Worthington Psychological Associates
Dr. Lisa McCarthy, PSY.D
Felicia Maxwell, LISW-S
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An association of Independent Practitioners
5884 North High Street
Worthington, Ohio 43085
Telephone (614)888-1800 ~Fax (614)888-9664

Dear Client:

Please be aware of our policy for cancelling or missing appointments. If you need to cancel, please do so at least 24 hours in advance. Neglecting to cancel with sufficient notice will result in a charge to your account. Failing to call or show up will also result in a fee charged to your account. The fee is $69.00. The fee must be paid prior to your next appointment.
By signing this, you are acknowledging that you have read and understood this fee agreement. Thank you.

Client Name_____

Signature_____

Date_____

Witness_____

Worthington Psychological Associates

Client Information Sheet

For Staff Use:	Checklist:
Insurance Type:	All intake data complete_____
PPO HMO	All signatures obtained_____
	Copied insurance card_____
DX Code: _____	HIPPA_____

Initial Information **Today's Date: _____**

Please make sure that all information is complete before your session begins. If we do not have your information, we cannot bill your insurance company._____

Client Name: _____

First Middle Last

Street Address: _____

City: _____State:_____Zip:_____

Home Phone: _____ Work Phone _____ Cellular_____

E-Mail_____

DOB _____ Age_____ Sex:_____ Social Security#_____

Employer/School_____ Occupation/Grade_____

Marital Status (of client) _____ Spouse's Name_____

Parent(s)/Guardian(s) (if client is a minor):

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Home Phone: _____ Home Phone:_____

Cell Phone: _____ Cell Phone:_____

Relationship to client_____ Relationship to client_____

Employer_____ Employer_____

Employer Phone:_____ Employer Phone:_____

Responsible Party Information: If the client is not financially responsible for payment of services, please complete the following information concerning the responsible party.
****** RESPONSIBLE PARTY MUST BE PRESENT IN ORDER TO FILL OUT AND SIGN ADDITIONAL FORMS; OTHERWISE, BILLS WILL GO DIRECTLY TO CLIENT.

Responsible Party First Name:_____ Last Name_____

Street Address:_____City:_____State:_____Zip:_____

Social Security Number:_____ Birthdate:_____

Relationship to Client: Parent(s)_____Guardian_____ Spouse_____ Other_____

Home Phone: _____ Work Phone:_____ Cell Phone:_____

If we need to contact you, messages can be left at (check all that apply):

_____Home voice mail/answering machine _____Cell Phone voice mail _____

_____Work voice mail/answering machine _____E-mail (please provide)_____

Primary Insurance

*You must complete this section if the subscriber is someone other than the client.

Primary Insurance Company Name: _____

Identification number on the Card: _____

Group Number (if applicable): _____

Subscriber's Name: _____ _____ _____
(person who holds the policy) First Middle Last

Subscriber's Social Security Number: _____

Subscriber's Street Address: _____

City:_____ State:_____ Zip:_____

Subscriber's phone:_____ Clients relationship to Subscriber_____

Subscriber's Birthdate:_____ Subscriber's Sex: _____

Subscriber's Employer:_____ Subscriber's Work Phone:_____

Authorization Number:_____

FEE POLICY

The Person Responsible for Payment of Account is required to sign this fee policy. Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company, unless, as is often the case, our providers are in contract with the managed care insurance companies. The client/patient is only responsible for their co-fee as defined in their insurance plans.

The Person Responsible for Payment (as noted in the Payment Contract for Services) will be financially responsible for payment of provider fees. The Person Responsible for Payment of Account is financially responsible for paying all fees not paid by insurance companies or third party payers after 60 days, except in cases when your provider has/have contract(s) with the managed care corporation that administers your plan. Any payments owed by the client/patient and not received after 90 days are subjected to collections. A $10 per month charge is added to the account for any balances over 60 days that remain unpaid.

