PHILIP LANE, MSW, LCSW

PL Therapy, LLC
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Client Intake Form

Name: ____

Home Address: ____

____

Phone Number: ____

Email Address: ____

Date of Birth (MM/DD/YYYY): ____

Sex: ______________ Marital Status: _____________________________

Emergency Contact:

Name: ____

Relationship to Client: ____

Phone Number: ____

Reason for Seeking Therapy: ____

____

____

____

Please circle one: **I have** / **have not** had therapy in the past.

I do / **do not** take psychiatric medications. If yes, please list:

____

I hereby certify that I have read this therapist's disclosure agreement as well as all other documents provided. I understand the contents of these documents and agree to the terms set forth therein.

Client Signature: ____ Date: ___________________

Payment Agreement

Payment for psychotherapy sessions is due at time of service. Payment may be rendered via cash, personal check (for in-person sessions only), credit card, or electronic payment method such as Venmo, PayPal, or Zelle. A receipt can be provided upon request. If you are paying through a sliding scale agreement, your signature below confirms your agreement to the payment amount negotiated. If you are unable to keep a scheduled appointment, please make notice at least 24 hours prior to your appointment, otherwise you may be subject to a cancellation fee. Accounts three (3) payments in arrears will be sent to a collections agency.

For Clients Using Insurance:
I agree to pay the provider the copay or coinsurance rate dictated by my insurance plan. This payment is due at the time of service. I understand that I may not be eligible to pay this rate until my deductible is met, in accordance with my specific insurance plan. It is my responsibility to understand my insurance plan's restrictions and requirements. Please be sure to complete the insured client information form in this packet and provide a picture of your insurance card (front and back).

I agree to make this payment via **(please circle one):**
Cash Check Credit Card Venmo PayPal Zelle

For Clients Paying Out-of-Pocket:
I agree to the following rates:
$125 per 50-minute psychotherapy session OR sliding scale fee agreed to: $_____ per session. If you are opting out of using your insurance, please sign the opt-out form in this packet.

I agree to pay the agreed upon session rate via **(please circle one)**:
Cash Check Credit Card Venmo PayPal Zelle

Other fees:
$50 cancellation fee if given less than 24 hours' notice or for a no-show.
$25 letter fee if therapist provides a letter or form to your employer or school, as well as reimbursement for any mailed or faxed documents.
$10 fee for out-of-session communication that does not regard scheduling or billing.

I, ____, agree the terms above.
Client Name

Client Signature: ____ Date: _________________

Office Signature: ____ Date: __________________

Insured Client Information Form

Client Name: ____
Date of Birth: ____
Telephone #.: ____
S.S. # (REQUIRED for insurance claims):
____
Address: ____
Telephone: ____

Insurance Information

Insurance Company: ____
Insurance Company Address (back of card): ____
Insurance Company Telephone (Mental Health): ______________________________________
Insurance ID #: ____
Subscriber's Name/Relationship: ____
Address (If different than client): ____

Is there any other insurance coverage? If yes, provide the secondary insurance information below:
Insurance Company: ____
Insurance Company Address (back of card): ____
Insurance Company Telephone (Mental Health): ______________________________________
Insurance ID #: ____
Subscriber's Name/Relationship: ____
Address (If different than client): ____

As the client, you are responsible for:

- Advising your therapist/office of any health insurance changes or cancellations.
- Paying your co-pay or the fee that has been agreed upon prior to each session.
- If an insurance fails to pay for covered sessions, you are responsible for any outstanding balances with your provider.

Assignment of Benefits

I authorize the release of any medical or other information necessary to process all claims. I also authorize payment of any benefits to for services rendered. I understand that I am financially responsible for all services provided including co-payments, deductibles, and outstanding balances should my insurance fail to pay for services rendered etc.

