

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Chart #: \_\_\_\_\_



**Patient Information**

<b>Legal Name:</b>	
<b>Preferred Name:</b>	
<b>Date of Birth:</b>	
<b>Pronouns:</b>	
<b>Race:</b>	
<b>Emergency Contact:</b>	
<b>Emergency Contact #:</b>	

<b>Physical Address</b>	<b>Mailing Address (If different from Physical)</b>

**Contact Information**

<b>Main</b>	
<b>Other</b>	
<b>Other</b>	
<b>Email</b>	

Your email will be used to send MYIO portal access. **Please note:** If you have multiple patients at Anchor, our system requires a separate email address for each user.

**Appointment Reminder Preference** (Select one): \_\_\_\_ Text \_\_\_\_ Phone \_\_\_\_ Email

<b>Marital Status Selection</b>	<b>Single</b>	<b>Married</b>	<b>Divorced</b>	<b>Widowed</b>

<b>Student?</b>	<b>Yes – Full Time</b>	<b>Yes – Part time</b>	<b>No</b>

<b>Name of Employer:</b>	
<b>Address:</b>	
<b>Phone Number:</b>	

<b>Who is authorized to schedule and make payments?</b>	
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**Guardian Information**

<b>Legal Name of Parent / Guardian 1:</b>	
Date of Birth	
SSN	
Address	
Phone Number	
Email	
Marital Status	
Relationship to Patient	
<b>Legal Name of Parent / Guardian 2:</b>	
Date of Birth	
SSN	
Address	
Phone Number	
Email	
Marital Status	
Relationship to Patient	
Who is Responsible for Payments?	

<b>How did you hear about us?</b>	Friend	Psychiatrist
	Primary Care Provider	Other Clinician
	Psychology Today	Previous Client
	Anchor Website	School Counselor

<b>Primary Care Provider</b>	
<b>Phone Number</b>	
<b>Address</b>	

**Please select the custody arrangement that is most appropriate for your situation.**

Other:	Biological parents still married, living together
Biological parents separated with a legal court ordered a custody plan.	Biological parents separated with no legal court ordered custody plan.
Biological parents separated and ONE parent have full custody.	Child living with court appointed legal guardian (non-biological parent).

**In juvenile cases where a divorce is involved, we require a copy of your custody of paperwork to make sure we are following the rules set out for consent to care.** It is our preference to have a signature from both parents consenting to treatment regardless of custody arrangement. We are here to help children, not testify, and will only treat children who have an active court signature on file due to the dual relationship this causes and ethical concerns that arise which can hurt the therapeutic relationship.

<b>Parent / Legal Guardian 1 Signature:</b>	
<b>Parent / Legal Guardian 2 Signature:</b>	
<b>Date:</b>	

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**Patient Questionnaire**

Depression	Body Image
Stress	Eating Disorder / Eating Issues
Anxiety	Physical Abuse
Attention Problems	Sexual Identity Issues
Self Esteem / Confidence	Racial / Cultural Issues
Hyperactivity	Physical Health
Impulsivity	Decision Making
Grief / Loss	Financial Problems
Pregnancy Past / Present	Delusions
Learning Disability	Hallucinations
Academic Troubles	Suicidal Feelings
Anger Management	Loneliness / Isolation
Sexual Abuse / Molestation	Military Related Problems
Sexual Assault	Reintegration
Flashbacks	Nightmares
Legal Problems	Sleep Problems
Romantic Problems	Divorce / Separation
Mania	Homicidal Feelings
Fears / Phobias	Substance / Alcohol Abuse
Obsessive Thoughts / Compulsions	Other

<b>Additional Clarification for Visit</b>

<b>Please list all Medications and supplements</b>	<b>Medication/ Supplement Name</b>	<b>Dosage</b>

<b>Please list any Allergies</b>	

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**Insurance Information**

Primary Insurance Carrier	
Insurance Company Name	
Member/Subscriber ID #	
Group #	
Name of Policy Holder	
Policy Holder Date of Birth	
Policy Holder SSN	
Relationship to Patient	
Secondary Insurance Carrier	
Insurance Company Name	
Member/Subscriber ID #	
Group #	
Name of Policy Holder	
Policy Holder Date of Birth	
Policy Holder SSN	
Relationship to Patient	

