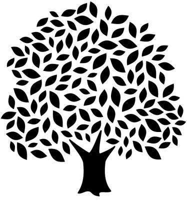

Beech Tree
Consulting &
Psychological Services

Client (Child) Information

↗ Today's date

***Note**: If the child has been a patient here before, please fill in only the information that has changed.*

A. Identification

↗ Child's name | Date of birth | Age

↗ Preferred name

↗ Home street address | Apt.

↗ City | State | Zip

↗ Who does the child live with? | Is this person the child's legal guardian? ❑ Yes ❑ No

Would you like appointment reminders? ❑ Yes ❑ No
If yes, you prefer reminders by ❑ Phone ❑ Text ❑ E-mail

6249 South East Street, Suite I
Indianapolis, Indiana 46227

317 300 4515 phone
317 780 1698 fax

beechtreepsych.com

B. Parent or Guardian's Information

↗ Parent or legal guardian's name | Relationship to child

↗ Home street address | Apt.

↗ City | State | Zip

↗ Home/evening phone | E-mail

↗ Calls or e-mails will be discreet, but please indicate any restrictions

↗ Employer | Address

↗ Work phone (or other means of communication)

Do we have permission to contact you at work? ❑ Yes ❑ No

C. Referral

Who referred you/your child to Beech Tree?

↗ Name | Phone

↗ Address

May we have your permission to thank this person for the referral? ❑ Yes ❑ No

↗ How did this person explain how I might be of help to you?

D. Child's Medical Care

↗ Clinic/doctor's name | Phone

↗ Address

Keeping your child's medical doctor informed of treatment helps us coordinate the child's care. Do we have your permission to share information about the treatment received from Beech Tree Consulting with the medical doctor listed above? ❑ Yes ❑ No

E. Emergency Information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to the child, who should we call?

↗ Name | Phone | Relationship

↗ Address

↗ Significant other/nearest friend or relative not residing with you | Phone

Financial Information

Beech Tree Consulting & Psychological Services truly appreciates that you've chosen us for your psychological care. Part of providing high-quality service without distraction or disruption is a clear understanding of our financial arrangements.

- Your health insurance may pay for a part of the cost of your treatment here, depending on your coverage. To find out for you, we need the information requested below. If you'd like any part of this or any other form explained in more detail, please ask.

F. Health Insurance Information
If you'd like to use your health insurance to help pay for your treatment, please fill in the information below so we can determine your levels of coverage. **Please note: We do not accept secondary insurance.** Provide information regarding only your primary insurance.

↗ Name of patient or subscriber	Date of birth	Social Security #
↗ Identification #	Group #	
↗ Plan #	Effective date	
↗ Claims address (usually found on the back of the insurance card)		
↗ Claims phone (usually found on the back of the insurance card)		

G. Spouse Information (if applicable)

↗ Spouse's name	Birthdate	Phone
↗ Occupation	Employer	Work phone

H. Alternative Payment Information

If you do not have insurance, how will you pay for services rendered by this office?

I. Agreement to Conditions

- By signing below, I give Beech Tree Consulting permission to release any information obtained during examinations or treatment of this patient that is necessary to support any insurance claims on this account and secure timely payments due to the assignee or me.
- By signing below, I understand that I am responsible for all charges, regardless of insurance coverage. I also understand that I must pay all account balances within 30 days of the issuance of an invoice. If I am unable to pay this balance, I understand that this child's treatment will be postponed until I can pay the total of my account balance.

J. Assignment of Benefits

I hereby assign medical benefits, including those from government-sponsored programs and other health plans, to be paid to the therapist above for treatments rendered. Medicare regulations may apply. A photocopy of this assignment is to be considered as good as the original.

↗ Parent/Guardian's) signature, indicating agreement to all of the statements above	Printed name	Date
↗ Licensed Clinical Psychologist	Date	

Consent to Treatment

I do hereby seek and consent to ___________________________________ (child's name, hereinafter referred to as "Child") taking part in the treatment by the therapist named below.

I understand that developing a treatment plan with this therapist and regularly reviewing work toward meeting the treatment goals are in Child's best interest. I agree to play an active role in this process.

I understand that no promises have been made to me or Child as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop Child's treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services Child already has received. I understand that I may lose other services or may have to deal with other problems if I stop Child's treatment. (For example, if Child's treatment has been court ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and Child does not show up, I will be charged for that appointment.

