501 Darby Creek Road, Suit 50
Lexington, KY 40509
LexingtonTherapy@gmail.com

Lexington Therapy, LLC

www.LexingtonTherapy.com

New Client Intake Paperwork

This information is required before any services are rendered.

Last Name:				
First Name:				
Middle Initial:				
Goes By (if other than above):				
Date of Birth (mm/dd/yyyy):				
Age:				
Client/Responsible Party Social Sec. #				
Client's Gender:	Female	Male		
Client's Marital Status:	Single	Married	Other	
Client's Employment Status:	Employed	FT Student	PT Student	Other
When did current symptoms appear (mm/dd/yyyy)?				
First date of same/similar illness (mm/dd/yyyy)?				
Related to accident or workers comp? No Yes If Yes Explain				
Client's Email address:			May we email you?	
Address line 1:				
Address line 2:				
City:				
State:				
Zip Code:				
Home Phone Number:			May we leave a message?	
Cell Phone Number:			May we leave a message?	
Work Phone Number:			May we leave a message?	
Work Extension:				
Other Responsible Party (who is financially Responsible?)				
Responsible Party Street Address:				
Responsible Party City:				
Responsible Party State:				
Responsible Party Zip Code:				

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If insurance will be used please fill in this section.

Primary Insurance Company:
Insurance ID. Number:
Insurance Group Number:
Effective Date (mm/dd/yyyy):
Referring Physician (rarely needed):
Referring physician NPI (Tricare only):
Client's relationship to Insured: **Self** **Spouse** **Child** **Other:**
Insured Name (Last, First, MI):
Insured's Street Address:
Insured's City:
Insured's State:
Insured's Zip Code:
Insured's Phone # (with dashes):
Insured's Date of Birth (mm/dd/yyyy):
Insured's Gender:
Insured's Employer:
Phone # for Mental Health Benefits:
Insurance Company Claims Street Address, City, State, Zip:
Deductible Amount: $ medical and mental health ***Note that deductibles may differ and or be calculated separate
Deductible Amount Met: $ (if not, the deductible will be charged until met)
Required to pay at:
Copay Amount: $
Visit Limit ?(unlimited = 99)
Is this an EAP referral/visit? **Yes** **No**
Preauthorization required for Mental Health? **Yes** **No**
Authorization Number:

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Are you currently taking any prescription medication? Yes No

Please list: _____

Have you ever been prescribed psychiatric medication? Yes No

Please list and provide dates: _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (Please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise do you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns:

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression?

Yes No

If yes, how long? _____

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6. Are you currently experiencing anxiety, panic attacks, or have any phobias? Yes No

If yes, when did you begin experiencing this? _____

7. Are you currently experiencing any chronic pain? Yes No

If yes, please describe: _____

8. Do you drink alcohol more than once a week? Yes No

9. How often do you engage recreational drug use?

Daily Weekly Monthly Infrequently Never

10. Are you currently in a romantic relationship? Yes No

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicated the family member's relationship to you in the space provide (father, grandmother, uncle, etc).

Alcohol/Substance Abuse	Yes	No
Anxiety	Yes	No
Depression	Yes	No
Domestic Violence	Yes	No
Eating Disorders	Yes	No
Obesity	Yes	No
Obsessive Compulsive Behavior	Yes	No
Schizophrenia	Yes	No
Suicide Attempts	Yes	No

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Fee Agreement

Service Type	Charge
Individual Session 45-50 minutes	$45.00 - $80.00
Intake 45-50 minutes (with Nurse Practitioner)	$125.00
Family or Couples Session 45-50 minutes	$55.00 - $100.00
Follow-Up Session 25 – 45 minutes (with Nurse Practitioner)	$ 75.00
Returned Check Fee	$40.00
Fail To Keep Appointment	$80.00
Late Cancelation Fee (Without 24 Hour Notice)	$40.00
Deposition	$250 plus $200 per hour
Substance Abuse Evaluation-Non Dot	$225
Court Appearance	$300 plus $175 per hour
Letter Writing	$35/page
Telephone Consultation (Per 15 minutes)	$25
Any matter in which we must hire an attorney to assist or protect our office involving your Case, the case of a minor or a related case and any action brought upon our office by any attorney for any reason related to your case.	All attorneys' fees billed to us by our attorney, plus any regular fees that we charge.
Letters, phone calls, reviewing testing, or any work related to your case not covered in a session.	$100 per hour billed in $25 increments for ¼ of Hour minimum.

