The Self Center

Robert & Joyce Simpson, Family Counseling Professional Corporation

18671 Allegheny Drive • North Tustin, CA 92705 • (714) 997-9600 • Fax: (714) 997-9607
Email: RDSimpson@aol.com

Diagnostic History Self Report

Name: ______________________________ Today's Date: ___/___/___

Please give us a detailed history of yourself. Tell us all about yourself, your experiences, values, feelings, accomplishments, strengths and weaknesses and problems or difficulties in the following categories. Please give this some thought. Thank you for helping us help you.

Family History:

Relationship History: (dating, marriage(s) etc.)

Developmental and Medical History**: (include major illnesses, accidents, surgeries and current meds)**

Work History: (include your feelings about your work/profession)

School/educational History: (what classes did you enjoy or not enjoy)

Any other factors about your life that might help us get a complete picture of you:

Please let us know your goals in terms of what you would like to get out of counseling/therapy:

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General Intake Sheet

Name:________________________________ Date of Birth: __/__/__ Today's Date: __/__/__

Age: ______ Social Security No.: _________________________ Driver's Lic. No.:___________

Address: _________________________City: ____________________State & Zip: ___________

Home Phone: (___) _______________Cell Phone: (___) ____________Work Phone: (___) _____

E-mail Address: ____________________________ Education: _______ Religion: __________

Occupation: _______________ Employer: __________________ Length of Employment: _____

Employer's Address: ___________________ City: _________ State:____ Zip:________

Family: (list names and ages of family members living with you) ___________________________

____

Marital Status: ___________Spouse's (or significant other's) name: _______________________

Length of Relationship: ____

Have you ever had counseling or psychotherapy? Yes___ No____ When: _____________

Name and location of former psychotherapist: ______________ City & State: ____________

Physician: (name)_________________Address:________________City:_________________

State:___Zip:_______phone: (___)__________________ fax: (___)______________________

List current health problems: ____

____

List all medications, both prescribed and not prescribed, that you are taking: ___________

____

Do you drink alcohol or take illegal drugs? Yes ___ No ___ Type:______ Frequency: _____

Authorization: I understand that I am personally responsible for payment for all professional services whether or not covered by my insurance. I also understand that I am responsible for paying for any session not cancelled at least 24 hours in advance. Furthermore, I authorize The Self Center to request and release information to professionals that are involved in my treatment.

Signature: (client or guardian)______________________ Dated: ____________________

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Exceptions to the Rules of Confidentiality between a Psychotherapist and Client

I understand that all communication between myself and my psychotherapist is privileged communication and that confidentiality shall be maintained in all circumstances except the following:

If I am, or some one I know is, or has been a victim of child or elder abuse. This is to include, as of the year 2000, emotional abuse inflicted on a minor.

If I am a danger to myself.

If I am a danger to others or property..

If I am gravely disabled.

If I have sought or obtained the services of my psychotherapist to enable or aid anyone to commit or plan to commit a crime or tort or to escape detection or apprehension after the commission of a crime or tort.

If I communicate information to my therapist in a setting outside her/his office when one or more other people are present.

If I do not pay the fees for treatment, I waive the privilege of confidentiality, specifically regarding my status as a patient/client. I also understand that the psychotherapist can pursue the collection of such fees through legal processes.

If I am in couples, family and/or a group setting where others would be privy to this information

If I waive confidentiality by signing a Release of Information form.

If I waive confidentiality by signing the Insurance Claim form.

My signature below verifies that I have read and understood the above exceptions to the rules of confidentiality in my relationship with my psychotherapist/counselor.

Patient/client signature:________________________________ Dated: __/__/__

Parent or Guardian's signature:___________________________ Dated: __/__/__

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GUIDELINES FOR COUNSELING

LENGTH OF SESSIONS: Our time together is set for 45 minutes. I will be prepared to begin our meetings at the designated time we have agreed upon. I will give you my undivided attention at our sessions. If I am late, I will make up the time. However, if you arrive late, please understand that I will have to end our session on time.

PAYMENT: Payment is expected at each session. If you are writing a check, please prepare it in advance of our meeting so we can maximize our time together. **Cash is acceptable and we request that all insurance co-payments be made in the form of cash.** Accounts past due beyond 30 days will be subject to a 1.5% monthly finance charge.

INSURANCE: Many insurance companies pay for psychotherapy. We can assist you in determining your insurance benefits. Your insurance benefits must be clarified prior to your first counseling session. Please inform us if your insurance plan changes during the course of your therapy. You will be held responsible for full payment if your insurance company does not make the expected payment to us.

RESCHEDULING: The nature of our work requires us to schedule a specific hour for you. I understand emergencies may arise that might make it impossible to attend our scheduled meeting. Please call us as soon as you can to advise us of your urgency. Instead of cancellation, you have 3 options that will work for both of us. You can reschedule your appointment for another time during the same week (every attempt will be made to find another time for you); you can schedule a phone session with me; or you can simply pay for the missed appointment and arrange to meet at our next regular session.

PHONE CALLS: I am available to assist by phone, when necessary, at no charge, for up to 5 minutes. If you wish further assistance, we can schedule an additional individual session or we can proceed with a phone session, for which you'll be charged at your regular fee, on a pro-rated basis.