I am aware that an agent of Child's insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments received. I understand that if payment for the services received here is not made, the therapist may stop Child's treatment.

My signature below shows that I understand and agree with all of these statements.

____

↗ Signature of person acting for client　　　　Date

____

↗ Printed name　　　　Relationship to client

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

____

↗ Licensed Clinical Psychologist　　　　Date

❑ Copy accepted by person acting for client　❑ Copy kept by therapist

This is a strictly confidential patient medical record.
Re-disclosure or transfer is expressly prohibited by law.

Summary of Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Please talk to our privacy officer (see the end of this form) about any questions.

We will protect your privacy
Beech Tree Consulting and Psychological Services is dedicated to your privacy. We are also required by law to keep your information private. These laws are complicated, so because we must give you this important information, **this is a summary version of the attached, full, legally required notice of privacy practices**.

With your permission, this is how we may use and share your information
We mainly will use the information we collect about you in three ways:

- to provide you with **treatment**,
- to arrange **payment** for our services, and
- for other business activities the law calls **health care operations.**

After you have read this notice, we will ask you to sign a consent form (Consent to Use and Disclose Your Health Information) to let us use and share your information in these ways. **If you do not consent/sign this form, we cannot treat you.**

If we want to use or send, share, or release your information for other purposes, we will discuss this with you in advance and ask you to sign an authorization form to allow it.

When the law requires us to share information without your consent
There are some times when the law requires us to use or share your information, such as:

- When there is a serious threat to the health and safety of you, another person or the public. (Even then, we will only share information with persons who are able to help prevent or reduce the threat.
- When we are required to do so by lawsuits and other legal or court proceedings.
- If a law enforcement official requires us to do so.
- For workers' compensation and similar benefit programs.

Other rare situations are described in the longer version of our notice of privacy practices.

If you would like a copy of the full HIPPA Privacy Practices, please ask your therapist.

Your rights regarding your health information

- You can ask us to communicate with you in a particular way or at a certain place that is more private for you. For example, you can ask us to call you at home, and not at work, to schedule or cancel an appointment. We will try our best to do as you ask.
- You can ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends.
- You have the right to look at the health information we have about you, such as your medical and billing records. You can get a copy of these records, but we may charge you for it. Contact our privacy officer to arrange how to see your records. See below.
- If you believe that the information in your records is incorrect or missing something important, you can ask us to make additions to your records to correct the situation. You have to make this request in writing and send it to our privacy officer. You must also tell us the reasons you want to make the changes.
- You have the right to a copy of this notice. If we change this notice, we will post the new version in our waiting area, and you can always get a copy of it from the privacy officer.
- You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our privacy officer and with the Secretary of the U.S. Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way. Also, you may have other rights that are granted to you by the laws of our state, and these may be the same as or different from the rights described above. We will be happy to discuss these situations with you now or as they arise. If you have any questions regarding this notice or our health information privacy policies, please contact our privacy officer, who is Dr. Robbi Crain and can be reached by phone at 317-780-5750.

Consent to Use and Disclose Your Health Information

This form gives us your consent to everything that's in the Summary of Notice of Privacy Practices you just read. If you choose not to sign this form, we will be unable to treat you.

When we examine, test, diagnose, treat, or refer you to another provider, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information to select and provide treatment to you.

We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you.

By signing this form, you are agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our Summary Notice of Privacy Practices, which explains in more detail what your rights are and how we can use and share your information.

In the future, we may change how we use and share information. If so, we may change our notice of privacy practices, and you can get a copy from you therapist.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to give us these conditions in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer; we then will stop using or sharing your PHI, but cannot change whether we have already used or shared some of it before the revocation.

↗ Signature of client or his or her personal representative Date

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↗ Printed name of client or personal representative Relationship to the client

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↗ Signature of authorized representative of this office or practice

❑ Copy given to the client/parent/personal representative

Services Policy

A crucial part of our therapeutic relationship is open, honest, and clear communication. Please review the reminders below. By making sure you understand these policies now, we won't have to waste precious therapeutic time dealing with anything other than your mental health.

