

Responsible Party Information: If the client is not financially responsible for payment of services, please complete the following information concerning the responsible party.
******RESPONSIBLE PARTY MUST BE PRESENT IN ORDER TO FILL OUT AND SIGN ADDITIONAL FORMS; OTHERWISE, BILLS WILL GO DIRECTLY TO CLIENT**

Responsible Party First Name: _____ Last Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Birthdate: _____

Relationship to Client: Parent(s) _____ Guardian _____ Spouse _____ Other _____

Home Phone: _____ Work Phone: _____ Cell Phone _____

If we need to contact you, messages can be left at (check all that apply):

_____ Home voice mail/answering machine _____ Cell phone voice mail
_____ Work voice mail/answering machine _____ E-mail (please provide) _____

**Who Referred You To This Office? Court _____ Agency _____
School _____ Other _____**

Name _____ Position _____

Address _____ Phone _____

If referred by a court, please provide the following information:

Attorney Name _____ Phone: _____

Opposing Counsel _____ Phone: _____

Guardian ad Litem _____ Phone: _____

Magistrate/Judge _____ Court: _____

If county funded, please provide the following information:

County Name _____

Case Manager _____ Phone: _____

Primary Care Physician Name: _____
First Last

Physician Street Address: _____

City: _____ State: _____ Zip: _____

Primary Insurance/Medicare/Medicaid Information

*** You must complete this section if the subscriber is someone other than the client.**

Primary Insurance Company Name: _____

Identification Number on Card: _____

Group Number (if applicable): _____

Subscriber's Name: _____
(person who holds the policy) FIRST MIDDLE LAST

Subscriber's Social Security Number: _____

Subscriber's Street Address: _____ City: _____

State: _____ Zip: _____

Subscriber's Phone: _____ Client's Relationship to Subscriber: _____

Subscriber's Birthday: _____ Subscriber's Sex: _____

Subscriber's Employer: _____ Subscriber's Work Phone: _____

Authorization Number: _____
If you do not have an authorization number, please call your insurance company to obtain this



*** Please remember, we DO NOT bill secondary insurance. You may bill this on your own. ***



EAP: Employee Assistance Program

***If you are utilizing your EAP benefits, please fill out the following information completely.**

Insurance Company: _____

EAP benefits phone number: _____

Employer: _____

Employer phone: _____

Authorization Number: _____

Number of sessions allowed: _____ Coverage dates: _____

Behavioral Health/ Medical Information

To assist us in helping you, please fill out this form as fully and honestly as possible. All information is held in the strictest confidence within the legal limits. If certain questions do not apply to you, please leave them blank.

Presenting Problem: _____

How long has this problem persisted? _____

Have you previously been involved in counseling for any reason? _____

Are you currently seeing a psychiatrist? _____

Have you ever been psychiatrically hospitalized? _____

If yes, please provide further information:

1. Date of Hospitalization: _____ Number of days _____

Hospital name: _____

Chief Reason: _____

2. Date of Hospitalization: _____ Number of days _____

Hospital name: _____

Chief Reason: _____

Are you currently taking any medications (for psychiatric reasons or other reasons)? _____

If yes, please list:

Medication Name: _____ Medication Name: _____

Daily Dosage: _____ Daily Dosage: _____

Purpose: _____ Purpose: _____

Medication Name: _____ Medication Name: _____

Daily Dosage: _____ Daily Dosage: _____

Purpose: _____ Purpose: _____

Release of Information Authorization in Third Party

I (we) authorize Lilley and Associates, Stoneburner and Associates, LLC, and/or the professional mental health clinicians who provide services to us to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested materials) to the third-party payer or insurance company listed on the "Initial Information" form that we completed on this date, for the purpose of receiving payment reimbursement directly to our clinical provider and Lilley and Associates, and Stoneburner and Associates, LLC.

