Center for Professional Psychology

Benjamin W. Storie, LPC-S
5401 Rogers Ave Suite 201 Fort Smith, AR 72903

CLIENT REGISTRATION FORM

Client Last Name:________________________ First Name:____________________________Middle:_______

Gender: M F Date of Birth: _____ / _____ / _____ Age:_________ SS#:____________________________

Marital Status: (circle one) Single Married Divorced Separated Widowed

Home Address:____

City: ____State:____________________Zip:__________

Home Ph:________________________Cell Ph:_________________________Work Ph: ________________

Employer:___________________________________Occupation:_______________________________

SPOUSE OR PARENT/GUARDIAN

Last Name:____________________________ First Name:____________________________Middle:_______

Employer:___________________________________Occupation:_______________________________

Home Ph:________________________Cell Ph:_________________________Work Ph: ________________

Date of Birth: ______ / ______ / ______ SS#:___________________________

EMERGENCY (Name and phone number of nearest relative or friend not living with you)

Last Name:____________________________ First Name:____________________________Middle:_______

Home Ph:________________________Cell Ph:_________________________Work Ph:________________

Relation to Client:____

INSURANCE

We need a copy of your card for our records.

Primary Insurance Company ____

Primary Insured's Name ________________________________Primary Insured's Date of Birth________________

Phone # ____ID/Policy# ______________________________

Group/Plan# ________________________________

RESPONSIBLE PARTY

Complete this section if you are not the patient but are responsible for the payment of services.

Responsible Party: ____

Relationship to Client: ____________________________SSN:______________________

Home Address:____

City: ____State:____________________Zip:__________

Home Ph:________________________Cell Ph:_________________________Work Ph: ________________

MY CERTIFICATION

I certify that the above information is correct and I request services. I certify that the signature below is a true and accurate representation of my signature.

____ ________________________

Signature of client or parent/guardian Date

MY PRIVACY

I have received a copy of the Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment; Obtain payment from third-party payors; Conduct normal healthcare operations such as quality assessments and accreditation.

____ Signature of client or parent/guardian

_______________________ Date

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Medical/Mental Health Treatment Summary

Client Name: ______________________________

Client Allergies or Adverse Drug Reactions: ______________________________

Primary Care Physician: ______________________________

Other Physicians You See: ______________________________

Current Prescription Medications:

Start Date	End Date	Medication	Dosage	Reason for Use	Doctor

Over-the-Counter Medications/Herbs/Vitamins:

Start Date	End Date	Medication	Dosage	Reason for Use

Hospitalizations/Surgeries: ______________________________

____

Mental Health Diagnosis: ______________________________

____

______________________________ ______________

Signature of Client or Legal Representative Date

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Credit/Debit Card Payment Consent

Client Name: ____

Name on card if different than client: ______________________________

I authorize Center for Professional Psychology/ Benjamin W. Storie, LPC-S to charge my credit/debit/health account card for professional services the same day of our scheduled appointment. If I do not cancel prior to 24 hours before my appointment or if I fail to attend a scheduled appointment, I recognize that Benjamin W. Storie, LPC-S will charge my card as a late cancellation fee or a no-show charge at the posted late-cancel/no-show rate.

I verify that my credit card information, provided above, is accurate to the best of my knowledge. If this information is incorrect or fraudulent or if my payment is declined, I understand that I am responsible for the entire amount owed and any interest or additional costs incurred if denied. I also understand by signing this form that if no payment has been made by me, Benjamin W. Storie, LPC-S has the right to pursue collections action, either through a collections agency or in small-claims court if another alternative payment is not made within thirty days.

____ ________________________

Signature of Client or Legal Representative Date

No Show, Late Cancellation and Co-Payment Policy

1. I understand that I will be charged a LATE CANCELLATION fee of $95 if I fail to give at least 24 hour notice prior to cancelling my appointment.
2. I understand that I will be charged a NO-SHOW fee of $95 if I fail to show for my appointment.
3. I understand that I am responsible for knowing my co-payment amount and deductible amount.
4. I understand that I will be charged a $10 service charge if I fail to make my payment and/or co-payment at the time of my appointment.
5. I understand that these charges are an out-of-pocket expense and that my insurance carrier will not cover these charges.
6. I understand that the therapy sessions will last 50 minutes. I understand that if I am late to the appointment, I will still have to end the session at the allotted time. By signing this, I am agreeing to the above stated terms and stipulations regarding the services I receive from this therapist.

