Jupiter Psychological Group

ADULT INFORMATION FORM

BACKGROUND INFORMATION Today's date: _____

Client Name: _____ Date of birth: _____
Birthplace: _____ Age: _____ Social Security #_____-____-_____
Home street address: _____ Apt.:_____
City: _____ State: _____ Zip: _____
Cell phone: (____)_____ Home/evening phone: (____)_____ Work phone: (____)_____
Calls will be discreet, but please indicate any restrictions:_____
Emergency Contact :_____ Phone: _____

REASON FOR SEEKING TREATMENT AT THIS TIME: _____
_____
_____
_____

How long have these difficulties been present? _____
What are your goals for treatment? _____
_____

WHOM MAY WE THANK FOR THIS REFERRAL?

Name: _____ Phone: _____

☐ Internet website (which?): _____ ☐ Seminar _____ ☐ Other: _____

MARITAL HISTORY

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

If married, Spouse Name: _____ Number of years married: _____ Spouse's Age: _____
Is this your first marriage? YES / NO If no, please explain: _____
_____

EMPLOYMENT/EDUCATIONAL HISTORY:

Employment
Occupation: _____
Place of Employment: _____
Years employed: _____
Work phone #: _____

Spouses' Employment (if applicable)
Occupation: _____
Place of Employment: _____
Years employed: _____
Work phone #: _____

Education
Highest Degree
Completed: _____
Major: _____

Education
Highest Degree
Completed: _____
Major: _____

FAMILY HISTORY:

Children (if any)?

Name	Age	Sex	Living at home?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Is there anyone else living at home?:_____

Your mother's name: _____ Age: ___ Living: ___ Deceased: ___

Your father's name: _____ Age: ___ Living: ___ Deceased: ___

If your parent(s) is/are deceased, how old were you when this occurred? _____
If your parents are divorced, how old were you when this occurred? _____
Briefly describe your current relationship with your parent(s): _____
_____

Siblings:

Name	Age	Relationship

What was your birth order: _____ out of _____

MEDICAL HISTORY:

Please list all medical problems:

_____
_____
_____

Allergies: _____

Physician: _____
Physician's Address: _____
_____
Physician's phone #: _____
Physician's fax #: _____

Current Medical Medications:

MENTAL HEALTH HISTORY:

Previous Mental Health Treatment:

Date(s)	Therapist/Facility	Reason for seeking treatment	Was treatment helpful?

Are you currently prescribed any psychiatric medications?

Date(s)	Medication	Reason for prescription	Is medication helpful?

Have you been prescribed any psychiatric medications in the past?

Date(s)	Medication	Reason for prescription	Reason stopped

Psychiatrist (if applicable): _____
Psychiatrist's Address: _____
_____
Psychiatrist's phone #: _____
Psychiatrist's fax #: _____

Have you ever been hospitalized for mental health reasons: ☐ No ☐ Yes, If yes, please describe: _____
_____

History of suicidal thoughts or threats: ☐ No ☐ Yes, If yes, please describe: _____
_____

Suicidal gestures and/or attempts: ☐ No ☐ Yes, If yes, please describe: _____
_____

Any legal history: ☐ No ☐ Yes, If yes, please describe: _____
_____

History of involvement in lawsuits: ☐ No ☐ Yes, If yes, please describe: _____
_____

History of substance abuse and/or treatment for alcohol and/or drug use?: ☐ No ☐ Yes, If yes, please describe:
_____
_____

FAMILY BACKGROUND INFORMATION:

History of psychiatric/psychological disorders in family: ☐ No ☐ Yes, If yes, please describe: _____
_____

History of substance abuse in family: ☐ No ☐ Yes, If yes, please describe: _____
_____

Is there a history of suicide in the family? ☐ No ☐ Yes, If yes, please describe: _____
_____

OTHER:
Is there anything else I should know that doesn't appear on this or other forms, but that is or might be important?

_____

_____

_____

My signature below indicates that I have voluntarily and accurately completed the Jupiter Psychological Group Adult Information Form. A photocopy of this agreement will be considered as valid as an original.

	X	
Client name	*Signature of Client*	*Date*
Witness name	*Signature of Witness*	*Date*

CONSENT FOR TREATMENT

I do hereby seek and consent to take part in the treatment and/or Psychological Evaluation with the below named Independent Contractor. If the patient is a minor, I hereby give my consent as a parent/legal guardian for my child to participate in Psychotherapy and/or complete Psychological Evaluation by the above named clinician. I understand that it is my sole responsibility to notify my child's other parent of these Psychological Services. I also understand that no promises have been made to me as to the results of treatment, evaluation or of any other procedures provided by this clinician, as treatment benefits, while likely, cannot be guaranteed. I have the right to inquire fully about the credentials, education, and experience of my clinician or my child's clinician and to have my questions answered to my satisfaction.

I am aware that I may discontinue services with this clinician at any time. My only obligation will be to pay all outstanding fees for the services I have already received. I understand that under certain circumstances I may lose other services or may face other consequences if I stop treatment (for example, if my treatment has been Court-ordered, my discontinuing treatment may have an adverse effect on the outcome of the Court proceeding). I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show for my appointment, I will be charged the session fee for that service. I understand that if I do not pay for the services I receive, those services may be discontinued.

