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 |
|  |   |  |
|  |   |   |
|  |   |   |
| 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? |
|  |  |  |  |
|  |  |  |  |

**Good Faith Estimate**

This document is for informational purposes only. No need to sign this document.

**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

Campbell Counseling

No-show (late cancellation) Policy

We do understand that situations sometimes arise which may make it necessary for you to need to cancel your appointment. We respectfully request that you provide as much notice of those cancellation needs as possible. Ideally, a 24-hour notice is perfect. It allows us enough time to offer your unused time slot to someone else on a wait list. We also recognize that there are rare, uncontrollable instances where you cannot make your appointment, but you do not know that information 24 hours in advance. Our intention is not to penalize you for those unexpected instances. We simply appreciate knowing (as much in advance as possible) that you will not be attending, and no fee will be associated with a cancelled appointment.

No-shows, however, are a problem. **We define a no-show as a scheduled time that has been set aside for you specifically, but you do not appear for therapy, and you do not give us any notice (call/text/email/carrier pigeon) that you will not be attending**. Because these no-shows are a problem, we have implemented a fee for the first no-show session. The no-show fee will be $25.00 for the *first* no-show session. This fee must be paid before a new appointment will be scheduled for you. After the second no-show, you will be released from the practice.

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