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SPECTRUM
COUNSELING

CLIENT INFORMATION

CLIENT NAME: _____
Last First Preferred Name Pronouns

CLIENT'S DATE OF BIRTH: _____ AGE: _____ E-MAIL: _____

PARTNER'S NAME: _____
Last First Preferred Name Pronouns

PARTNERS'S DATE OF BIRTH: _____ AGE: _____ E-MAIL: _____

PARENTS' NAMES (for minor child): _____

WHICH PHONE NUMBER MAY WE USE TO CONTACT YOU? _____

ADDRESS:_____

EMPLOYER: _____ OCCUPATION: _____

SCHOOL: _____ GRADE:_____

FINANCIAL RESPONSIBILITY

The Client/responsible party is responsible for payment of professional services. A signature below certifies the client/responsible party acknowledges Dr. Haddox does not accept ANY health insurance and will not submit claims for reimbursement. Credit card information will be kept on file and charged for No Show/Late Cancel Fees or unpaid balances that the client has not paid in full at the time of services.

CREDIT CARD: _____ ACCT #: _____ CVC #: _____ EXP: ___/___

SIGNATURE: _____ DATE: _____

PERSONAL INFORMATION

REASON FOR COUNSELING: _____

_____

REFERRED BY: _____

PREVIOUS COUNSELING: _____

_____

CURRENT MEDICATIONS/REASONS:_____

_____

_____

MEDICAL PROBLEMS/CONCERNS:_____

_____

_____

PROBLEM CHECKLIST *(Please circle all that apply):*

Nervousness	Pornography	Excessive Worry	Restlessness
Shyness	Masturbation	Loss of Appetite	Hopelessness
Drug Use	Irritable Bowel	Excessive Appetite	Low self-esteem
Anger	Alcohol Use	Unusual Fears	Tearfulness
Sleep	Stress	Excessive Fears	Irritability
Anxiety	Social Difficulties	Obsessive Thoughts	Memory Loss
Legal Issues	Lack of Friends	Racing Thoughts	Weight Gain
Loss of Energy	Excessive Fatigue	Suicidal Thoughts	Weight Loss
Loneliness	Poor Decision-Making	Unhappiness	Muscle Tension
Education	Depressed Mood	Relationship Issues	Impulsivity
Job Difficulties	Poor Concentration	Sexual Difficulties	PMS
Lack of Motivation	Poor Physical Health	Feelings of Inferiority	Nightmares
Stomach problems	Career Uncertainties		

HIPPA INFORMATION AND CONSENT FOR TREATMENT

CONFIDENTIALITY

All sessions are completely confidential in accordance with law and recognized professional standards. If your therapist needs to communicate with another about your case, you must give written permission to do so. The only exception to this is, if in accordance with law and reasonable professional judgment, such communication appears needed to protect you or others from harm, or in response to legal process, or in other proper circumstances, the privileged nature of your communication ceased in these circumstances. Possible exceptions include, but are not limited to, the following situations: child abuse, abuse of the elderly or disabled, threats of suicide or homicide.

The Health Insurance Portability and Accountability Act (HIPPA) provides safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

INFORMED CONSENT

Therapy is an interactive process between client and therapist, and the results of therapy depend on your cooperation. It is meant to promote change and understanding. Sometimes this process can be emotionally painful, and at other times, very fulfilling. You will be expected to contribute to all decisions regarding therapeutic intervention devised for you, including out of session assignments. You have the right to refuse or alter any service and intervention. While we will use our best efforts to assist you, the nature of psychological services is that there can be no assurance of results, and no promises can be made regarding the outcome of any services provided. You should question the rationale of any services, intervention, and discussion if these seem unclear to you.

FEES/PAYMENT

Our Fees are based on 60-minute sessions. Longer phone sessions are prorated accordingly. Payment is expected at the time services are rendered, by cash, check or credit. Psychological or court reports will not be issued until full payment for services is received. Additional fees may apply for letters/completion of forms.

MISSED APPOINTMENTS

If you are unable to keep an appointment, please notify the therapist immediately. **If an appointment is cancelled without 24-hour notice, you will be billed for the missed session at the rate of $75. Third and subsequent late cancelations, as well as appointments that are missed without ANY notice, will be billed the full fee. These fees may be charged to the credit card on file.**

INITIAL _____

RESPONSIBILITY

The client (or responsible party) is considered responsible for payment of professional services. Fees not paid within 30 days from the date of billing will be subject to an interest charge of 10% of the outstanding bill and the credit card on file will be charged for total balance due.

I voluntarily agree to receive mental health assessment, care, treatment, or services and authorize my therapist to provide such. I understand and agree that I will participate in the planning of these services and that I may stop such care at any time. I acknowledge that I have both read and understood all terms and information contained herein.

_____ _____

Client/Spouse or Partner Signatures OR Date

Parent/Guardian Signatures

PAYMENT/INSURANCE

Dr. Haddox is considered out-of-network for all insurance plans and does not submit claims directly to insurance companies where she is out-of-network. However, if you would like to submit a claim to your insurance company for reimbursement, we can assist by providing a diagnosis and procedure code.

The following questions may help you discuss your mental health coverage with your insurance company:

- Do I have benefits for mental health services?
- Do I have a deductible and, if so, has it been met?
- How many sessions per year does my plan cover?
- Do I have a co-payment and, if so, how much is it?
- What is the coverage amount for out-of-network providers?
- Is preapproval required from my primary care physician?

For clients who choose to self-pay WITHOUT applying for out-of-network reimbursement, you have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the law, health care providers need to give clients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises.

Please initial one:

_____ I will NOT be utilizing any healthcare benefits.

_____ I would like a Good Faith Estimate.

_____ I will be applying for out-of-network reimbursement and do NOT require a Good Faith Estimate.

Signature below certifies the Client/Responsible Party understands these policies:

_____

Printed Name of Client Date

_____

Signature of Client/Responsible Party Date