The initial appointment for Psychotherapy is a diagnostic intake session with a fee of $ _____. The standard fee for Psychotherapy is $_____ for a full 45 minute session, which will be billed at the conclusion of each session. Due to financial hardship, reduced fees may be available for 20-30 minute sessions. I understand that my treatment and/or treatment of a minor will not be compromised due to my financial situation. I agree to be responsible for a reduced rate of $ _____ per session. Fees for therapeutic groups are $ _____ per person per session or as otherwise agreed between myself and my treatment provider.

I understand that the fee for Psychological Testing is $_____ per hour, which will be billed at the conclusion of each testing session and following the completion of the Psychological Report; or a flat-rate of $_____. This flat-rate is payable in two parts: a deposit of $_____ payable before the start of this (these) services, and a second payment of the balance due on the completion and delivery of any report (or, for depositions, testimony, or other services, at the time these services take place). Additional fees may be charged for tests requiring computer scoring. If completing Psychological Testing, I understand that these services may include direct, face-to-face contact, interviewing, and/or testing. They may also include the psychologist's time required for the reading of records, consultations with other psychologists and professionals, scoring, interpreting the results, and any other activities to support these services.

I am aware that the procedures utilized for selecting and implementing therapeutic interventions; selecting, giving, and scoring psychological tests; interpreting and storing testing results; and maintaining my privacy will be carried out in accord with the rules and guidelines of the American Psychological Association and other professional organizations. All interventions and assessment measures that are chosen will be suitable for the purposes described above (in psychological terms, their reliability and validity for these purposes and population have been established in relevant scientific and psychological research). All service-related documents, psychological tests and test results will be kept in a secure place.

Historically, mental health services have been associated with absolute confidentiality between the family and clinician. Currently, Federal and Florida laws and regulations and professional ethics require clinicians to maintain complete confidentiality of information and communications revealed in the course of treatment. In these cases, the clinician cannot release any information about my family without my expressed and informed permission. There are some exceptional circumstances where clinicians are required or permitted to communicate information about mental health services to persons outside the family. I am aware that an agent of my insurance company, billing service or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. Other exceptions include the following situations:

- The client presents a clear and present danger to himself or herself and refuses to accept appropriate treatment.
- The client communicates to the clinician an imminent threat of physical violence against a clearly identified or reasonably identifiable victim, or the clinician has a reasonable basis to believe there is a clear and present danger of physical violence against such a victim.
- The client introduces his or her mental condition as a defense in a legal proceeding.
- In child custody or adoption cases, the judge determines that the clinician has information bearing significantly on the client's ability to provide suitable care or custody and this information bears significantly on the welfare of the child.
- The client initiates legal action against the clinician, and client information is necessary or relevant to the clinician's defense.
- The clinician has grounds to believe a child under the age of 18, an elderly person (over age 60), or a handicapped adult, has been or is at risk of being abused or neglected.
- A Judge orders a clinician to release client information.

With a properly signed Release of Information, I understand that Treatment Summary letters may be provided in lieu of releasing the complete psychological records to a requesting party.

I have discussed responsibility for payment for treatment and I assume financial responsibility for myself and/or my family members for all psychological services rendered; including psychotherapy, psychological testing, and other psychological services. I understand that if I am using an insurance plan, payment by an insurance company cannot be guaranteed. I understand that I am responsible to meet my insurance deductible and co-payments, in addition to payment for any services not covered by my insurance carrier. If my insurance carrier refuses to make payment, I accept responsibility for prompt payment for any treatment and services rendered to myself and/or my family. Independent Contractors reserve the right to release necessary and relevant information to a collection agency regarding overdue balances or fees owed for services provided.

If an emergency arises after working hours and in the event that I cannot contact my clinician or the clinician on call, I will call 911 or go to the nearest emergency room if I believe I am a danger to myself or others or my child may be a danger to him/herself or others.

My signature below shows that I have read, understand and agree with all of the statements within this Consent for Treatment. A photocopy of this agreement will be considered valid as an original.

X_____ _____

Signature of Client *Date*

X_____ _____

Signature of Parent or Guardian *Date*

My signature below shows that I have received the Notice of Privacy Practices regarding the use and disclosure of my Protected Health Information from Jupiter Psychological Group and that I consent to the use and disclosure of my Protected Health Information for the purposes of Treatment, Payment, and Health Care Operation on this date:

X_____ _____

Signature of Client/Parent or Guardian *Date*

As the treating and/or testing clinician, 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. As an Independent Contractor of Jupiter Psychological Group I understand that all services rendered by me and any future implications or consequences of these services are my sole responsibility.