____ ________________________

Signature of Responsible Party Date

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Child Intake Form

Please provide the following information about your child:

Full Name: ____

Nick Name: ______________________

Birth Date: ____________________ Today's Date: __________________

Behavioral Excesses:
What does your child currently do too often, too much, or at the wrong times that gets him/her in trouble? Please list all the behaviors you can think of.

Behavioral Deficits:
What does your child fail to do as often as you would like, as much as you would like, or when you would like? Please list all the behaviors you can think of.

Behavioral Assets:
What does your child do that you like? What does he/she do that other people like?

Others Concerns:
Do you have any other concerns about your child or your family that you have not mentioned yet?

Treatment Goals:
From your preceding list of your child's behavior and your family concerns, what problem behaviors do you want to see change FIRST: and how much must they change for you to be satisfied?

Family History:
The name of the child's biological parents:

Mother: ____________________________ Father: __________________________

Who has legal guardianship of your child?
Who are other household members with your child?

Names	Ages	Relationship to child

Who are your child's significant others NOT living with your child?

Names	Ages	Relationship to child

Please describe any past counseling treatment that either your child or any family member has received.

Does anyone in the child's family use currently (or in the past) any type of drug, tobacco, or alcohol? _________ If yes, please describe:

Education History:
What school does your child attend?

Current Grade: ______________

What does your child's teacher(s) say about him/her?

Other schools attended (including pre-school):

Has your child ever repeated a grade? If so which one(s) and what was the reason for retention?

Has your child ever received special education services or special academic accommodations? If yes, please describe.

Has your child experienced any of the following problems at School?

Fighting	Lack of friends	Drug/Alcohol	Detention
Suspension	Learning Disabilities	Poor attendance	Poor grades
Gang influence	Incomplete homework	Behavior problems	

Medical History:

What is the name of your child's primary care physician? ________________________

Address: ___________________________________ Phone: ______________

Date of your child's last medical examination: ___________________________

Did the child's mother smoke tobacco or use any alcohol, drugs or medications during the pregnancy? If so, please list which ones:

Did the child's mother have any problems during the pregnancy or at delivery? If so, please describe them:

Has your child experienced any of the following medical problems?

A serious accident	Hospitalization	Surgery	Asthma
A head injury	High fever	Convulsions/seizures	
Eye/ear problems	Meningitis	Hearing problems	
Allergies	Loss of consciousness		Other

Please list any current medical problems or physical handicaps:

Please list any medications your child takes on a regular basis:

Other History:
Has your child ever experienced any type of abuse (physical, sexual, or verbal? If so, please describe:

Has your child ever made statements of wanting to hurt him/herself or seriously hurt someone else?

Has he/she ever purposely hurt himself or another?
If yes to either question, please describe the situation:

Has your child ever experienced any serious emotional losses (such as a death of or physical separation from a parent or other caretaker)? If yes, please explain:

Finally, what are some of the things that are currently stressful to your child and his/her family?

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INFORMED CONSENT FOR TREATMENT

I hereby request and consent to the performance of behavioral health treatments (also known as psychotherapy) and any other associated procedures or therapy requested by the licensed practitioners of this practice.

I understand that in order to help create a therapeutic environment, it is the policy of this office that no cell phone usage is allowed in the counselor's office and especially video of any type in the office lobby area. I understand that ABSOLUTELY NO photography or video is allowed in our waiting room or our offices without express written therapist approval and with the appropriate signed forms.

I UNDERSTAND THAT, FOR THE SAFETY OF ALL, CHILDREN UNDER THE AGE OF 12 MUST BE ACCOMPANIED BY AND MONITORED BY A RESPONSIBLE PERSON (GENERALLY AN ADULT 18 OR OLDER) WHILE THEY ARE IN THE WAITING ROOM. I, AS THE ADULT IN CHARGE OF BRINGING CHILDREN TO THE OFFICE, WILL ASSUME ALL RESPONSIBILITY FOR THEIR WELFARE AND ASSUME FULL RESPONSIBILITY FOR ANY DAMAGES THEY MAY CAUSE IN THE WAITING ROOM.

