# Chantele Mercier Ferguson, PhD, LLC

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## PATIENT INFORMATION FORM

**Date:_____**

**CLIENT NAME(AS IT APPEARS ON YOUR INSURANCE CARD):_____**

**DOB:_____ SSN:_____ EMPLOYER/SCHOOL:_____**

**YOUR ADDRESS:_____**

**CITY, STATE, ZIP:_____**

**HOME PHONE: (_____)_____OKAY TO LEAVE MESSAGE?_____**

**WORK PHONE: (_____)_____OKAY TO LEAVE MESSAGE?_____**

**CELL PHONE: (_____)_____OKAY TO LEAVE MESSAGE?_____**

**(CIRCLE ONE) SINGLE MARRIED DIVORCED SEPARATED WIDOWED**

**SPOUSE'S NAME (IF APPLICABLE):_____SSN:_____**

**HAVE YOU EVER BEEN A PATIENT HERE BEFORE? YES NO IF YES, WHEN?_____**

**REFERRED BY:_____**

**FAMILY PHYSICIAN:_____ PHONE: (_____)_____**

**ADDRESS: _____**

**LIST ANY MEDICATIONS YOU ARE TAKING:**

**_____**

**_____**

**ALLERGIES: _____**

**EMERGENCY CONTACT (OTHER THAN SPOUSE):**

**NAME: _____RELATIONSHIP:_____**

**PHONE: (_____)_____ ADDRESS:_____**

**RESPONSIBLE PARTY / PARENT / GUARDIAN:**

**NAME:_____ DOB: _____ RELATIONSHIP:_____**

**ADDRESS: _____**

**CITY, STATE, ZIP: _____**

**HOME PHONE: (_____) _____ WORK PHONE: ( _____) _____**

**EMPLOYER: _____SOCIAL SECURITY NUMBER:_____**

## FINANCIAL RESPONSIBILITY STATEMENT

WE WILL FILE YOUR PRIMARY AND/OR SECONDARY INSURANCE **AS A COURTESY** YOU. IF INSURANCE DENIES FOR ANY REASON AFTER FILING THREE TIMES, YOU WILL BE RESPONSIBLE FOR ALL CHARGES. ANY CO-PAYMENTS, DEDUCTIBLES OR NON-COVERED CHARGES ARE THE RESPONSIBILITY OF THE PATIENT. PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

YOU ARE RESPONSIBLE FOR CHECKING WITH YOUR INSURANCE CARRIER ABOUT WHAT MENTAL HEALTH SERVICES ARE AVAILABLE TO YOU AND IF AUTHORIZATION FOR SERVICES IS NEEDED. IT IS YOUR RESPONSIBILITY TO BE SURE THAT ANY REQUIRED AUTHORIZATION IS IN PLACE THROUGHOUT YOUR COURSE OF TREATMENT.

## PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE:_____

WHO HOLDS THE PLAN:_____ ID #:_____ PLAN HOLDER'S DOB:_____ RELATIONSHIP TO PATIENT:_____

(THE OFFICE MUST HAVE A COPY OF YOUR CARD ON FILE)

## SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

NAME OF INSURANCE:_____

NAME OF PLAN HOLDER:_____ ID #:_____ PLAN HOLDER'S DOB:_____ RELATIONSHIP TO PATIENT:_____

(THE OFFICE MUST HAVE A COPY OF YOUR CARD ON FILE)

## CANCELLATIONS

TWENTY-FOUR HOUR NOTICE IS REQUIRED FOR ALL CANCELLATIONS. **IF 24-HOUR NOTICE IS NOT GIVEN, A FEE OF $65 WILL BE CHARGED.** INSURANCE COMPANIES DO NOT PAY FOR MISSED APPOINTMENTS. THIS CHARGE WILL BE THE RESPONSIBILITY OF THE PATIENT.

## FEE

INITIAL CONSULTATION $165

INDIVIDUAL PSYCHOTHERAPY $150

**NO SHOW/LATE CANCELLATIONS $65**

**IT IS YOUR RESPONSIBILITY TO NOTIFY OUR OFFICE OF ALL INSURANCE INFORMATION OR ANY CHANGES IN INSURANCE, ADDRESS OR TELEPHONE NUMBER. IT IS ALSO YOUR RESPONSIBILITY TO BE SURE OUR OFFICE RECEIVES A COPY OF ANY NEW INSURANCE CARDS.**

## IF FILING INSURANCE:

I AUTHORIZE MY THERAPIST AND HER STAFF TO ACT AS MY AGENT IN HELPING OBTAIN THE FULLEST PAYMENT FROM MY INSURANCE COMPANY. I AUTHORIZE PAYMENT DIRECTLY KAREN SCHIESS WAGNER PHD AND TO RELEASE INFORMATION DIRECTLY TO ALL OF MY CARRIERS. I UNDERSTAND THE OFFICE POLICY AND AGREE TO PAY AT THE TIME OF SERVICE, ANY COPLAY OR DEDUCTIBLE REQUIRED BY MY INSURANCE POLICY.