1. We ask that you pay your portion of the charge in full at the end of each session. We are willing to set up a payment plan incase there are financial difficulties interfering with your ability to pay. Please discuss this with your therapist if there are concerns.
2. We do file insurance claims as a courtesy to those clients who are eligible for reimbursement through their insurance. The client is always responsible for any unpaid balance.
3. We will make every effort to work out a suitable payment plan with each client. We ask that you adhere to the contract you establish and notify us if the payment contract would need to be renegotiated. We do utilize the services of a collection agency. Any unpaid balance over 3 months past due will be referred to the collection agency.
4. We require 24-hour notice of cancellation of a scheduled session. Failure to cancel within this period will result in a charge for the session, at the discretion of the therapist.
5. We believe that the issues you have brought to counseling are important. We ask that you participate in this counseling contract by keeping the appointments you schedule.

I understand that if for any reason the account is turned over to a collection agency, I will be responsible for the collection fee of 35% and should non-payment of your account result in litigation, the collection fee shall increase to 50% because of added attorney fees, and I will also be responsible for court cost and service of summons cost.

_____ _____

Client/Parent Signature Date

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Credit Card Authorization

NO SERVICES WILL BE RENDERED WITHOUT A COPY OF THIS FORM ON FILE

Your information is confidential and protected by federal and state privacy laws. This form is not intended for primary method of payment. Our office prefers cash or check. Our primary goal is to have expenses paid at the time of services.

We keep a copy in your confidential record for the reasons below.

1. To bill any unpaid charges that may accrue as a result of having a deductible, co-payment, or coinsurance and or any other fees agreed upon that were not paid at the time of service delivery. Also to collect fees for individual, family, marital or assessment procedures that were not paid in full at the time of service or that were not paid by your insurance company, EAP program or managed care company.

2. To bill any Fail to Keep Appointment Fees or Cancellation Fees that are not paid by you.

3. Any NSF or Returned Unpaid Check amount plus returned check fees from your bank.

By providing the information below you agree to allow our offices to bill the above mentioned fees and any other agreed upon fees located in the Informed Consent of Fee Schedule not paid by you in person or by regular billing. You also agree that all NSF or unpaid checks will be charged an extra $40.00 charge. Your signature is authority to release your billing statement to your credit card company/bank for the purpose of collecting the appropriate fees charged to your credit card.

Name exactly as it appears on card _____

Type of Card (Visa and MC ONLY) Visa MC

Card Number _____

Expiration Date Month_____ Year_____

CCV/Security Number (3 digits on back of card) _____

Billing address for Card Same as home address? Yes No (if no fill in below)

_____

_____

Phone number for card _____

Client or Parent Signature _____

Date _____

Thank you!

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Part I: Your Rights as Client(s)

1. You have the right to ask questions about any procedures used during therapy; if you wish, I will explain my approach and methods to you. If I see a child under the age of consent (which varies for different states/jurisdictions), all custodial parents have a right to information shared in the session. Custodial parents should be aware that exercising this right may be detrimental to the therapeutic process, and so may wish to allow confidentiality between the child and therapist.

2. You have the right to deicide not to receive therapeutic assistance from me; if you wish, I will provide you with the names of other qualified professionals whose services you might prefer at a cost equal to or less than my own usual customary fee.

3. You have the right to end therapy at any time without any moral, legal, or financial obligations other than those already accrued. I ask that you contact me by phone if you make such a decision without consulting with me.

4. You have a right to review your records in the files at anytime. I do not keep any "secret notes", so please do not ask me to do so.

5. One of the most important rights involves **confidentiality**: Within limits of the law, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without you written permission. Additionally, when more than one family member is being seen in therapy, the therapist views the family as a whole as the client. Therefore, releases of information for family sessions require the written approval of every consenting member of the family who was present at any time during the treatment.

6. If you request it, any part of your record in the files can be released to any person or agency you designate, I will tell you at the time whether of not I think releasing the information in question to that person agency might be harmful in any way to you.

