Del Ray Psychological & Wellness Associates

Dr. Lauren Fisher, PsyD, PLLC Dr. Eleni Boosalis, PsyD, PLLC

CLIENT DEMOGRAPHIC INFORMATION

TODAY'S DATE:		CLINICIAN:	
CLIENT NAME (FIRST, MIDDLE, LAST)	**DATE OF BIRTH**	**AGE**	**SEX**
HOME PHONE	**WORK PHONE**	**CELL PHONE**	**PH PREFERENCE**
STREET ADDRESS	**CITY**	**STATE**	**ZIP CODE**
OCCUPATION/EMPLOYER	**EMPLOYER ADDRESS & PHONE #**	**RELATIONSHIP TO CLIENT(self/parent)**	
REFERRAL SOURCE	**TREATMENT: THERAPY OR PSYCHOLOGICAL ASSESSMENT**	**REASON (S) FOR TREATMENT**	

INSURANCE INFORMATION

DO YOUR WANT YOUR CLAIMS TO BE SUBMITTED THROUGH INSURANCE? _____Y/N. IF YES, PLEASE FILL OUT THE FOLLOWING INFORMATION AND PROVIDE A COPY OF YOUR INSURANCE CARD.

PRIMARY INSURANCE COMPANY NAME/PLAN	**INSURANCE ID#**	**GROUP #**	
INSURED'S NAME	**ADDRESS (IF OTHER THAN PT)**	**DOB (IF OTHER)**	**SUBSCRIBER'S SS# (Tricare)**
SECONDARY INSURANCE COMPANY NAME/PLAN	**INSURANCE ID#**	**GROUP #**	**CLIENT SS# (Tricare)**
CLIENT RELATIONSHIP TO SUBSCRIBER	**_____SELF**	**_____SPOUSE**	**_____PARENT**

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CLIENT SERVICE AGREEMENT

Informed Consent to Treatment

I, _____, (name of client or guardian as applicable), agree and consent to participate in behavioral health care services offered and provided by _____a licensed clinical psychologist. I understand that I am consenting and agreeing only to those services that the above named provider is qualified within: (1) the scope of the provider's license, certification, or training; or (2) the scope of the license, certification, and training of the behavioral health providers directly supervising the services received by the client. If the Client is under the age of 18 or unable to consent to treatment, I attest that I have legal custody of this individual an am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Meetings

Pre-surgical assessment are typically conducted in one session, lasting approximately two hours. During this session, there will be a structured interview and some psychological assessment measures to be filled out. In some cases, further psychological testing is deemed necessary and additional sessions will be scheduled to better assist candidates with their preparedness for surgery. Clients are required to provide 24 hour notice if they need to cancel appointment. If it is possible, I will try to find another time to reschedule the appointment. Missing an appointment or making a late cancellation results in loss of revenue and the forfeit of multiple hours that another client could be using. **Therefore, a missed appointment or cancellation under 24 hours advance notice of cancellation, will result in a $125.00 charge.** If you arrive late for a scheduled appointment, only the remainder that session will be available. If I run late with a prior appointment for some reason, you will still receive the full amount of time. If local schools are closed due to weather conditions, please check my voicemail to see if I will be in the office. We may need to reschedule the appointment and you will not be billed for not attending due to inclement weather conditions.

Fees

Bariatric & Spinal assessments are $500.00 without insurance coverage. Extensive testing costs $150.00 per hour and is only performed when medically necessary. Fees for any addition feedbacks session or other weekly services are $135 per 50-minute session. In addition, I charge the same hourly rate for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than a few minutes, consulting with other professionals (with your permission), preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

Financial Policy & Insurance Reimbursement

You are responsible for your payment at each session, unless we agree otherwise. Payment schedules for other professional services will be agreed to when they are requested. Cash, check, or credit card is an acceptable form of payment. There will be a $30 charge for the return of a check from the bank. Payments not received after 90 days are subject to collections. If I do accept your insurance and you would like to file claims through insurance, you can provide permission for me to submit claims on your behalf. If I am not a participator with your insurance, your insurance company may reimburse you according to guidelines they have established for out of network providers. Your health insurance policy will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. **If using insurance, please fill out this part:**

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I, the undersigned certify that I (or my dependent) have insurance coverage with _____. I understand that if I am using an insurance plan, payment by an insurance company cannot be guaranteed. I understand that I am responsible to meet my insurance deductible and copayments, in addition to payment for any services of treatment not covered by my insurance carrier, at the time of service. In the event that my insurance carrier refuses to make payment against my claim for services, I accept responsibility for prompt payment for any treatment and services rendered to myself and/or my family. Additionally, if I receive any insurance payments directly from my insurance carrier for services performed, I will immediately (no later than 5 days) pay over such payments to my clinician. I authorized the release of any payment and medical information necessary to process mineor my family member's insurance claim and related claims. I hereby authorize payment directly to my clinician of the insurance benefits otherwise payable to me for all professional services.

Client orParent/GuardianSignature_____Date_____

Forensic and Litigative Services

It is the stated philosophy of this practice that I do not participate in lawsuits of any type on a plaintiff's behalf, unless compelled to do so by subpoena or court order. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time, including preparation, deposition, telephone time, transportation costs, court appearance, report writing, consultation and supervision, even if I am called to testify by another party. Because of the complexity of legal involvement, I charge $200 per hour for preparation and attendance at any legal proceeding.

Contacting Me

I am often not immediately available by telephone. Although I may be in my office during business hours, I will not answer the phone if I am with a Client. When I am unavailable, please leave a message on my voice mail. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. In the case of psychiatric emergencies, you should contact my cell phone and specify that it is an emergency. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or go to the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact during my absence. Please limit the use of my cell phone to emergencies only. If a phone call is 10 minutes or less, there is no charge. Calls that last longer than 10 minutes will be billed at fee rate. Texting can also be used to contact me for the purposes of scheduling appointments or a request for a return phone call. I also use email for exchange of information regarding appointment times. I do not use it for discussion of clinical issues as email is not a secure, confidential form of communication and should not be used for urgent communication.

Professional Records

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted by and/or upsetting to untrained readers. If you wish to see your records, I recommend you review them in my presence so that we can discuss the contents. Clients will be charged an appropriate fee for any professional time spent in responding to information requests.

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Minors
If you are under 18 years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request that I will provide parents only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concerns. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have about it.

Confidentiality
In general, the law protects the privacy of all communications between a client and a psychologist, and I can release information about our work to others only with your written permission. But there are a few exceptions. There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly, or disabled person is being abused, I am required to file a report with the appropriate state agency. If I believe that a client is threatening serious bodily harm to another, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the client. If the client threatens to harm himself or herself, I may be obligated to seek hospitalization for him or her or to contact family members or others who can help provide protection. I will make every effort to fully discuss this with a client before taking any action. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he or she determines that the issues demand it.

**My signature below indicates that I have carefully reviewed the client service contract and that I agree to all terms stated within this contract.*

Printed Name:_____Signature:_____Date_____

Clinician:_____Date:_____