____________________________________ ________________
Signature Date

Insurance Opt-Out Agreement

I understand and agree that:

- I have voluntarily elected not to use my insurance for counseling sessions.
- My therapist did not encourage, initiate, coerce, persuade, imply, or otherwise cause me to opt out of my insurance, verbally or otherwise; this decision is my own for my own reasons.
- I am not opting out of using my insurance to gain a specific time slot or any auxiliary benefits provided by my therapist, implied or otherwise.
- My treatment was not threatened in any way by either signing (or not signing) this opt out form.
- Opting out of my insurance means that I must pay out-of-pocket for the counseling sessions.
- I have made my therapist aware that I am voluntarily decided to opt out of using my insurance for counseling sessions even if she is in-network or out-of-network.
- I will let my therapist know if anything changes, and I either obtain alternative insurance and/or decide that I would like my sessions billed to my insurance.
- If I opt of out using my insurance, I cannot use the payment of sessions towards my deductible and my therapist will not provide superbills for reimbursement purposes.
- I cannot opt out of services individually (i.e.., I want to opt out of insurance for video sessions but not for in-person sessions) and that by opting out, I am opting out of entirely using my insurance for all services.
- If I elect to voluntarily use my insurance in the future, my therapist reserves the right not to allow me to opt out of using my insurance again.
- If I choose later to use my insurance, my therapist is not liable and is not obligated to reimburse previous sessions where I have chosen to opt out of billing my insurance.
- If I choose later to use my insurance, my opting back into using insurance will start from the day I notify my therapist of the change and cannot be backdated to previous sessions.
- This agreement is in effect from ____________ until I voluntarily elect to make changes and use my insurance.

I acknowledge that I have been given the opportunity to ask questions, and that my provider has verbally explained the risks and benefits of signing the Insurance Opt-Out Agreement. I have read, understood, and agree to the terms contained in the Insurance Opt-Out Agreement.

____ ________________

Client Name Date

____ ________________

Client Signature (Parent/Guardian if under 18) Date

Confirmation of Receipt of HIPPA Notice of Privacy Practices

Your signature below confirms that you have been given a copy of the Notice of Privacy Practices, explaining your rights regarding your medical records under HIPPA (Health Information Portability Act). Please feel free to inquire about any questions you might have regarding these rights.

Client Signature:____ Date:_________________________

Print Client Name:____

NOTICE OF PRIVACY PRACTICES AND CLIENTS' RIGHTS

THIS NOTICE DESCRIBES HOW MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective 3/16/2022, information related to your private medical information will be released only in accordance with state and federal laws and the ethics of the social work profession.

Use and disclosure of protected health information for the purposes of providing services. Providing treatment services, collecting payment and conducting healthcare operations are necessary activities for quality care. State and federal laws allow us to use and disclose your health information for these purposes.

Treatment: Your health information may be used and disclosed in order to provide, manage, or coordinate care with consultants and/or referral sources.

Payment: Your health information may be used and disclosed in order to verify insurance and coverage and to process claims and collect fees.

Healthcare Operations: Your health information may be used and disclosed in order to review treatment procedures, review business activities, provide staff training, and comply with licensing activities.

Other Uses and Disclosures Without Your Consent: Your health information may be used and disclosed in the case of mandated reporting, emergencies, criminal damage, appointment scheduling, treatment alternatives, and as required by law.

Client Rights:
You have a right to request where we contact you.

You have a right to release your medical records as well as a right to revoke release in writing.

You have a right to inspect and copy your medical billing records.

You have a right to add information or amend your medical records.

You have a right to accounting of disclosures with the exception of disclosure for treatment, payment or healthcare operations, disclosures pursuant to a signed release, disclosure made to client, disclosures for national security or law enforcement.

You have a right to request restrictions on uses and disclosures of your healthcare information in writing.

You have a right to grievance. Please contact me first and, if not satisfied, contact the U.S. Dept. of Health and Human Services. You have the right to not be retaliated against for filing a grievance.

You have a right to receive changes in policy.

My signature below indicates that I understand and accept the above:

Client Signature: ____ Date: ______________

Office Signature: ____ Date: ______________

Telemental Health Informed Consent

Please fill out if utilizing teletherapy.

I, ___________________________________(name of client) hereby consent to participate in telemental health as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical healthcare services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

-We will use a secure platform for our telemental health sessions in order to maintain privacy and confidentiality.

-I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

-There are risks and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and or breaches of confidentiality by unauthorized persons, and or limited ability to respond to emergency situations.

-There will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

-If I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis, that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

-If technical difficulties occur, resulting in service interruptions, and we are unable to reconnect within ten minutes, please call your therapist on the cell number provided since we may have to reschedule.

-My therapist, as a mandated reporter, may need to contact the appropriate authorities in the case of an emergency.

Client Signature:____ Date:__________________