I (we) understand that access to this information will be limited to determining insurance Benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

_____/_____
Signature(s) of Person(s) Responsible for Payment Name(s) of Person(s) Responsible for Payment Date

_____/_____
Signature(s) of Person(s) Receiving Services Name of Person Receiving Services Date

_____/_____
Signature(s) of Parent(s) or Guardian(s) Name(s) of Parent(s) or Guardian(s) Date

_____/_____
Witness Signature Date

Fee Policy

The professional staff of sole proprietors at Lilley and Associates and Stoneburner and Associates, LLC (hereafter referred to as management company) are committed to providing caring and professional mental health care to all of our clients/patients. As part of the delivery of mental health services, we have established a financial policy that provides payment policies and options to all consumers. The financial policy of the management company is designed to clarify the payment policies as determined by the management of Lilley and Associates, and Stoneburner and Associates LLC.

The Person Responsible for Payment of Account is required to sign this fee policy. Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company, unless, as is often the case, our providers are in contract with the managed care corporation that administers your mental health plan. In those situations, such as with managed care insurance companies, Medicare and Medicaid, the client/patient is only responsible for their co-pay fee as defined in their insurance plan and is not responsible in any way for fees that are charged by their clinicians or the management company to the client's/patients managed care corporation.

The Person Responsible for Payment (as noted in the Payment Contract for Services) will be financially responsible for payment of provider fees. The Person Responsible for Payment of Account is financially responsible for paying all fees not paid by insurance companies or third-party payers after 60 days, except in cases when your provider(s) has/have contract(s) with the managed care corporation that administers your plan. Any payments owed by the client/patient and not received after 90 days are subject to collections. A 1.5% per month interest rate is charged for accounts over 60 days.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g. if there were previous visits to another mental health provider since January of the current year that were prior to the first session at Lilley and Associates, or Stoneburner and Associates, LLC.), this amount will be collected by the management company until the deductible payment is verified to the management company, the insurance company or third-party provider.

All insurance benefits will be assigned to the management company or your clinician (by insurance company or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance each session.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors may be denied non-emergency service unless charges have been pre-authorized to an approved credit plan, charge card or payment at the time of service.

Missed appointments and cancellations made less than 24 hours prior to the appointment are charged the full session fee of \$150 or a reduced fee as chosen by the clinician. There is normally no charge for phone consultations with clients and with other professionals if such phone contacts are 15 minutes or less in duration. Calls exceeding 15 minutes will be prorated at the clinician's standard hourly rate.

Payment methods include check, cash or the following charge cards: VISA, MASTERCARD, or debit card.

Questions regarding the financial policies can be answered by your clinician.

I (we) have read, understand and agree with the provisions of the financial Policy.

Signature of Person Responsible for Payment Account

Date

Signature of Co-responsible Party

Date

Witness Signature

Date

**Lilley and Associates
Stoneburner and Associates, LLC**

Consent for Treatment

For adults receiving services:

I hereby give my consent to receive treatment and related services from the designated professional(s) providing services to me at Lilley and Associates or Stoneburner and Associates, LLC. I understand that this consent is for the duration of the services to be provided.

Client Name (please print)

Client Signature

Date

Witness Signature

Date

If patient is a minor, the parent or guardian should sign this statement:

I hereby give my consent as parent or guardian for the following individual to receive treatment and related services from the designated professional(s) providing services at Lilley and Associates, or Stoneburner and Associates, LLC. I understand that this consent is for the duration of the services to be provided.

Client Name (Please print)

Parent or Guardian Name (please print)

Parent or Guardian Signature

Date

Witness Signature

Date

STATEMENT OF UNDERSTANDING CONFIDENTIALITY

Confidentiality is one of the essential elements of the counseling relationship. Your clinician is committed to maintaining confidentiality except in cases where intervention is a professional or legal mandate, including the following:

1. Any threat to harm yourself or others, including murder, suicide, and assault.
2. Any reports of actual or suspected child abuse, endangerment or neglect.
3. Any reports, actual or suspected, of abuse of the elderly.
4. Clinician is court ordered to testify.

Your clinician may discuss cases with professional colleagues, without use of names, as deemed necessary.

For adults receiving services:

I have read, understood, and agree with the limits of confidentiality. I hereby give my consent for treatment.

Client Name (please print)

Client Signature

Date

Witness Signature

Date

If patient is a minor, the parent or guardian should sign this statement:

I have read, understood, and agree with the limits of confidentiality. I hereby give my consent as parent or guardian for the following individual to receive treatment.

Client Name (Please print)

Parent or Guardian Name (please print)

Parent or Guardian Signature

Date

Witness Signature

Date