CALIFORNIA THERAPY CENTER & PSYCHOLOGICAL SERVICES, INC.

TODAY'S DATE: _____ EMAIL: _____

Referred by: _____ Referral Phone No. (____)_____ OK to Contact? _____

Patient Last Name: _____ First Name: _____ Middle Name: _____

Patient Street Address: _____ City: _____ State: _____Zip: _____

Home Tel. # (____)_____Work Tel. # (____)_____ Cell # (____)_____

Patient Sex: _____ Patient Age: _____ Patient DOB: _____ Patient Marital Status: _____

Race:_____Ethnicity:_____Language: _____Smoke: YES or NO

Patient Driver's License No. & State _____//_____ Patient Social Security No. _____

FINANCIAL RESPONSIBLE PARTY INFORMATION

PRIMARY RESPONSIBLE PARTY INFO

Last Name: _____First Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Tel. No. (____)_____

Driver's License No. _____State: _____

Social Security No. _____ DOB: _____

Employer's Name: _____

Employer Street Address: _____

City: _____ State: _____ Zip: _____

Work Tel. No. (____)_____

SECONDARY RESPONSIBLE PARTY INFO

Last Name: _____First Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Tel. No. (____)_____

Driver's License No. _____State: _____

Social Security No. _____ DOB: _____

Employer's Name: _____

Employer Street Address: _____

City: _____ State: _____ Zip: _____

Work Tel. No. (____)_____

INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE PARTY INFO

Insurance Co. Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Insurance Company Tel. No. (____) _____

Insurance Group No. _____

Authorization No._____ No. of Sessions Auth. ____

Dates of Authorization: _____

SECONDARY INSURANCE PARTY INFO

Insurance Co. Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Insurance Company Tel. No. (____) _____

Insurance Group No. _____

Authorization No. _____No. of Sessions Auth. ___

Dates of Authorization: _____

Limits of Confidentiality Statement

All information between practitioner and patient is held strictly confidential. There are legal exceptions to this:

1. The patient authorizes a release of information with a signature.
2. The patient's mental condition becomes an issue in a lawsuit.
3. The patient presents as a physical danger to self (Johnson v County of Los Angeles, 1983).
4. The patient presents as a danger to others (Tarasoff v Regents of University of California, 1967).
5. Child or Elder abuse and/or neglect are suspected (Welfare & Institution and/or Penal Codes).

In the latter two cases, the practitioner is required by law to inform potential victims and legal authorities so that protective measures can be taken.

All written and spoken material from any and all sessions is confidential unless written permission is given to release all or part of the information to a specified person, persons or agency.

Initial here: _____

Release of Information

I authorize release of information to my Primary Care Physician, other health care providers, institutions and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. I further authorize the release of information to my health plan/ insurance carrier for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan/insurance carrier.

Initial here: _____

Emergency Access:

Practitioners are available after hours to handle **emergencies**. If you are in imminent danger, call 911 or go to your nearest emergency room. By calling the main office number after hours, you will be instructed how to contact the on-call practitioner. We do not guarantee immediate return calls when paged for any emergencies.

Initial here: _____

Financial Terms: Insurance Coverage, Co-payments and Statements

You are responsible for obtaining prior authorization for treatment from your insurance carrier. We will bill your insurance. However, you are responsible for co-payment amounts and deductibles as set by your benefit plan. California Therapy Center & Psychological Services,inc. and its agents bill as a courtesy. The contract for insurance is between you, your employer and the insurance carrier, not our office. Thus, final responsibility for all incurred charges is the patient's. You, as the patient, are personally responsible for all payment of fees, including those not paid by their insurance carrier within 120 days after the rendering of services.

I understand and accept full financial responsibility for all chargers incurred by me or my dependents. At any time during treatment should I become ineligible for insurance coverage, I will notify my clinician and I understand I will be responsible for 100% of the bill.

We do charge fees for lengthy telephonic communications, court attendance and report/letter writing. Missed or late cancelled appointments are not covered by your insurance and the charges associated with them are your responsibility. Co-payment and annual deductible amounts are set by your benefit plan. **These payments are due and payable at each appointment. If you are unable to pay your co-pay and/or deductible at the time of your visit, the doctor may refuse to see you.**

Please carefully watch your insurance company statements to see that your insurance carrier is paying their portions in a timely manner to avoid becoming responsible for the total amount due.

Please make all checks payable to the clinician you see for proper credit. We strongly encourage you to fill in the payee blank yourself.