Scheduling
Most appointments are considered "standing appointments." This means you will be seen on the same weekday at the same time every week. **If you'd like to receive appointment reminders by phone, text or email, please let us know.**

If we ask you to confirm an appointment, simply call our office.

Cancellations
If you can't avoid cancelling an appointment, **you must give 24 hours' notice.** Simply call our office. During office hours, you can speak with any staff member. After hours, wait for the voicemail and leave your name, scheduled appointment time, and therapist's name.

If you cancel with less than 24 hours' notice, a fee of $50 will be charged to your account. This fee is not covered by insurance and will be due at or prior to your next session. If this fee isn't paid in full at or before your next session, we will postpone future sessions until we receive the $50. If you believe an emergency or unavoidable circumstance prevented 24 hours' notice, speak with your therapist as soon as possible to discuss this fee and your next session.

No-Shows
If you don't show up to an appointment on time without notifying us in advance (a no-show), you will be charged a fee of $50 for a missed appointment, and we cannot guarantee you will be seen that day. This a fee is not covered by insurance and will be due at or prior to your next session. If this fee isn't paid in full at or before your next session, we will postpone future sessions until we receive the $50.

After two consecutive no-show appointments, we will automatically remove your regularly scheduled appointment time from the schedule. This does not mean you are discharged from therapy; you must contact your therapist right away to discuss alternate scheduling options.

Payment

Because healthcare expenses can add up quickly, we've taken steps to help you maintain your accounts with us.

- Payment in full must be made on the same day you receive a service.
- All co-pays must be made prior to or at the start of each session.
- Fees for late arrivals (no-shows) and late cancellations (less than 24 hours' notice) must be paid before treatment can resume.
- We will let you know what deductible amounts you are required to pay.
- If you believe circumstances force you to carry a balance on your account, let us know; we can arrange a payment plan so your psychotherapy is not interrupted.
- We file your insurance claims on your behalf.

Due to the complexities of insurance billing, we do not accept nor file claims for secondary insurance. Likewise, we will resubmit a denied claim once. If the claim is denied again, you will be responsible for the full amount due. **Please remember that submitting a claim to your insurance company does not guarantee the company will pay for the claim.**

If you cannot pay for services, we may postpone our work together to minimize financial strain on you and our practice. Tell us right away if you think you may have trouble paying; we may be able to work out a payment plan, but not if you are in arrears. Always let us know when you change insurance.

You will receive a monthly invoice from Beech Tree Consulting and Psychological Services. Payment in full is due within 30 days of the date on the invoice. Failure to pay your balance by the due date may force us to postpone future sessions.

Fees

- Initial Intake $225
- Individual Therapy .... $150 (30 minutes); $175 (45 minutes); $200 (60 minutes)
- Group Therapy .... $75 (75 minutes)
- Family Therapy.. $175 (45 minutes)
- Psychological Assessment/Testing............... $250/unit or hour
- No-Show/Late Cancellation $50
- Non-Covered Services* .... $15 per 5-minute increments

**Non-Covered Services* include all services not typically covered by third-party payers (mental health/medical insurance). These services most often include:

- Review of records
- Case conferences with schools (in person, via e-mail, or via teleconference)
- Preparation of reports or letters for other providers/legal counsel, etc.
- Completion of documents for disability claims, extended insurance reviews, worker's compensation, etc.
- Duplication of medical records
- Evaluation or treatment services not covered by your mental/medical health insurance
- Services for diagnoses not covered by insurance companies – such as pre-existing conditions and some diagnostic categories

Consultations by telephone, e-mail or in person (no charge for first 5 minutes)

Service Limitations

We do not provide legal or forensically informed therapeutic services. We will be happy to refer you to qualified mental health professionals if you need these services. We also will not voluntarily provide letters to attorneys or legal counsel regarding our work together. If you are involved in a legal suit, please inform us immediately so we can develop an appropriate treatment plan and provide necessary referrals.

Office Hours

Our office hours are Monday–Friday, 8:30 am–2:00 pm

Please feel free to call at any time and leave a voice message. We do check messages frequently and will return your call as soon as possible. **If you are in crisis and can't reach us, call the crisis line at 317-251-7575 or visit your nearest emergency room.**

____

↗ Client Signature Date

____

↗ Licensed Clinical Psychologist Date

❑ Copy accepted by client

❑ Copy kept by therapist