_____ _____

Signature of Clinician *Date*

INFORMED CONSENT CHECKLIST FOR VIDEO/TELEPSYCHOLOGICAL SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- If psychological testing measures are used, copies of the materials will not be made and pictures of the material will not be taken.
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your clinician, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

X_____ _____

Signature of Client/Parent or Guardian *Date*

_____ _____

Signature of Clinician *Date*

WITHIN PRACTICE RELEASE OF INFORMATION AUTHORIZATION FORM

Client Name: _____ Date of Birth: ____/____/_____ Age: _____

I, _____ hereby authorize Jupiter Psychological Group to share any and all information with all Independent Contractors and Employees within the practice for the purpose of clinical case review, clinical coverage, and/or independent consultation.

I have been informed that I may revoke this authorization at any time and for any reason by written communication to Jupiter Psychological Group. In the event that I do not revoke this consent in writing, this release will expire when the purpose for which the consent was given has been accomplished. A photocopy of this Release of Information will be considered as valid as the original.

_____	X_____	_____
Client name	*Signature of Client/Parent or Guardian*	*Date*
_____	_____	_____
Clinician name	*Signature of Clinician*	*Date*

RELEASE OF INFORMATION AUTHORIZATION FORM

Client Name: _____ Date of Birth: ____/____/_____ Age: _____

I, _____ hereby authorize Jupiter Psychological Group to:
Client/Legal Guardian

☐ Release Protected Health Information to:

☐ Receive Protected Health Information from:

☐ Share Protected Health Information with:

_____
Name of Facility/Individual

_____
Address

(_____)_____ (_____)_____
Phone Number *Fax Number*

Purpose of this disclosure:

☐ To facilitate treatment and/or evaluation of myself or a family member

☐ Other: _____

This authorization shall expire:

☐ When the purpose for which this consent was given has been accomplished ☐ Once treatment has been terminated ☐ Date: _____

I have been informed that I may revoke this authorization at any time and for any reason by written communication to Jupiter Psychological Group. In order for the revocation of this authorization to be effective, it must include: Client's name, address, phone number, and date of birth; Effective date of the revocation of the Authorization to Release Protected Health Information; Client and/or Legal Guardian's signature. All requests must be sent to Jupiter Psychological Group and are not effective until received. I understand that only information obtained or produced by Jupiter Psychological Group is subject to release. I certify that this form has been fully explained to me and that I understand its contents. A photocopy of this Release of Information will be considered as valid as the original.

I understand that information sent, released, or disclosed pursuant to this Release of Information Authorization form may be subject to additional disclosure by the recipient of your information and is no longer protected by HIPAA Privacy Laws.

_____	_____	_____
Client name	*Signature of Client/Parent or Guardian*	*Date*
_____	_____	_____
Clinician name	*Signature of Clinician*	*Date*

GOOD FAITH ESTIMATE

Client Name: _____ Date of Birth: ____/____/_____

Provider:

Service: Outpatient Psychotherapy

Diagnosis Code: _____

Expected Service Code: 90837

Expected Charge: $____/session **without insurance**. Expected Total Yearly Cost based on an average treatment length of 8 sessions **without insurance**: $____. There may be additional services that I recommend as part of the course of care that are not reflected in the good faith estimate. Total number of sessions is unknown and is based on your progress and preferences.

The information provided in the good faith estimate is only an estimate regarding items reasonably expected to be furnished at this time and actual charges may differ from the good faith estimate.

You have rights to initiate the specified dispute resolution process if the actual billed charges are substantially in excess of the expected charges included in the good faith estimate. Information on how to file a dispute can be found at www.cms.gov/nosurprises or call 800-985-3059.

A good faith estimate is not a contract and does not require you to obtain the services from me.

I agree with and accept this Good Faith Estimate.

_____ _____

Signature of Client/Parent or Guardian *Date*

Financial Form

I _____ understand that the fee for _____ is $ _____.

I understand that if I decide to utilize my health care insurance that I will be responsible for the payment of the copay, deductible, or services not reimbursed by my insurance company.

At Jupiter Psychological Group, we are committed to providing you with the most ethical and effective treatment possible. Therefore, we value every appointment that we schedule and will reserve that day and time for you. This reservation, however, also preserves your clinician's time and precludes your clinician from scheduling other clients. Therefore, if you are unable to attend your session we require that you call your clinician to cancel your session with a minimum of 24 hours notice. If the appointment is not cancelled within 24 hours, you will be charged a late cancellation fee of $70. If you do not attend your scheduled appointment and you do not call to cancel, you will be charged your full and customary fee. We at Jupiter Psychological Group understand that extenuating circumstances may arise over which you have no control, and for these isolated incidents, there will be no charge. In any event, please call our office as soon as possible to inform us that you will not be able to attend your scheduled session. Thank you for your cooperation and understanding.

I authorize Jupiter Psychological Group to charge my credit card for expenses incurred.

Credit Card Information

Please Check One:

☐ Visa ☐ MasterCard ☐ AmEx ☐ Discover

_____ _____ _____

Name on Credit Card | Account Number | Expiration Date

_____

Security Code

Address Associated with card:

_____ _____ _____ _____

Street Address | City | State | Zip Code

I have read, understand, and agree with the entire contents of this form:

_____ _____ _____

Client name | *Signature of Client/Parent or Guardian* | *Date*