Your expected deductible is: $_____
Your expected co-payment is: $_____
Your expected out-of-pocket payment is: $_____

Initial here: _____

Collection Policy

Our office retains a professional collection agency for pursuit of accounts that become delinquent. If it becomes necessary to transfer your account to our collection agency, your financial records will be released to them and your delinquent balance will be recorded with the 3 major credit bureaus, i.e., Trans Union, Equifax and Experian. If legal proceedings become necessary, the patient hereby agrees to bear all financial responsibility for all attorney and court costs associated with collecting an unpaid debt. Please be aware that we take this action only as a last resort.

Initial here**:** _____

Assignment of Benefits

I authorize my insurance carrier to directly pay my practitioner.

Initial here**:** _____

Cancellation and Missed Appointment Policy

Scheduled appointment times are reserved especially for you. If an appointment is missed or canceled with less than 24 hours notice, you will be charged the $___ missed appointment fee or full fee. Frequent cancellations and no-shows may result in the termination of your treatment. Your compliance in keeping appointments and active participation in treatment is vital.

Initial here: _____

Appeals and Grievances

I acknowledge my right to request reconsideration (an Appeal) in the case that outpatient care is not certified by my Managed Care Company. I understand that I would request an Appeal directly through my Managed Care Organization.

I also understand that I may submit a Grievance to my practitioner at any time to register a complaint about my care or I may send the complaint directly to my insurance company. My practitioner has access to information to facilitate this.

I understand that the California Department of Managed HealthCare (DMHC) is responsible for regulating health care services. The California DMHC has a toll-free telephone number (800-400-0815) to receive complaints regarding health care plans. If I have a grievance about an appeal that has not been satisfactorily resolved by the plan, I can contact the Managed Care Company or the DHMC.

Initial here: _____

Consent for Treatment

I authorize and request my practitioner to carry out psychological and/or psychiatric exams, treatment and/or diagnostic procedures, which now, or during the course of my treatment become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that that while the course of my treatment is designed to be helpful; my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and myself.

Initial here: _____

Please be aware that each clinician at California Therapy Center & Psychological Services, Inc. is not an employee, but an independent practitioner. Thus, other clinicians do not share any legal liability for the acts of your clinician in the practice.

Initial here:_____

1. When it becomes necessary to contact you by phone, please list the number(s) where you wish us to call. May we leave messages, such as lab results, appointments or other medical information on an answering device, or with another person who answers the phone, at the number? Yes ( ) No ( ) Number(s):_____-_____
2. Name and phone of emergency contact person not living with you_____ #_____

_____ _____
Patient/Parent/ or Guardian Signature Date

_____ _____
Partitioner/Witness Signature as needed Date

If you desire a copy of this document, please inform the front desk.

California Therapy Center & Psychological Services, Inc.
1101 N. Pacific Ave. Suite 204
Glendale, CA-91202

Phone 818-396-5343
Fax 818-561-3997

General Consent for Child or Dependent Treatment

I am the legal guardian or legal representative of the dependent patient and on the patient's behalf legally authorize the practitioner/group to deliver mental health care services to the dependent patient. I also understand that all policies described in the previous three pages of the registration form also apply to the dependent patient I represent.

_____ _____
Patient Name Patient Social Security #

_____ _____
Signature of Legal Guardian/Legal Representative #1 Date
Relationship to Patient

_____ _____
Signature of Legal Guardian/Legal Representative #2 Date
Relationship to Patient

Regarding Dependents of Divorced Parents

As recommended by the California Board of Psychology, when one parent of the dependent child seeks psychiatric or psychological treatment, clarification in writing is requested regarding the presenting parents' ability to individually authorize the delivery of psychiatric/psychological services.

Thus, California Therapy Center & Psychological Services, inc. requests a copy of the legal papers permitting the presenting parent to seek psychological/medical services without the consent of the other parent. If such documentation cannot be presented, the second parent will also need to sign a consent for treatment. Thank you in advance for you kind understanding and compliance.

California Therapy Center & Psychological Services, Inc.

Notification and Acknowledgement of Notice of Privacy Practices Regarding Protected Health Information

Our 2-page Notice of Privacy Practices provides detailed information about how we may use and disclose protected health information about you. As a patient, you have a right to a copy of that document/Notice. You may obtain a copy of the Notice from the office manager or:

California Therapy Center & Psychological Services
1101 N. Pacific Ave. Suite 204
Glendale, CA 91202

Tel. 818-396-5343 fax. 818-561-3997

We reserve the right to change the Notice, and if we do, you may obtain a copy of the revised Notice from the same location noted above.

Please acknowledge your receipt of this notification by signing below and returning it to our office manager. Thank you.

Sign here: _____

Date: _____