Jacquelyn J. Bradbard, MSW, LCSW

Today's Date:______________________________ Email:____

Client Last Name:__________________________ First Name:__________________________ Middle Name: ___________

Client Address:____________________________ City:____________________ State:_____ Zip Code:_______________

Client Home #: (_____)_____-__________ Client Work #:(_____)______-__________ Client Cell #:(_____)______-_________

Okay to contact or leave message at: Email? Y__ N__ Home? Y__ N__ Work? Y__ N__ Cell? Y__ N__

Referred by:____

Primary Care Physician:______________________ Phone No.:(_____)______-_____________

Gender: M__ F__ Age: _____ Client DOB: __ __ / __ __ /__ __ __ __ Client Marital Status:_______________________

Name of Spouse/Partner: ____ Primary Language: _________________________

Client Driver's License: State:_______ Number:____________________

What type of counseling are you seeking? Adult Individual _____ Child/Adolescent Individual_____ Couples____ Family_____

Ethnicity: ________________________ Religion/Spiritual Views: ____

Are you taking any medication? If yes, please list. ____

Reason for medication: ____

Have you been hospitalized for physical or mental illness? Y__ N__ If yes, when? ______________________________________

Please provide details: ____

Any history of mental illness in your family? If yes, who/what? ____

Previous therapy/counseling? Y__ N__ If yes, name/phone of Therapist: ____

Do you smoke? Y__ N__ How much? ___________________ Drink alcohol? Y__ N__ How much? ________________________

Take drugs? Y__ N__ If yes, what kind? ____________________________ How much/how often? _________________________

FINANCIAL RESPONSIBLE PARTY INFORMATION

Relationship To Client:_______________________________

Last Name:_______________ First Name:_______________

Street Address:______________________________________

City:__________________ State:______ Zip:_____________

Home Telephone Number:(_______)_________-___________

Driver's License State & No.__________ _________________

Social Security No.: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

DOB: __ __ / __ __ / __ __ __ __

Employer's Name: ___________________________________

Employer's Street Address:____________________________

City:__________________ State:______ Zip:_____________

Work Telephone No.: (______) _______- ________________

INSURANCE COMPANY INFORMATION

Insurance Co. Name:_________________________________

Street Address:______________________________________

City:_____________________ State:_____ Zip:__________

Insurance Telephone No.:(_______)________-_____________

Subscriber ID No.:___________________________________

Group No.:____

Authorization Number:________________________________

Number Sessions:_____________________________________

Dates of Authorization:_______________________________

LIMITS OF CONFIDENTIALITY:

All information between therapist and client is held strictly confidential. There are legal exceptions to this:

1. The client authorizes a release of information with a signature.
2. The client's mental condition becomes an issue in a lawsuit.
3. The client presents as a physical danger to self, others or property of others (CA EVID 1024; Tarasoff v Regents of University of California, 1967).
4. Child or Elder abuse and/or neglect are suspected (Welfare and Institution and/or Penal Codes).
5. Terrorism (U.S. Patriot Act of 2001).In cases of suspected chid abuse/neglect, elder abuse/neglect and harm to others the therapist is required by law to inform legal authorities and potential victims so that protective measures can be taken.

Initial here _______

RELEASE OF INFORMATION:

I authorize release of information to my Primary Care Physician, other health care providers, institutions and referral sources for the purpose of diagnosis, treatment, consultation and professional communication I further authorize the release of information to my health plan/insurance carrier for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan insurance carrier. In addition I consent to electronic communication (email) with my therapist and electronic claims filing to my insurance company via Office Ally (if applicable). **Initial here**___________

EMERGENCY ACCESS:

In case of an emergency, your therapist may not be available after business hours (8am -5pm) to handle emergencies. If you are in imminent danger, call 911 or go to your nearest emergency room. By calling my office number after hours, you will be reminded to do so.

Initial here:________

FINANCIAL TERMS: Insurance Coverage, Co-payments and Statements:

You are responsible for obtaining prior authorization for treatment from your insurance carrier. We will bill your insurance. However, you are responsible for co-payment amounts and deductibles as set by your benefit plan. I bill as a courtesy. The contract for insurance is between you, your employer and the insurance carrier, not our office. Thus, final responsibility for all incurred charges is the client's. I understand and accept full financial responsibility for all charges incurred by my dependents or myself. Clients are personally responsible for all payment of fees, including those not paid by their insurance carrier within 120 days after the rendering of services.

