

New Patient Intake

Name: _____ **Date of Birth:** _____

Preferred Name _____ **Pronouns:** _____ **Gender:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone (Home/cell): _____ **May we leave a message? Yes** **No**

Marital Status: **Single** **Married** **Separated** **Divorced** **Widowed**

Employer: _____ **Job title:** _____

Email Address: _____ **Who suggested you contact us:** _____

Please briefly describe your reason for seeking therapy: _____

Primary Care Physician? _____

PRIMARY INSURANCE INFORMATION:

Insurance Company Name: _____

ID Number: _____ **Group Number:** _____

Insurance Guarantor's Name (if different from patient) _____ **DOB:** _____

Relationship to Client: _____ **CoPay:** _____

SECONDARY INSURANCE INFORMATION:

Insurance Company Name: _____

ID Number: _____ **Group Number:** _____

Insurance Guarantor Name and DOB (if different from patient): _____

Relationship to Client: _____ **CoPay:** _____

CURRENT HOUSEHOLD MEMBERS

Name	Age	Relationship
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Are your parents alive? _____

What is your relationship with them _____

CURRENT MENTAL HEALTH MEDS

Medication	Dose	Reason

PAST BEHAVIORAL HEALTH/SUBSTANCE ABUSE TREATMENT

Date	Reason	Facility/Provider	Helpful?

Campbell Counseling
4380 W. 12th Street, Suite 2
Erie, PA 16505
814-881-5277

Good Faith Estimate

Name: _____ Date of birth: _____

In accordance with the 2022 No Surprises Act, this is your Good Faith Estimate of the cost of treatment *if you are uninsured or if you do not want to use your insurance* for this care. Since we haven't met, and don't yet know if you want to use insurance for your treatment, the information below is based on "fee for service" (out of pocket) rates.

If you **DO** intend to use insurance, check with your insurance carrier (usually a toll-free number on the back side of your insurance card) to find out what your copayment or coinsurance rates will be—they are likely much smaller.

Since I have not yet evaluated your difficulties or symptoms, I must at this point estimate your course of treatment based on the national average for a course of psychotherapy, which is 18 encounters.

The initial estimate is valid for 12 months, but you are entitled to receive an update of this estimate at any time upon written request.

Current ICD-10 diagnosis R69 (diagnosis deferred)

Anticipated treatment:

- 1 session of CPT 90791 (diagnostic evaluation) at **\$70** per session
- 17 weekly, bi-weekly, or monthly sessions of CPT 90837 (psychotherapy, 53 minutes) at **\$65** per session
- Total of estimated "fee for services" treatment without insurance **\$1175**

This is just a rough estimate based on national averages. The duration of our work together can be longer or shorter depending upon your symptoms, your work between sessions, and your response to treatment. You are free to discontinue treatment at any time. You are also free to discuss other modifications to treatment modalities, frequency, or duration. Sessions may take place here, in our office, or via Doxy.me, our HIPPA compliant telehealth website.

Mark V. Campbell, LPC

Tax ID: 83-2522000

NPI: 114-479-4884

Janet Campbell, LPC, LPN

Tax ID: 86-2285040

NPI: 102-368-7571

Consent for Treatment And Limits of Liability

Limits of Services and Assumption of Risks:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any “cures” cannot be guaranteed for any condition due to the many variables that affect therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy.

Limitations of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written, may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect

If you disclose a plan or threat to harm yourself or another person, the therapist is required to warn the possible victim and/or the proper authorities.

Abuse of Children or Vulnerable Adults

If you disclose, or it is suspected, that there is abuse or neglect of children, elderly, or disabled persons, the therapist must report this information to the appropriate state agency and/or legal authorities.

Insurance Providers

Insurance companies and other third-party payers are given information that they request regarding services to the clients. The type of information they might request include types of services, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing the form below, I agree to the assumption of risk and limits of confidentiality and understand their meanings and ramifications.

Client Signature (Parent/Guardian if under 18)

Date