers, Sisters)

NAME	RELATIONSHIP	AGE OR DATE OF DEATH	BIRTHPLACE	WHERE LIVING & OCCUPATION	MARITAL STATUS

CHILDREN LIVING AWAY FROM HOME

HEALTH HISTORY QUESTIONN/

Name:_____ Date:_____

D.O.B.:_____ Age:_____ Sex:_____ Hgt:_____ Wt:_____

[redacted] Therapist:_____ Primary Care Physician:_____

Date last seen by Medical Doctor:_____ Date last Physical Exam:_____

Laboratory Used:_____

Allergies:

Drugs:_____
Food:_____
Other:_____

Current Medication:

Name of Medication	Dose	Frequency

FAMILY HISTORY

			Relationship
Emotional Problems	Yes [ ]	No [ ]	
Substance Abuse	Yes [ ]	No [ ]	
Cardiovascular Disease	Yes [ ]	No [ ]	
Hypertension	Yes [ ]	No [ ]	
Kidney Disease	Yes [ ]	No [ ]	
Respiratory Disease	Yes [ ]	No [ ]	
Cancer	Yes [ ]	No [ ]	
Diabetes Mellitus	Yes [ ]	No [ ]	

PERSONAL HISTORY

Emotional Problems	Yes [ ]	No [ ]	Substance Abuse	Yes [ ]	No [ ]
Cardiovascular Disease	Yes [ ]	No [ ]	Hypertension	Yes [ ]	No [ ]
Kidney Disease	Yes [ ]	No [ ]	Liver Disease	Yes [ ]	No [ ]
Respiratory Disease	Yes [ ]	No [ ]	Tuberculosis	Yes [ ]	No [ ]
Diabetes Mellitus	Yes [ ]	No [ ]	Cancer	Yes [ ]	No [ ]
Thyroid Abnormalities	Yes [ ]	No [ ]	Neurological Abnormalities	Yes [ ]	No [ ]
Head Injuries	Yes [ ]	No [ ]	Other:_____		

Past Surgeries (Date and Types):_____

Hospitalizations (Date and Types):

Medical:_____

Psychiatric:_____

Do you Smoke? Yes [ ] No [ ] How much per day?_____ How many years?_____

Do you use alcohol or drugs? Yes [ ] No [ ] Type:_____

How much per day?_____ If yes, have you felt the need to cut down?_____

Do you have access to a gun or other weapon? ___Yes ___NO

Psychologist

Addiction Counselor

Patrick A. Quigley, Ph.D., LSAC

AN AGREEMENT FOR PSYCHOLOGICAL SERVICES

A psychologist is a licensed health care professional. Psychologists, who practice in a community or neighborhood setting, usually offer psychological counseling and sometimes psychological testing to their clientele. These services are offered to people of all ages and in individual, family, or group settings. My psychological practice is a general, clinical practice. I work with children, adolescents, and adults. I see people individually, in couples, or as a family. Most of my work involves psychotherapy. This is the use of verbal communications to help individuals resolve personal behavioral emotional, mental, or relational problems.

Psychotherapy comes in different varieties. I will make the best match between your goals, the resources you make available for these services, and the commitment you are willing to make to achieve your personal goals. Where your goals are unclear, I will strive to help you define them. If your goals or resources change in the course of treatment please let me know so that I can make adjustments. Honesty, candor, and trust are obviously essential for this process to work. The work of personal change can be quite anxiety provoking and at times you may feel that you are not making progress when, in fact, you are. I will make every effort to provide a safe, nurturing, and informative environment. Anything less than total candor will undermine the goals for treatment. You will need to let me know about any feelings of discomfort so that I can make appropriate adjustments or help you understand why we should not. I will not knowingly ask or suggest that you do anything harmful.

Your treatment is confidential and privileged. I will not disclose your presence here or the content of our sessions without your explicit consent. Imminent danger to yourself or another is a legally and ethically limiting condition to this confidentiality. Also I am a mandated reporter of child abuse and neglect. Should you decide to use insurance to pay for part or all of your treatment, I may have to disclose some information to help you access your benefits.

My practice, whether doing psychotherapy or assessment, is clinical and not forensic. My work with people is for the resolution of personal issues and difficulties and not for legal documentation or assessment. If you would like your records for this purpose, I will provide you with a copy and not more than this. I do not work as an *expert witness*. I do not do custody evaluations. Custodial and forensic psychology services are best handled by specialists and I will be glad to make the appropriate referral.

My fees are $175 for the initial consultation and $160 for subsequent sessions. The sessions are usually 45 minutes. Full fees or insurance plan co-pays are due at the end of each session. Time spent scoring tests or preparing reports are billed the same as individual, face-to-face sessions. Many people use their insurance to pay for part or all of their treatment. Your insurance plan will have its own requirements and limitations, which may or may not coincide with the goals and purposes of your treatment. I will make the clinical differences known to you, as I am aware of them. However, it is *your responsibility* to know the parameters of your insurance coverage and *you are ultimately responsible for the payment of services received.* Insurance is accepted only as an accommodation to you. Professional time spent obtaining insurance benefits authorizations, completing insurance-related reports or coordinating with insurance care managers is billed directly to you at the session rate in quarter-hour increments. Delinquent accounts overdue at 90 days may be sent to collections.

Return appointments are scheduled in advance, at the end of each session. This is the best time to change the schedule if necessary. An appointment must be cancelled at least 24 hours in advance to avoid a $100 late cancellation fee.

If we decide that your treatment should involve an additional health care provider, at your discretion, I will endeavor to establish coordination of care with the other provider.

Your participation in psychotherapy is voluntary. You may stop at any time. I feel that this decision is best discussed face to face. Likewise, if I feel that our work together should suspended or terminated, I will share this with you.

Accepted by: _____ _____

Signature of responsible party — Date

form date 11 14 2012

PATRICK QUIGLEY, Ph.D.

POLICIES REGARDING PAYMENT FOR SERVICES

For services covered by insurance this office will request payment through your insurance carrier.

Payment for all services not covered by insurance, including copays and deductibles, is due at the time services are rendered. Unless paid by cash or check, payment will be charged to the debit, credit or HSA card used to setup the patient account. If not already done, please fill out the credit card information below and provide an email address where you can receive charge notifications.

PAYMENT IS DUE:

- For a counseling session at the time of the session, including payment for insurance copays and deductibles.
- For evaluations, which may involve scoring, interpreting and creating reports from client data, will be billed at the same hourly rate as a counseling session and payment in full must be received at the time the report is reviewed in person. Copies be available during the session.
- For No Shows or Late Cancels (less than 24-hours' notice) - $100.00 per event. NOTE: If you are unable to attend a scheduled session, but we can conduct a confidential session, either by phone or other tele help tool, the session will be billed to your insurance in the usual manner and there will not be a No Show or Late Cancel charge. Copays apply as usual.
- Miscellaneous charges:
    - copies of records – they are available to you in this office. Please schedule an appointment and we can go over them together. Your consent for release involves you actually witnessing what is going out. No charge for the copy. Regular session fees apply.
    - forms for record reviews, disability, FMLA will be completed only when you are present. Regular session fees apply.
    - Payment for depositions, testimony must be arranged in advance and details will be provided on a case by case basis.

THANK YOU.

Name on card: _____

Billing address: _____

Card Number:_____Exp. Date.

_____Security Code: _____

Email address: _____