I understand, that psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems I bring forward. There are many different methods your health care provider may use to deal with the problems that I hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on my part. In order for the therapy to be most successful, I will have to work on things we talk about both during our sessions and at home.

Therapy Services

I understand that my first few sessions will involve an evaluation of my needs. By the end of the evaluation, my health care provider will be able to offer me some first impressions of what work will be included and a treatment plan to follow that is best for me. I understand that I should evaluate this information along with my own opinions of whether I feel comfortable working with my therapist, if I decide to continue with therapy. Because therapy involves a large commitment of time, money, and energy, I should be very careful about the therapist I select. If I have questions about suggested therapies or procedures, I should discuss them whenever they arise. If my doubts persist, the office or my therapist will be happy to help set up a meeting with another mental health professional for a second opinion.

I understand that Benjamin W. Storie, LPC-S is not a medical doctor and cannot prescribe any medications, at any time, for any reason.

I understand that I may request access to my medical records at any time. Center for Professional Psychology requires approximately 7 days to process medical records releases.

If there is any dispute about the care I am receiving in the above named office, I agree to a resolution by binding arbitration in accordance to the American Arbitration Association guidelines.

Benefits and Risks

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of my life, I may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what I will experience. NO session may be taped or recorded without the acknowledgement and permission of both the client and therapist. Also, NO session or portion of a session may be posted or used for any type of social media or network.

Confidentiality

As part of the therapist-patient agreement, all of the information gathered about you and/or your child will be treated with great care. Legal and ethical considerations prevent my office from divulging information about you and/or your child, including information about whether you are a patient in my office, without your express written consent.

However, you should know before we begin our professional relationship that there are certain legal and ethical limits to confidentiality. In some circumstances, I am required to break confidentiality in order to protect you, your child, or others, for example:

*If a patient threatens grave bodily harm or death to another person, I may be required to inform appropriate legal authorities and the intended victim.
*If a patient expresses a serious intent to grievously harm himself/herself, I may be required to notify family members and/or persons authorized to respond to such emergencies, in order to protect the patient from harm.
*If I have good reason to suspect that a child is the victim of physical or sexual abuse, or a victim of neglect, I am required to report the abuse or neglect to the appropriate authority.
*If a patient is being evaluated in response to court order, the results of the evaluation will be revealed to the court.
*If a court of law issues a court order signed by a judge, I am required to provide information (though I will restrict the information to that which is specifically requested in the court order).
*If your insurance company (or other third-party payer) requests information including diagnosis, reports, recommendations, and/or chart notes, this information must be provided.
*If you fail to meet the financial obligations outlined in this form, I reserve the right to pursue collections or small claims court.
*Please note that noncustodial parents can access a child's records, unless the parent's rights have been terminated. As a result, it is important for me to have a good understanding of the custody arrangements and parental rights at the start of services and if the circumstances change during the course of services.

Please be assured that I take your confidentiality very seriously, and I will make every effort to safeguard it. In any of the above situations, when I must break confidentiality, I will make every effort to discuss this with you ahead of time, unless there is a good reason not to do so. Additionally, I would only reveal the specific information required in the situation. Be aware that administrative personnel only have access to the minimum necessary amount of protected health information.

Financial Policy and Obligations

I understand that obtaining therapy services can be a substantial financial commitment on your part. As such, I believe it is extremely important for you to know exactly what your financial obligations are. You are responsible for ensuring that all of the associated fees are paid on your account. Since you are responsible, this means that even if another person/entity, such as another parent or your insurance company, is expected to cover the charges and does not, you will be held financially responsible. If for any reason, your account is delinquent, I have the right to pursue collections action, either through a collections agency or in small-claims court. A monthly late-fee of $25.00 will be applied to balances that remain unpaid for 30-days (unless prior payment plan arrangements have been made).

This office will provide insurance billing services for you, if you so desire, as a courtesy. Remember that you are ultimately responsible for any charges incurred in this office. It is your legal responsibility to pay any deductible amount, co-insurance, and/or any other balances not paid by your insurance carrier.