**Please bring a current copy of all insurance cards with you to your first appointment. If you have an electronic card, please email it in advance of your intake appointment to: [officemanager@anchorpsychological.com](mailto:officemanager@anchorpsychological.com).**

**All Clients: Assignment of Insurance Benefits**

I hereby assign all medical and/or therapy benefits, including major medical benefits to which I am entitled, Private Insurance, Tricare, Medicare, and any other health plans to Anchor Psychological & Counseling Services, PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand my signature requests that payment be made and authorize the release of all information necessary to adjudicate the claim and secure payment for services rendered. If "other health insurance" is indicated, my signature authorizes the release of all information to the insurer or agency that is necessary to adjudicate the claim. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and that I am responsible for deductible, co-insurance, and any non-covered services. I understand that I am financially responsible for all charges whether the charges are paid by said insurance. Please be advised that the contract with health insurance companies requires that Anchor provide it with information relevant to the services that are provided to you. Anchor is required to provide a clinical diagnosis. Sometimes Anchor is required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. By signing this Agreement, you agree that we can provide requested information to your carrier if deemed necessary.

<b>Signature:</b>	
<b>Date:</b>	

\*I understand that if I have a MEDIGAP policy to which my Medicare Carrier automatically "crosses over," Anchor is required to keep a separate signature on file. I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier for any information needed to determine benefits or the Benefits payable for related services.

<b>Signature as it appears on MEDIGAP Card:</b>	
<b>Date:</b>	

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### **Office Procedures + Financial Policy**

For patients with Medicare: We will bill Medicare on your behalf. As a courtesy, we will also bill secondary insurance carriers on your behalf. You are responsible for all deductible, co-insurance, and non-covered service payments.

For patients with Insurance: All applicable co-payments, co-insurance payments, and deductibles are due at the time of services. We will bill insurance carriers on your behalf if we have a current contract with the carrier.

- Please be advised that your agreement with your insurance carrier is a private one and that ultimately, you are responsible for payment.
- If an insurance carrier has not paid a claim within 60 days of billing, our fees are due and payable to you.
- Preauthorization of a procedure is not a guarantee for payment. Any procedure may be considered not covered under the terms of your agreement with your insurance company.
- Your insurance carrier will decide on payment once the claim is received and reviewed. If the claim is reviewed and it is determined by your insurance company that the procedure is not covered you will be financially responsible for Anchor Psychological & Counseling Services, PLLC, for the charges and will be billed for those services not covered by your insurance company.

### Phone Calls

- Typically, there is no charge for phone calls. However, phone calls that are extended and/or constituted therapy will be billed at the rate of \$20 for every 15 minutes directly serviced to the client because insurance does not cover this service.

### Testing Fees

- Charges for psychological testing apply to all tests taken and scored. Sometimes insurance does not reimburse for testing. In this event, you will be responsible for uncovered testing at the self-pay rate. Testing fees will be determined by the type and length of testing.

### Collateral Appointments

- Appointments about a client without the client present, (i.e., parents meet with therapist without the child). Some insurance companies do not reimburse them for appointments when the client is not present. This could result in the client being billed at the self-pay rate.

In some circumstances, depending on the time involved and the nature of the task, you may be charged for additional services such as extended sessions, writing letters of advocacy or documentation on your behalf, extensive clinical coordination, and extended consultations with other providers regarding your treatment.

### Missed Appointments

- We require at least 24 hours' notice (one business day) to cancel an appointment. (Appointments scheduled on Mondays must be cancelled no later than 12PM on the Friday prior).
- A \$50 fee will be charged for any missed appointment (no show) or appointment cancelled late (without 24-hour notice). Waivers will be at the providers' discretion.
- Missing more than 2 appointments without providing 24-hour notice is ground for discharge from the practice.

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- Please be advised that reminder calls are an additional courtesy, and you will be billed for late cancellations and no shows regardless of whether you received the reminder's message.

Returned Checks

- There will be a fee of \$35.00 charged for each check returned to us by your bank.