7. You should also know that there are certain situations in which I am required by law to reveal information obtained during therapy to other persons or agencies without your permission. Also, I am not required to inform you of my actions in this regard. These situation are as follows: (a) if you threaten grave or bodily harm or death to another person, I am required by law to report those threats to the appropriate authorities; (b) If a court of law issues a legitimate court order (signed by a judge), I am required by law to provide the information specifically described in that order; (c) If you reveal information relative to child abuse, child neglect, or elder abuse, I am required by law to report this to the appropriate authority; (d) If you are in therapy by order of a court of law, the results of the treatment ordered must be revealed to the court; and (e) If you are seeking payment through an insurance company, I will be required to reveal confidential information to them (each insurer is different).

8. You have the right to know about the possible harmful results of therapy. In my years of psychotherapeutic service delivery and supervision, the only clear harm I have witnessed has resulted from clients' insistence on using medical insurance for psychotherapy. Harmful events included: denial of insurability when applying for medical and disability insurance due to DSM-IV-TR diagnosis (mental illness diagnosis, which are usually required for reimbursements under medical insurance); company (mis) control of information when claims are processed; loss of confidentiality due to the large number of persons handling claims; loss of employment, and repercussions of diagnosis in situations which require truthfulness about "metal illness", including driver's licenses applications, concealed weapon permits, and job application.

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Part II: The Therapeutic Process

Therapy will seek to meet goals established by all person involved, usually revolving around a specific presenting problem. A major benefit that may be gained from participating in therapy includes a better ability to handle or cope with marital, family, and other interpersonal relationships. Another possible benefit may be a greater understanding of family and personal goals and values; that may lead to a greater maturity and happiness as individual and increased relational harmony. Other benefits relate to the probable outcomes resulting from resolving specific concerns brought to therapy.

In working to achieve these potential benefits' however, therapy will require that firm efforts be made to change and may involve the experiencing of significant discomfort. Therapeutically resolving unpleasant events and relationship patterns can arouse intense feelings. Seeking to resolve problems can similarly lead to discomfort as well as relationship changes that may not be originally intended.

Part II: Fees and Length of Therapy

1. I agree to enter into therapy with Lexington Therapy, LLC I agree to pay $_____ for each session.
   (a) Payment is due at the end of each session, and no balance will be carried.
   (b) Co-payment is due at the end of each session. I am responsible for cooperating with my insurance company to support prompt payment.

2. I understand that I can leave therapy at any time and that I have no moral, legal, or financial obligation to complete the maximum number of sessions listed in this contract; I am contracting only to pay for completed therapy sessions.

3. A 24-hour notice is required for cancellation of a scheduled session. If I do not meet this requirement, I agree to pay the full session fee. I understand that this will be my responsibility, not that of the third-party payer.

4. I understand that if my insurance company does not pay for treatment that I will be responsible for payment in full.

5. I understand that the therapist has the right to seek legal recourse to recoup any unpaid balance. In pursuing these measures, the therapist will only disclose biographical information and the amount owed, in order to ensure confidentiality.

Client(s): _____ Date: _____

_____ _____

_____ _____

Therapist: _____ Date: _____

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Consent to Release Confidential Information to Insurance Company

Client Name (print): _____

**This release is good for the duration of your current insurance,
or the duration of your current therapy here, whichever is shorter.**

I authorize the release of any information to my insurance company when necessary to process my claims.

I also authorize payments under my insurance programs to be made directly to me or to the above provider for any services furnished by this provider. I agree that if the amount is insufficient to cover the bill, I will be responsible for payment of the difference, and, if my treatment is not covered by my insurance policy, I will be responsible to the provider for the entire amount.

I further permit copies of this authorization to be used in place of the originals.

Please not the following points regarding confidentiality:

(a) This information has been disclosed to you from records whose confidentiality is protected by state and federal law. Federal regulations (42 C.F.R. Section 2.31 (a) and 2.33) and state regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. Federal and state rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

(b) Please restrict the availability of these records to those persons in your employ who have the training and experience to interpret and understand the information contained in them. This ethical and perhaps legal responsibility is yours.

_____ _____

Client/Guardian Signature Date