

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

Authorization to Treat a Minor

Minor's Information

Minor's Name: _____ Today's Date: _____

Age: _____ D.O.B. _____ Phone: _____

Minor's Address: _____ City: _____ Zip: _____

Minor's SSN: _____ Grade: _____ School: _____

Teacher's Name: _____

Minor's Physician: _____ Phone: _____

Physician's Address: _____

Parent's Information:

Parent's (legal guardian's) Name: _____

Parent's Address: _____ City: _____ Zip: _____

Parent's Phone: _____ Parent's SSN: _____

I/We, _____, hereby give my/our consent to Robert and/or Joyce Simpson, Licensed Marriage, Family and Child Therapists, to render counseling services and treatment to my child, _____. I/We further authorize The Self Center and Robert and/or Joyce Simpson to obtain and release documents and information to other professionals who may be working with my child.

Signature of Parent/Guardian: _____ Date: _____

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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 _____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

CARRIER

PICA										PICA									
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>										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 <input type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY STATE										7. INSURED'S ADDRESS (No., Street)									
ZIP CODE TELEPHONE (Include Area Code)										CITY STATE									
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. RESERVED FOR LOCAL USE									
a. OTHER INSURED'S POLICY OR GROUP NUMBER										11. INSURED'S POLICY GROUP OR FECA NUMBER									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>										a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
c. EMPLOYER'S NAME OR SCHOOL NAME										b. EMPLOYER'S NAME OR SCHOOL NAME									
d. INSURANCE PLAN NAME OR PROGRAM NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME									
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 _____									
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									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
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 I MODIFIER E. DIAGNOSIS POINTER										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.									
25. FEDERAL TAX I.D. NUMBER SSN EIN										23. PRIOR AUTHORIZATION NUMBER									
26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? <small>if or govt. claims, see back</small> <input type="checkbox"/> YES <input type="checkbox"/> 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. _____									

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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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.