Outstanding Balances

- You are responsible for paying any balance due on your account.
- Once we receive the Explanation of Benefits from your insurance carrier, your balance may be adjusted based on your carrier's allowed amount.
- If an account has an unpaid balance, ongoing services may be immediately postponed until full remittance is received.
- We do not offer payment plans at this time. All charges are due at the time of service. We do accept CareCredit, which will allow you to finance any balances too large for immediate payment.
- If you previously discontinued your care or were discharged from treatment and you desire to resume receiving services at Anchor Psychological, you will be expected to remit any unpaid balance prior to being seen.

Collection Agency Costs

- In the event that your account is forwarded to a collection agency, you agree to pay an additional fee equal to 33% of the balance forwarded to the collection agency for balances under \$75.00 and 40% for balances over \$75.00 and any additional attorney fees or court fees.

**These are our conditions of registration as well as our policies with respect to the billing and collections of your account. By signing, you agree that you have read the Office Procedures & Financial Policy, and you agree to be bound by these terms.**

**I agree with the Office Procedures and Financial Policy stated above.**

<b>Signature:</b>	
<b>Date:</b>	

**Credit Card Payment Authorization**

I understand and authorize Anchor Psychological and Counseling Services to charge the credit card on file for the amount stated by my insurance policy or payment agreement and that payment is due at the time services are rendered. I also understand that this card will also be charged a fee of up to \$50 for an appointment that is cancelled without adequate notice or no showed. This fee is at the discretion of the provider and is outlined in the financial policy. You are required to have a credit card on file for Telehealth appointments. If you refuse to have a card on file, you are responsible for calling our office PRIOR to your appointment.

- I understand this form is only a consent for saving cards on file, and it is my responsibility to provide a card to Anchor Psychological for processing.

<b>Name of Patient</b>	
<b>Billing Address</b>	
<b>Signature of Patient / Guardian</b>	
<b>Date</b>	

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**Rights & Consent to Treatment**

- You have the right to be respected as an individual, regardless of your gender, race, religion, sexual orientation, or disability status.
- You have the right to be treated in accordance with professional and ethical standards of conduct.
- You have the right to confidentiality. We will not disclose any information outside of Anchor Psychological without your written consent.
- Clinical records will be maintained in a secure, locked environment.
- Please be advised that state law requires that confidentiality be broken in certain emergency situations, such as to protect you or someone else from imminent danger, to report child or elder abuse, or if mandated by a court order.
- The state law also allows for exchange of clinical information with other medical professionals to assist with coordination of care to provide optimal care.
- You have the right to discontinue therapy at any time. However, it is expected that you will confer with your therapist rather than end treatment abruptly. If you decide to discontinue treatment, you have the right to request a treatment summary and referrals to other professionals.
- I understand that sessions run for 45 minutes and will not be extended to accommodate tardy clients.
- In addition, if your session runs beyond the allotted time (such as in an emergency situation), your fee will be adjusted accordingly.
- I consent to take part in treatment with this clinician. I understand that it is in my best interest to actively participate in treatment and follow treatment recommendations.
- I understand that there is no guarantee that any particular outcome will result from treatment.
- I understand and give my consent to the Anchor Psychological clinical staff to consult with each other as needed to provide me with the most effective, ethical treatment possible. The clinicians at Anchor Psychological are **Mary Godin, MA, LCMHCS – Kimberly Giddo, M.Ed., LCMHC, LCAS, NCC, Ed.S - Gabriele Jones PhD – Ameer Little, MSW, LCSW – Andrea Gillespie, MA, LCMHC, LCAS – Jessica Cramer, MSW, LCSW – Tracy Goldberg, MSW, LCSW – Phebe Crawshaw, MSW, LCMHC, LCASA – Michael Bradley, E.d.D - Lydia Sommer, MSW, LCSW – Audry Peters, MSW, LCSWA, Melissa Jaworowski, M.Ed, LCMHCA – Erin Watlington, M.Div, MA, LCMHCS – Alexis Redman, MSW, LCSWA, LCASA, and Melinda Dunlap LCSWA – Cailin Holt, MSW, LCAS, LCSWA.**
- I understand that my therapist may consult and share clinical information with their supervisor and/or clinical board to provide legal and ethical treatment. They may also do so to meet the requirements set forth for their licensure or certification.