Insurance deductibles and co-payments are due at time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (i.e. If there were previous visits to another mental health provider since January of the current year that was prior to the first session at Worthington Psychological Associates), this amount will be collected until the deductible payment is verified

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors may be denied non-emergency services unless charges have been pre authorized to an approved credit plan, charge card or payment at the time of service.

Missed appointments and cancellations made less than 24 hours prior to the appointment are charged a fee of $69. There is normally no charge for phone consultations with clients and with other professionals if such phone contacts are 15 minutes or less in duration. Calls exceeding 15 minutes will be prorated at the clinician's standard hourly rate of $150. *Insurance does not cover phone consultations.*

Payment methods include check, cash, visa and MasterCard.

These forms must be completed during a scheduled appointment.
Family and Medical Leave Act (FMLA) form: No Charge
Disability Forms: No Charge
FEES: These are not covered by insurance.
Letters: $ 25 and up
Returned check fee: $50

I (we) have read, understand and agree with the provisions of the financial Policy.

Signature of Person Responsible for Payment Account Date

Signature of Co-responsible Party Date

Worthington Psychological Associates

This is to acknowledge my receipt of the Worthington Psychological Associates *Notice of Privacy Practices* on the date below.

_____ _____

Date Signature of Patient or Personal Representative

_____ _____

Witness Patient's Name (please print)

_____ _____

Name of Personal Representative (if applicable) Description of Representative's Authority to Act for Patient (e.g. Legal Guardian)

Statement of Understanding Confidentiality

Confidentiality is one of the essential elements of the counseling relationships. Your clinician is committed to maintaining confidentiality except in cases where intervention is a professional or legal mandate, including the following:

1. Any threat to harm yourself or others, including murder, suicide and assault.
2. Any report of actual or suspected child abuse, endangerment or neglect.
3. Any reports, actual or suspected, of abuse of the elderly.
4. Clinician is court ordered to testify.

Your clinician may discuss cases with other professional colleagues, without use of names, as deemed necessary.

For adults receiving services:
I have read, understood, and agree with the limits of confidentiality. I hereby give my consent for treatment.

If the patient is a minor, the parent or guardian should sign this statement:
I have read, understood, and agree with the limits of confidentiality. I hereby give my consent as a parent or guardian for the following individual to receive treatment.

_____ _____

Clients Name (please print) Clients Signature

_____

Parent or Guardian (please Print)

_____ _____

Parent or Guardian Signature Date

Release of Information Authorization in Third Party

I (we) authorize Worthington Psychological Associates to disclose case records (diagnosis, case notes, psychologist reports, testing results, or other requested materials) to the third party payer or insurance company listed on the "initial Information" form, for the purpose of receiving payment reimbursement directly to our clinical providers.

I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to the persons whose employment is to determine payment and or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice.

_____ /_____ _____
Signature(s) of Person(s) responsible for payment Name(s) of Person(s) responsible for payment Date

_____ /_____ _____
Signature(s) of Person(s) receiving services Name (s) of Person(s) receiving services Date

_____ /_____ _____
Signature(s) of Parent(s) or Guardian(s) Name(s) of Parent(s) or Guardian(s) Date

Dr. Lisa McCarthy, PSY.D
Consent for Treatment

For adults receiving services:

I hear by give my consent to receive treatment and related services from the designated professional(s) providing services to me at Worthington Psychological Associates, LLC. I understand that this consent is for the duration of the services to be provided.

_____
Clients name (please print)

_____ _____
Clients Signature Date

If patient is a minor, the parent or guardian should sign this statement:
I hereby give my consent as a parent or guardian for the following individual to receive treatment and related services from the designated professional(s) providing services at Worthington Psychological Associates, LLC. I understand that this consent is for the duration of the services to be provided.

_____
Clients Name (please print)

_____
Parent or Guardian (please Print)

_____ _____
Parent or Guardian Signature Date