PATIENT SIGNATURE:_____DATE:_____

(IF MINOR, PARENT OF GUARDIAN MUST SIGN FOR AUTHORIZATION TO TREAT)

**IF SELF PAY:**

IN LIEU OF FILING MY INSURANCE, I AGREE TO PAY FOR EACH VISIT IN FULL AT THE TIME OF THE VISIT. I UNDERSTAND THAT THE CANCELLATION POLICY STILL APPLIES.

PATIENT SIGNATURE:_____DATE:_____

# CLIENT RIGHTS

## YOU HAVE THE RIGHT:

1) TO BE TREATED WITH CONSIDERATION AND RESPECT
2) TO EXPECT QUALITY SERVICES PROVIDED BY A CONCERNED, COMPETENT STAFF
3) TO A CLEAR STATEMENT OF PURPOSES, GOALS, TECHNIQUES, RULES OR PROCEDURE AND LIMITATIONS AS WELL AS POTENTIAL DANGERS OF THE SERVICES TO BE PERFORMED PLUS ALL OTHER INFORMATION RELATED TO OR LIKELY TO EFFECT THE ON-GOING COUNSELING RELATIONSHIP.
4) TO OBTAIN INFORMATION ABOUT THE CASE RECORD AND TO HAVE THIS INFORMATION EXPLAINED CLEARLY AND DIRECTLY
5) TO FULL KNOWLEDGEABLE AND RESPONSIBLE PARTICIPATION IN THE ON-GOING TREATMENT PLAN TO MAXIMIZE FEASIBLE EXTENT
6) TO EXPECT COMPLETE CONFIDENTIALITY AND THAT NO INFORMATION WILL BE RELEASED WITHOUT WRITTEN CONSENT
7) TOO SEE AND DISCUSS CHARGES AND PAYMENT RECORDS.
8) TO REFUSE ANY RECOMMENDED SERVICES AND BE ADVISED OF THE CONSEQUENCES OF THIS ACTION

INITIAL_____

## CONFIDENTIALITY OF INFORMATION

LAWS THUS INSURING YOUR RIGHT TO PRIVACY PROTECT MATTERS DISCUSSED WITH YOUR THERAPIST. IN MOST CASES, YOUR THERAPIST IS PROHIBITED FROM DISCLOSING INFORMATION ABOUT YOUR CARE WITHOUT YOUR WRITTEN CONSENT AND THEN ONLY TO THE EXTENT YOU AUTHORIZE.

CASES WHERE INFORMATION MAY BE DISCLOSED WITHOUT YOUR CONSENT:

1) WHEN CHILD ABUSE IS KNOWN OR SUSPECTED (REPORTING REQUIRED BY LAW)
2) WHEN THE ABUSE OF AN ELDERLY OR DEPENDANT PERSON IS KNOWN OR SUSPECTED (REPORTING REQUIRED BY LAW)
3) IF YOU COMMIT A CRIME AGAINST A STAFF MEMBER OR ANOTHER PERSON ON THE PREMISES
4) IF YOU BRING CHARGES AGAINST YOUR CLINICIAN
5) IF THERE IS A SITUATION THAT IS POTENTIALLY LIFE THREATENING
6) WHEN RECORDS ARE SUBPOENAED BY THE COURT

INITIAL_____

## SECURITY OF RECORDS:

YOUR TREATMENT RECORD(S) AND RELATED FINANCIAL RECORDS ARE KEPT IN A LOCKED FILE CABINET IN AN OFFICE OR OTHER AREA NOT ACCESSIBLE TO THE PUBLIC. RECORDS WILL NOT BE COPIED OR OTHERWISE BE MADE AVAILABLE TO OTHERS WITHOUT A SIGNED AUTHORIZATION TO RELEASE INFORMATION.

**SPECIAL RULES RELATING TO THE RELEASE OF TREATMENT RECORDS CONTAINING DRUG AND ALCOHOL ABUSE:**

CFR 42 PART 2 PROHIBITS DISCLOSURE OF SUCH INFORMATION WITHOUT WRITTEN CONSENT OF THE CLIENT AND ONLY TO THE EXTENT SPECIFICALLY AUTHORIZED. THIS INFORMATION CANNOT BE DISCLOSED TO ANOTHER SOURCE WITHOUT WRITTEN CONSENT. A GENERAL RELEASE FOR MEDICAL OR OTHER INFORMATION IS NOT SUFFICIENT. USE OF INFORMATION IN RECORDS FOR CRIMINAL INVESTIGATION AND PROSECUTION IS PROHIBITED.

