Psychological Associates, Inc.

NEW CLIENT FORM

Approximate date you first called for appointment: _____ Date of first appointment: _____

Name of Client: _____ SS#: _____

Name of Parent / Guardian (If applicable): _____ SS#: _____

Client's Address: _____ City: _____ State: _____ Zip: _____

Client's Telephone #: (H/C) _____ ALTERNATE # (W/H/C): _____

Client's Birthdate: _____ Client's Marital Status: _____

_ Education: K-7____ 8-12 ____ 1-3 yrs. college (AA/Technical) ____ BA/BS degree____

If student, name of school currently attending: _____

Client's Employment Status: _____

Client's Occupation: _____ Client's Employer: _____

Who referred you to our office? _____

Name of Insurance: _____ ID # / EAP ID #: _____

Group #: _____ Co-pay amount: _____

*Name of Principal person Insured: _____ Birthdate of Insured: _____

Relationship to client: Spouse / Child / Other (Please specify): _____

*Please include address and phone of insured if different than that of the client's:

_____

As outlined on our policy sheet (pg. 2), the patient or guardian is responsible for payment if the deductible has not been met; for the portion of the fee not covered by insurance; or $25 for cancellations with less than 24-hour notice; and $50 for no-shows.

I HAVE REVIEWED **PAI'S** PRIVACY PRACTICES NOTICE (A COPY OF THE NOTICE IS AVAILABLE UPON REQUEST)

Signature _____

THIS SECTION IS FOR ASSOCIATE USE ONLY

Associate: _____ Date of 1st appointment: _____

DX CODE (S): _____, _____, _____, _____

Welcome to Psychological Associates, Inc.

We are a group of psychologists and therapists led by Dr. Steven Pasquinelli. We conduct counseling and testing services with children, adolescents and adults with a variety of psychological needs. In order to address questions you may have, please take a moment to read the information outlined below.

- **PURPOSE OF COUNSELING:**
  The purpose of our services is to assist you in understanding yourself and your current life situation. Exploration of your emotions, thoughts and interactions with other people will be an important part of treatment. Our goal is to assist you in making decisions and changes in your behavior that will benefit you. It is your responsibility to attend therapy sessions, and in some cases, to conduct between-session assignments.

- **CONFIDENTIALITY:**
  The information presented in therapy is personal and confidential. The only circumstances in which information will be shared without your written permission are when there is a clear intention to do harm to yourself or someone else, or when a court subpoena is issued. Also, it is required by law that mental health professionals report suspected physical, sexual, or emotional abuse of a child, disabled person, or elderly person to the appropriate authorities.

- **REACHING US:**
  We have 24-hour answering services. If you need to reach your therapist, simply call the office number and the service will direct your call. In case of emergency, please state this to the operator so that your therapist will be contacted immediately.

- **VACATION POLICY:**
  When your therapist will not be available, other associates will be covering for her or him. That person will know how to reach your therapist if necessary.

- **FEES FOR SERVICE:**
  The fees for counseling and testing sessions vary according to need. In many cases, your insurance will cover a portion of the fee. If you have difficulty in paying for therapy under the conditions described here, we can discuss an alternative plan. Your co-pay is due at time of service.

You are responsible for:

- Knowing the terms of your insurance policy, any copayments, and obtaining the required authorization from your insurance carrier.
- Payment if your deductible has not been met, and for the portion of the fee not covered by insurance.
- Keeping us informed in a timely manner of any changes to your insurance coverage.

Appointments will be scheduled at intervals which are determined by the nature of your treatment, typically once per week.

Your appointment time is being reserved for you. A $25.00 Cancellation fee will be billed to you if a cancellation is received with less than 24-hour notice OR $50.00 if you do not show for a scheduled appointment.

CLIENT'S CONSENT

I have read the materials presented to me in this disclosure statement. My signature indicates that I understand this information, agree with the conditions of my therapy that are either stated or implied here, and commit myself to compliance with them.

- I will make every effort to be open and honest in sharing my life situation, emotions and concerns in therapy.
- I understand that I have the right not to sign this form and can choose to discuss my concerns with the therapist before formal therapy.
- I understand that once therapy begins, I have the right to withdraw consent to participate in therapy at any time that seems appropriate. I will make every effort to discuss my concerns about the progress of therapy with my therapist before I terminate.

1. I give - _____ I do not give - _____

Permission for Psychological Associates, Inc. to release information to my primary care physician,

PCP Name: _____

2. I give - _____ I do not give - _____

Permission for Psychological Associates, Inc. to submit billing data to my insurance company.

3. I have read and understand Psychological Associates, Inc. policies, outlined on page 2.

_____ - Yes _____ - No

_____ _____

Client's Signature/Parent's if Client if 14 yrs. old or younger Date

_____ _____

Witness Date