Katz-Gilbertson Psychotherapy Associates, LLC Child Intake Form

Therapist_____ Diagnosis Code(s)_____Appointment Date_____

Client's Last Name_____First_____M.I._____
Date of Birth____/_____/____ Age____ Sex____
Preferred Cell Phone #_____
Email Address:_____
Street Address_____City_____State___Zip_____
Mother's Name_____Work Phone_____
Preferred Cell Phone#_____
Email address:_____
Father's Name_____Work Phone_____
Preferred Cell Phone #_____
Email Address:_____
Client Resides with: (circle) Both Parents Father Mother Other_____
Responsible Party: (circle) Both Mother Father Other_____

Please check one: Bill Insurance for Services_☐__Self Pay_☐__

I have checked with my insurance company regarding Mental Health coverage Y☐ N☐
I have received pre-authorization for outpatient Mental Health services Y☐ N☐

Primary Insurance Company_____
Insurance Street Address_____City_____State___Zip_____
Insured Last Name_____First_____M.I.__Rel. to Child_____
Employer_____Work Phone_____
DOB: ___/___/__Sex__Coverage-Single/Family (circle)
Policy Identification #_____Group Number_____

Secondary Insurance Company_____
Insurance Street Address_____City_____State___Zip_____
Insured Last Name_____First_____M.I.__Rel. to Child_____
Employer_____Work Phone_____
DOB__/__/__Sex__Coverage-Single/Family (circle)
Policy Identification #_____Group Number_____

Information about Fees:

The Initial Assessment fee___$195___
Fee for Individual Psychotherapy ___$190____
Fee for Marital/Family Therapy__$190__
Psychological Testing/Evaluation__$190__

If you are a member of a HMO/PPO, payment to your provider may be discounted from that stated above. It is important to be aware of your plan deductible and your co-pay responsibility. The expectation is that co-pays (or full fees for self pay clients) are paid on a per session basis to your treating psychologist. For your convenience, cash, check or credit card payments are accepted.

I hereby authorize *Katz-Gilbertson Psychotherapy Associates, LLC* to release such information as may be requested by my insurance company for purposes of billing or coverage clarification. Further, I hereby authorize any insurance coverage providing benefits or payments for psychological/mental health services received to be assigned to *Katz-Gilbertson Psychotherapy Associates, LLC*. I also permit a photocopy or other facsimile of this authorization to be used in place of the original assignment.

Responsible Party Signature_____Date_____

Treatment Agreement

Please read the following information and discuss it with your psychologist as desired.

Confidentiality: All contacts with your psychologist and our clinic management are confidential except in situations where you are deemed to be a potential danger to yourself or others. Reported child abuse victimization is required by state law to be reported by health care providers to child protection or other legal authority.

Disclosures for the purposes of billing, etc are detailed in the *Katz-Gilbertson Psychotherapy Associates Privacy Notice* you have been provided. Please review that notice and ask for clarification as needed.

Hours of Service: Katz-Gilbertson Psychotherapy Associates, LLC hours are flexible; appointment times and phone contacts are negotiated between clients and providers. For clients residing in Milwaukee County, emergency child/adolescent behavioral health consultation and response can be obtained by calling 414-257-7621 for the Mobile Urgent Treatment Team. All other emergency concerns should be addressed by calling 911.

Cancellations or Failed Appointments: Cancellations/schedule changes must be made ***24 hours in advance or you will be billed for the full professional fee***; clients will also be billed for missed appointments. Please be mindful that appointment times are limited and often scheduled weeks in advance.

Treatment Billing Policy

Insurance Responsibility: It is your responsibility to know what coverage your health insurance provides. All charges are the sole responsibility of the responsible party, regardless of insurance payments. If there is a problem with receiving payment from your health insurance carrier, or the claim process extends over two months, you will be expected to make payments. We will then reimburse you when the insurance company makes payments. If the insurance check is paid directly to you, you are obligated to promptly sign the check over, or make the payment to *Katz-Gilbertson Psychotherapy Associates, LLC*. Late payments (60 days past due) will result in an 18%APR interest fee that will be added to your account. Past due accounts will be given to our Collection Agency/Attorney. All fees incurred by this action will be the responsibility of the client.

If there are ever questions regarding your bill, please call Linda @ 414-321-6458. She will be happy to discuss any concerns or questions you might have.

Informed Consent

I/We understand and agree to the above administration/billing policies in this agreement. My treatment provider has reviewed this billing agreement with me, if requested, and I/we agree to pay the deductible and any fees my/our insurance does not cover. I/We are aware that all late or unpaid balances, and the corresponding necessary information will be provided to a Collection Agency/Attorney.

The listed items are understood by me and I feel comfortable asking for clarification if needed:
The benefits of the proposed treatment and services; the way the treatment is to be administered and services are to be provided; the expected treatment side effects or risks of side effects which are a reasonable possibility; alternative treatment modes and services; the probable consequences of not receiving the proposed treatment and services; the time period for which this consent is effective is no longer than 12 months from the time given; the right to withdraw informed consent at any time, in writing.

I received a copy of my Patient Privacy, Rights and Grievance Procedures.

Responsible Party Signature_____________________________________Date_____________________