INITIAL_____

**RETENTION OF RECORDS:**

TREATMENT RECORDS ARE RETAINED FOR A PERIOD OF SEVEN(7) YEARS FOLLOWING THE TERMINATION OF TREATMENT FOR ADULTS AND UNTIL THE AGE OF TWENTY-EIGHT(28) IN THE CASE OF MINORS. AT THE END OF THAT PERIOD, THE RECORDS ARE DESTROYED IN A MANNER THAT ASSURES THE CONFIDENTIALITY OF THE INFORMATION UNLESS THE CLIENT REQUESTS OTHERWISE, IN WRITING, PRIOR TO THE DESTRUCTION OF THE RECORDS.

**INFORMATION REGARDING PSYCHOTHERAPY:**

1) PSYCHOTHERAPY MAY INVOLVE REMEMBERING UNPLEASANT EVENTS AND CAN AROUSE INTENSE EMOTIONS OF FEAR AND ANGER, FEELINGS OF ANXIETY, DEPRESSION, FRUSTRATION, LONELINESS OR HELPLESSNESS MAY BE EXPERIENCED. OF COURSE, FEELING OF RELIEF, POWER, SELF-ACCEPTANCE AND WELL-BEING MAY OCCUR.
2) PSYCHOTHERAPY IS NOT ALWAYS EFFECTIVE AND MAY, IN SOME CASES RESULT IN DETERIORATION RATHER THAN IMPROVEMENT OF A CLIENT'S PSYCHOLOGICAL FUNCTION. PSYCHOTHERAPY HAS BEEN SHOWN EFFECTIVE IN ABOUT 75% OF CASES.
3) THERE ARE NUMEROUS FORMS OF PSYCHOTHERAPY WHICH VARY NOT ONLY IN UNDERLYING THEORY AND METHODS EMPLOYED, BUT ALSO IN TERMS OF TIME COMMITMENT AND COST. WE WILL ATTEMPT TO PROVIDE TREATMENT PLANS THAT ARE REALISTIC IN BOTH AREAS.
4) CURRENT RESEARCH HAS FAILED TO DEMONSTRATE THAT ANY ONE FORM OF PSYCHOTHERAPY IS NECESSARILY MORE EFFECTIVE THAN ANY OTHER.
5) DEPENDING UPON A CLIENT'S CONDITION, THERE MAY BE AVAILABLE ALTERNATIVES TO PSYCHOTHERAPY, SUCH AS MEDICATION OR BEHAVIOR MODIFICATION. WE WILL MAKE THESE RECOMMENDATIONS IF THEY ARE APPROPRIATE, BASED UPON OUR ASSESSMENT.

INITIAL_____

**CONSENT TO TREAT:**

I HEREBY GIVE MY CONSENT TO MY THERAPIST TO PROVIDE ASSESSMENT AND THERAPEUTIC SERVICES TO ME/MY CHILD, WITHIN THE SCOPE OF HER LICENSE. I UNDERSTAND MY THERAPIST WILL WORK WITH ME TO DEVELOP A TREATMENT PLAN AND TREATMENT WILL BE FORMULATED TO RESOLVE MY PROBLEM(S) AS QUICKLY AS POSSIBLE. I AGREE TO COOPERATE WITH MY THERAPIST IN THE TREATMENT PROCESS, TO CARRY OUT THERAPEUTIC HOMEWORK ASSIGNMENTS AND TO TAKE ANY MEDICATIONS PRESCRIBED AS PART OF MY TREATMENT IN THE MANNER DIRECTED BY

THE PRESCRIBING PHYSICIAN. I FURTHER AGREE TO KEEP MY SCHEDULED APPOINTMENTS AND UNDERSTAND THAT FAILURE TO DO SO MORE THAN TWO(2) TIMES MAY RESULT IN MY CARE BEING TERMINATED.

BY MY SIGNATURE BELOW, I AGREE TO THE PAYMENT ARRANGEMENTS SET FORTH, AFFIRM THAT ALL MY QUESTIONS HAVE BEEN SATISFACTORILY ANSWERED, AND GIVE INFORMED CONSENT TO MY/MY CHILD'S TREATMENT. I UNDERSTAND THAT I WILL BE FURNISHED A COPY OF THIS CONSENT WHENEVER I MAY REQUEST IT.

_____ _____

**(SIGNATURE OF RESPONSIBLE PARTY)** **(SIGNATURE OF PATIENT)**

_____ _____

**(WITNESS)** **(DATE)**