Welcome
to
Adaptive Therapy

Revised date 10/29/2018

Adaptive Therapy
Towards the life you want...

Please complete all pages (pages 2 through 6)

Name of Client _____

Street Address _____

City _____ State _____ Zip _____

Date of Birth _____ Age ____ Sex ____ Email _____

Home Phone _____ Cell Phone _____

Occupation _____ Work Phone _____

Emergency contact: _____ Phone # _____ Relation _____

Education (Yrs Completed) _____

Marital Status **(Circle):** ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Cohabitating

Name of Spouse/Partner _____

No. of years in relationship or married _____

Parent Information (for minor clients, under 18 years of age)

Parent Name _____

Date of Birth _____ Age ____ Sex ____ Email _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Occupation _____ Work Phone _____

Education (Yrs Completed) _____

Children (or siblings)

Full Name	Sex	Age	Comments

Names of those currently living in your home?

_____

How did you find us (friend, name of physician, internet search)?

_____

Why are you currently seeking counseling?

_____

_____

_____

Insurance information

Name of insurance carrier: _____ ID No. _____

Provider telephone number: _____ Group Number_____

Date of birth of Subscriber _____

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.

How We Collect Information About You: Adaptive Therapy collects data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails.

What We Do Not Do With Your Information: Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

I understand that:

- If my treatment is paid for by a public or private agency, an insurance company, managed care or other third party, your private health information will be provided in order to bill for services and/or to obtain initial and continuing insurance authorizations.

- I have the right to not give this consent; however, I also understand that my Health Care Provider does not have to treat me if I do not sign this consent.

- I have the right to request restrictions on this consent and to request limits on when and how my Health Care Provider uses and discloses my Protected Health Information, however, I understand my Health Care Provider is not obligated to agree to the restrictions or limitations I request.

- If my Health Care Provider agrees to a restriction, my Health Care Provider shall be bound by the restriction until I release my Health Care Provider from that restriction.

- I have the right to revoke my consent; however, it shall not be considered revoked to the extent my Health Care Provider has relied on it.

Exceptions to confidentiality:
1 - you express the desire and intent to harm yourself or someone else
2 - there is a credible report of child abuse, abuse of an elderly or disabled adult
3 - there is a court order or subpoena
4 - you give written consent granting me permission to speak with other health care providers

I hereby consent to all the uses and disclosures in my Health Care Provider's Notice of Privacy Practices.

Phone calls

Adaptive Therapy may call me, as well as leave messages for me at

Home ☐ Work ☐ Cell ☐

Email

Can Adaptive Therapy contact you via email with information about upcoming events or the forming of new therapy groups (emails will never exceed once per month)?

Yes ☐ No ☐

_____ _____
Client – Printed Name Guardian/Parent – Printed Name

_____ _____
Client Signature Guardian/Parent Signature

_____
Date

Fee Agreement

Those with insurance(s) we accept
You are only responsible for the deductibles, co-insurance/copay , no show and court fee amounts. All other amounts will be billed directly to insurance.

Those with insurance(s) that *we do not* accept
We will provide you with a copy of your receipt on a monthly basis (or more frequently if you request), which you can then submit to your insurance company for reimbursement. Please be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk. Not all issues/ conditions/problems dealt with in psychotherapy are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage.

Cancellation Policy:
Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours (1 day) notice is required to reschedule or cancel an appointment. If an appointment is missed without notice or canceled with less than 24 hours notice, a "no show" fee of $55 will be charged to your account (unless we are able to find a mutually agreeable time to reschedule the appointment within the same week). More than 4 cancellations in a calendar year may result in referral to another mental health provider, as a high cancellation rate is disruptive both to our clients and our practice.

Court fees:
I do not testify in any hearings unless compelled. I am not trained as an expert witness or forensic psychologist, therefore, it it is not in your best interest to ask that I testify for you. If you or your attorney choose to subpoena me for court testimony, including depositions or administrative hearings, you will be charged $1000 per four hour block of time, with a 4 hour minimum. Chargeable time includes preparation (including research), waiting to testify, travel time and actual testimony. These charges apply even if I do not actually testify. By signing this agreement, you agree to pay these charges two weeks prior to any proceeding. Should it become necessary for me to commence collection proceedings or retain an attorney to collect any fees due, you agree to pay attorney's fees and costs of collection incurred by me.

All fees are payable via cash, check, debit or credit card. Fees are expected to be paid at each session unless other arrangements have been made. We do not add a charge for returned checks but clients are responsible for all bank fees associated with returned checks.

I have read the above Fee Agreement document carefully, and I understand it and agree to comply with all its terms and conditions:

_____ Date: _____
Client Signature

_____ Date: _____
Clinician Signature

www.AdaptiveTherapy.com
240-253-7051 or 917-576-7237
Individual, Family & Couples Counseling
109 LaGrange Avenue, Suite 103
La Plata, MD 20646

Print Form Save Form