Please note:

1. You may pay our regular fee schedule and we will bill the insurance company for you. This notifies the insurance company that your deductible should be reduced by what you pay on each visit. If and when the deductible is met, your plan will likely switch to a co-pay status (please consult with your insurer to confirm your policy details), or
2. You may pay our private pay rates if you have no insurance or your insurance is out-of-network with Center for Professional Psychology, or
3. You may file with your insurance on your own if we are out-of-network with your insurance company.

We recognize open communication regarding payment is essential in maintaining a healthy relationship between the office staff and our clients. Feel free to contact our office if you have any questions or concerns regarding your payments, insurance, or account.

Clients with insurance benefits will receive our best estimate for the client portion of the fee. Please remember that your insurance policy is a contract between you and your insurance company. We are not responsible for any errors, non-payments or adjustments that your insurance company may make. However, we are committed to doing what we can to correct any problem. Your insurance company may require authorization for services. In most cases we are able to get the authorization for you. <u>Please be advised it is your responsibility to understand your</u>

policy and make sure your insurance company will pay for your sessions. You, the client, are ultimately responsible for any changes incurred in this office. All fees are due at the time of service, unless other arrangements have been made in advance.

In the event that a check is returned to me because of insufficient funds, I will notify you than an alternative means of payment is required plus a $25.00 returned check fee. I reserve the right to refuse to accept personal checks from persons who have previously written checks which were returned.

Please note that if I am asked to testify in court, for a deposition, or consult as part of court proceedings, I charge $250 per hour with a four hour minimum. The initial $1000 deposit for my time and expertise is required at least 36 hours before the scheduled deposition or court appearance. Also, I charge $200 an hour for my preparation time on all court-related matters.

Appointments and Scheduling

Occasional telephone calls to your therapist at the office may be necessary at times. Frequent calls or calls longer than 10 minutes may be subject to a session being charged to your account. This fee is not covered by your insurance company in most cases. It is billed in 15 minute increments at Mr. Storie's private pay rate.

I consider each scheduled appointment to be very important, and I ask you to do the same. Out of courtesy to me and to other patients who are also waiting for an appointment, please call as soon as you determine that you will be unable to keep your scheduled appointment, so that the time can be offered to another patient. If I must postpone an appointment, I will make every effort to reschedule you as quickly as possible. If you fail to show for an appointment, you will be asked to prepay for your next appointment.

Missed appointments or cancellations made with less than 24 hour notice will be subject to a "no-show" charge of $95. Your insurance provider will not cover cancellation fees. We may terminate our counseling relationship with clients having excessive "no-shows" or late cancellations. Advance scheduling is offered as a convenience for clients seeking a special session time. Clients who "no-show" for their appointment may have all remaining advance appointments cancelled. Future sessions shall not resume unless the client initiates contact and the "no-show" fees are paid. If you have not scheduled an appointment in four months, your chart will be closed. You may be placed on a waiting list if you decide to schedule an appointment again, depending upon the availability of your therapist.

In case of inclement weather, please notify the office if you are unable to attend your scheduled session. If our office does not close, and you do not show for your appointment, you may be charged a "no-show" fee. Please notify our office as soon as you are aware you may not be able to attend your appointment in severe weather situations. Mr. Storie's standing policy regarding inclement weather is to close the office if Fort Smith Public Schools are cancelled.

Requests for Forms and Letters

There is no charge for completion of forms needed to secure pre-authorization for therapy services from your insurance company. However, the following charges will apply for other forms or letters that are needed, including but not limited to, letter to insurance companies for justification of diagnosis, evaluation, or treatment, letters or forms needed for schools or state agencies regarding diagnosis, treatment, or information for IEP planning, letters to attorneys, etc. The charge for completion of brief forms and letters is $25.00. Each additional form requested at the same time will be charged at $10.00 each. Charges for lengthy or more detailed letters will be at the hourly rate $160/hour based upon the time involved in preparation. Payment for all forms must be made before the forms will be completed or the letter written. Please be aware there may be some forms issued to you that I am not capable of completing. Also, be aware that in most cases, I will not be able to complete forms on the same day as they are received and, in some instances, there may be a 10-day turn-around period for completion of forms and letters. However, I will make every effort to be as prompt as possible in addressing your request.