<b>Name of Client</b>	
<b>Name of Responsible Party</b>	
<b>Signature</b>	
<b>Date</b>	

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**Telehealth Consent**

- There are potential benefits and risks of videoconferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission of the other person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the Clinician will explain how to use it. Doxy.me will be used as our platform. This is HIPAA compliant, and you will assess it through our link posted on our website.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free from distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than free/public WiFi.
- It is important to be on time. If you need to cancel or change your telehealth appointment, you must notify the clinician in advance by phone or email.
- We need a backup plan (a phone number) to start the session or reschedule in the event of technical difficulties.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location in the event of a crisis.
- If you are not an adult, we need the permission of a legal guardian as well as their contact information for you to participate in your telepsychology.
- You should confirm with your insurance company that video sessions will be reimbursed. If they are not reimbursed, you will be responsible for full payment.
- Your clinician may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in person.

I agree to Telehealth Services and Above Policies: \_\_\_\_\_ Accept \_\_\_\_\_ Decline

<b>Name of Client</b>	
<b>Name of Responsible Party</b>	
<b>Signature</b>	
<b>Date</b>	

**No Court Statement**

I understand that my therapist will provide only psychological therapy and/or psychological testing services as desired by myself (the client) or parent/guardian, (as appropriate with the full knowledge as appropriate and possible of both parents/guardians). I understand that my therapist, the records maintained at Anchor Psychological & Counseling Services PLLC, nor any other person acting on behalf of Anchor will ever be expected, asked, or subpoenaed by a client, parent, legal guardian, or other representative to appear in court or for any legal proceedings on my behalf. Additionally, no judge will be asked by the client, parent, legal guardian, or other representative to order any Anchor Psychological staff to testify in any legal proceedings regarding past, present, or future matters.

<b>Signature:</b>	
<b>Date:</b>	

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**Authorization for Release of Health Information**

Authorization of Mutual Exchange of Information with Anchor Psychological & Counseling PLLC and Primary Care Physician, Psychiatrist, School, Disability Determination, Coordination of Care, Further Mental Health Care, Applying for Insurance, etc.

**Release to Self:** To release records to you or a parent/guardian we require a release of information on file to do so. Please fill out your information (or the parent/guardian) on the form below and select an option. **Please note: if you decline your release to self, we will NOT be able to release any notes, letters, psychological evaluations, etc. to you.** All requests for records must be submitted in writing and be approved by your therapist before records are released. Requests for release of psychotherapy notes cannot be combined with any other type of request.

Release to (Name):	
Agency:	
Address:	
Phone #:	
Relationship to Patient:	

Please **INITIAL** your selected option for information to be Released.

	My Entire Mental Health Record Including Substance Abuse
	Verbal Communication Only
	Only those portions pertaining to: _____
	Authorization for Psychotherapy Notes ONLY
	Other: _____
	Declined – NO RECORDS MAY BE RELEASED

**Release to PCP/Other:** To release records to any other provider, agency, therapist, etc. we require a release of information on file. Please fill out the information for the other party you would like records to be shared with and select an option.

Release to (Name):	
Agency:	
Address:	
Phone #:	
Fax #:	
Relationship to Patient:	

Please **INITIAL** your selected option for information to be Released.

	My Entire Mental Health Record Including Substance Abuse
	Verbal Communication Only
	Only those portions pertaining to: _____
	Authorization for Psychotherapy Notes ONLY
	Other: _____
	Declined – NO RECORDS MAY BE RELEASED

Note: Authorizations are valid for a maximum of one year unless noted otherwise. Date of Expiration: \_\_\_\_\_

**Notice of Rights and Other information:** Sign to acknowledge that you understand that you have the right to review the information that is being used or disclosed. You do not have to complete this authorization, and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits. The information used or disclosed by any authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws. You have a right to revoke this authorization at any time. You have a right to receive a copy of this signed authorization. Notice: This information has been disclosed to you from records protected by the Federal Confidentiality Rules (42 CFR, Part 2). The Federal rules prohibit us from making any further disclosure of this information unless further disclosure is expressly authorized for release of medical or other information. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol/ drug abuse patient.

<b>Name of Person Completing this form:</b>	
<b>Relationship to Patient:</b>	
<b>Signature of Person Completing this form:</b>	
<b>Date:</b>	