CONFIDENTIALITY: Our meetings are confidential, with a few exceptions that we will discuss with you in our first session.

OTHER RESOURCES: We are at your service to share our referral sources with you: lawyers, health care professionals including physicians, career specialists, and many other community resources that you may need. Feel free to ask for these resources.

OUR RELATIONSHIP: I regard our relationship as an important association. If you feel you benefit from our time together, I certainly welcome you advising and referring others to my services.

Having read and understood the above guidelines, we have an agreement.

Name______________________________ **Date**____________________

Therapist___________________________ **Date**____________________

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA   PICA

CARRIER

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO ***If yes,*** return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED ______ DATE ______

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED ______

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. ___ . ___   3. ___ . ___

2. ___ . ___   4. ___ . ___

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

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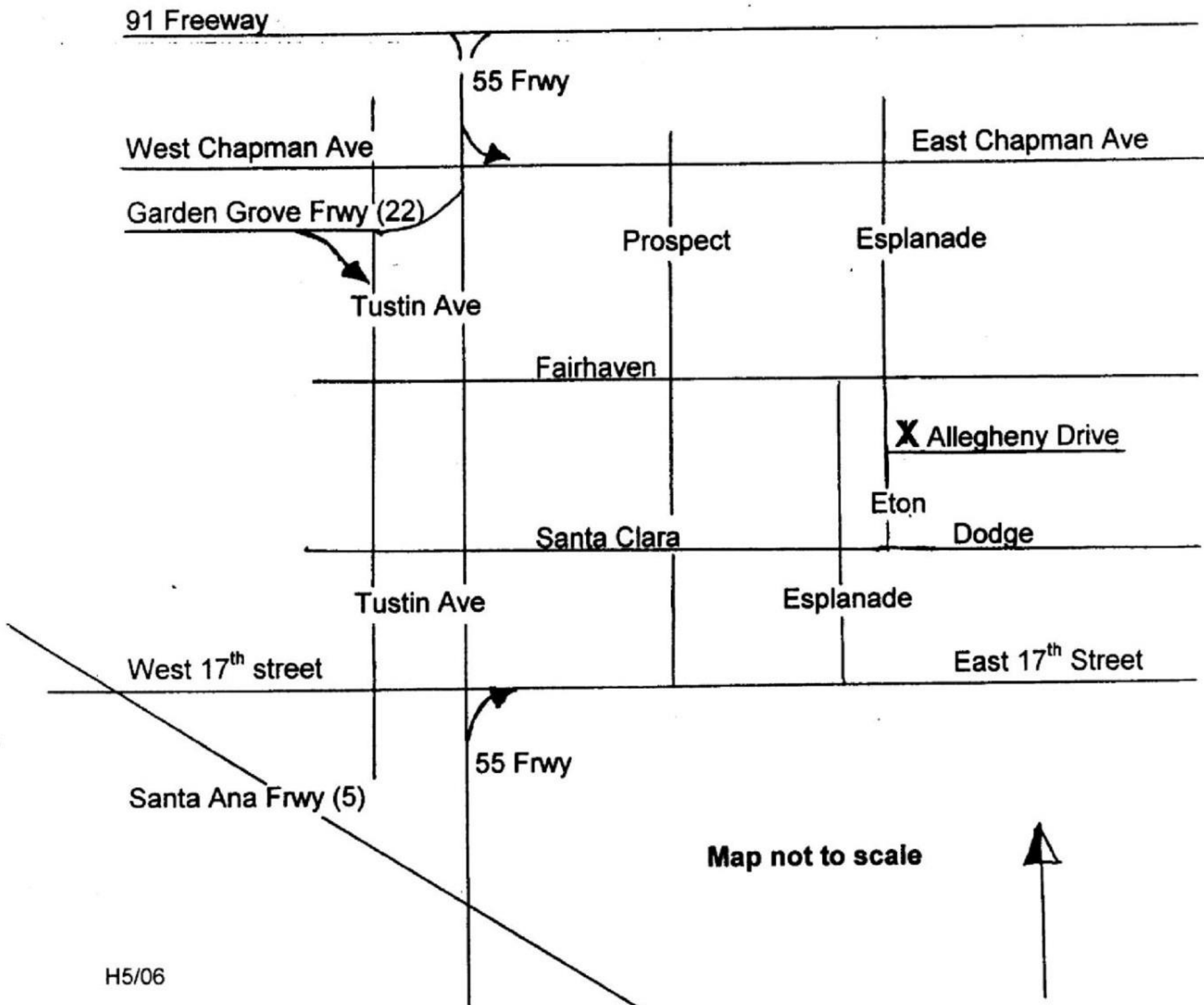
Map & Parking Instructions

Welcome to The Self Center. This map should help you get here. When you arrive at our home office, please park on Eton (the street on the side of our house). Please do not park on Allegheny. When you walk up our driveway and into the courtyard, you will see the door to our office on your right. Please arrive 20 to 30 minutes early, as there will be forms left out for you to complete. Please ring the bell on the office door (one time) to let us know you are here and have completed the forms. Thank you.



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