If You Need to Contact Me

I cannot promise that I will be available at all times. You can leave a message on my voice mail or with my assistant and I will return your call as soon as I can. Please not that if you have an issue that requires more than a few minutes of time, then I may recommend that we schedule an appointment so we can more thoroughly address your concern.

If you have an emergency or crisis and cannot reach me immediately by telephone, then you or your family members should call 911 or go to the nearest hospital emergency room.

Statement of Principles and Complaint Procedures

Problems can arise in our relationship, just as in any other relationship. If you are not satisfied with any area of our work, please raise your concerns with me at once. Our work together will be slower and harder if your concerns with me are not worked out. I will make every effort to

hear any complaints you have and to seek solutions to them. If you feel that I, or any other therapist, has treated you unfairly or has broken a professional rule, please tell me.

If you wish to report a complaint regarding privacy related issues you may contact the Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington DC, 20201. In any case there will not be any retaliation against you or your legal representative for filing a complaint.

In my practice, I do not discriminate against patients because of any of these factors: age, sex, marital/family status, race, color, religious beliefs, ethnic origin, place of residence, veteran status, physical disability, health status, sexual orientation, or criminal record unrelated to present dangerousness. This is a personal commitment, as well as being required by federal, state, and local laws and regulations. I will always take steps to advance and support the values of equal opportunity, human dignity, and racial/ethnic/cultural diversity. If you believe you have been discriminated against, please bring this matter to my attention immediately.

Benjamin W. Storie, LPC-S

Informed Consent Agreement

I, the patient (or his or her parent or guardian), understand I have the right not to sign this form. My signature below indicates that I have read and discussed the informed consent materials; it does not indicate that I am waiving any of my rights. I understand I can choose to discuss my concerns with you, the therapist, before I start (or the patient starts) therapy services. I also understand that any of the points mentioned above can be discussed and may be open to change. I have read or have had read to me, the issues and points included in the informed consent packet. I have discussed those points I did not understand, and have had my questions, if any, fully answered. I agree to act according to the points covered in this document.

You signature below indicates that you have had sufficient opportunity to read and understand the informed consent materials, and that you have asked me to clarify anything that you did not understand. Your signature also signifies that you are giving Benjamin W. Storie, LPC-S, consent to engage in the evaluation and treatment of you and/or your child.

____

Signature of Patient/Parent/Guardian Date

____

Printed Name

Relationship to Patient:

Signed by: ___ Patient ___ Guardian ___ Personal Representative

I, Benjamin W. Storie, have met with this patient (and/or his or her parent or guardian) for a suitable period of time, and have informed him or her of the issues and points raised in this brochure. I have responded to all of his or her questions. I believe this person fully understands the issues, and I find no reason to believe this person is not fully competent to give informed consent.

____

Benjamin W. Storie, LPC-S Date

Acknowledgement for Receipt of Privacy Practices

I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications. My signature indicates I have received a copy of the office's privacy practices.

Patient's Name (please print): ____

Signature: ________________________________ Date: ____/____/____

Signed by: ___Patient ___Guardian ___Personal Representative

Consent to Submit Private Health Information for Insurance Claims

I authorize Benjamin W. Storie, LPC-S to release any protected health information (PHI) necessary to process insurance claims. I also authorize my insurance carrier to make payments to Mr. Storie.

__________________________ ____________________

Signature of Insured/Representative Date

Coordination of Care

___ (Initials) I would like for Benjamin Storie to coordinate care with my/my child's primary care physician. If so, a separate authorization outlining information to be released will be obtained.

___ (Initials) I do not want Benjamin Storie to communicate information about services provided with my/my child's primary care physician.

Please note: Patients may change their mind about whether and what type of information can be shared with other treatment providers anytime (unless the information has already been released).

Emergency Plan

I consent to Dr. Janissa Jackson to handle my Protected Health Information in the event of an emergency in which I need to gain access to this information and Benjamin Storie, LPC-S is unavailable due to extenuating circumstances.

Patients Name: ________________________________ Date: __________________