Initial here:_______

ASSIGNMENT OF BENEFITS:

I authorize my insurance carrier to directly pay Jacquelyn J. Bradbard, LCSW.

Initial here:_______

OFFICE POLICIES:

A therapy hour is 50 minutes in length. Additional time or services will be billed in 15 minute increments (including phone communications beyond 15 minutes, court attendance and/or report/letter writing).

At any time during treatment should I become ineligible for insurance coverage, I will notify my clinician and I understand I will be responsible for 100% of the bill.

Missed or late cancelled appointments (less than 24 hours notice) are not covered by your insurance and the charges associated with them are your responsibility. Co-payment and annual deductible amounts are set by your benefit plan. **These payments are due and payable at each appointment.**

Your expected co-payment per session is: $_______

Your expected out-of-pocket payment is: $_______

Initial here:_______

COLLECTION POLICY:

My office retains a professional collection agency for pursuit of accounts that become delinquent. If it becomes necessary to transfer your account to our collection agency, your financial records will be released to them and your delinquent balance will be recorded with the 3 major credit bureaus, i.e., Trans Union, Equifax and Experian. If legal proceedings become necessary, the patient hereby agrees to bear all financial responsibility for all attorney and court costs associated with collecting an unpaid debt. Please be aware that we take this action only as a last resort.

Initial here:_______

CANCELLATION AND MISSED APPOINTMENTS POLICY:

Scheduled appointment times are reserved especially for you. If an appointment is missed or canceled with less than 24 hours notice, you will be charged the full fee. Frequent cancellations and no-shows may result in the termination of your treatment. Keeping appointments and active participation in treatment is vital. I understand that I am responsible for payment of any services and any not paid by my health insurance company including charges for missed or cancelled appointments.

Initial here:_______

APPEALS AND GRIEVANCES:

I acknowledge my right to request reconsideration (an Appeal) in the case that outpatient care is not certified by my Managed Care Company. I understand that I would request an Appeal directly through my Managed Care Organization.

I also understand that I may submit a Grievance to my practitioner at any time to register a complaint about my care or I may send the complaint directly to my insurance company. My practitioner has access to information to facilitate this.

I understand that the California Department of Managed HealthCare (DMHC) is responsible for regulating health care services. The California DMHC has a toll-free telephone number (800-400-0815) to receive complaints regarding health care plans. If I have a grievance about an appeal that has not been satisfactorily resolved by the plan, I can contact the Managed Care Company or the DHMC.

Initial here:_______

CONSENT FOR TREATMENT:

I authorize and request that Jacquelyn J. Bradbard, LCSW provide psychological assessments, treatment and/or diagnostic procedures, which now, or during the course of my treatment become advisable. I understand the purpose of these procedures will be discussed between me and my therapist and that they are subject to my agreement. I understand that the frequency and type of treatment will be decided between me and my therapist and in accordance with my insurance health benefits coverage (if applicable). I also understand that that while the course of my treatment is designed to be helpful, my therapist can make no guarantees about the outcome of my treatment. Further, psychotherapy can bring up uncomfortable feelings and reactions such as anxiety, sadness and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my therapist and myself.

Initial here:_______

_______________________________________ _______________

Client/Guardian Signature Date

_______________________________________ _______________

Therapist/Witness Signature as needed Date

If you desire a copy of this document, please inform your therapist.

Jacquelyn J. Bradbard, MSW, LCSW

GENERAL CONSENT FOR CHILD OR DEPENDENT TREATMENT

I am the legal guardian or legal representative of the dependent client and on the client's behalf legally authorize Jacquelyn J. Bradbard, LCSW to deliver mental health care services to the dependent client. I also understand that all policies described in the previous three pages of the registration form also apply to the dependent client I represent.

______________________________ ______________________________

Client Name Client Social Security Number

______________________________ ______________ ______________

Signature of Legal Guardian/Legal Representative #1 Relationship to Client Date

______________________________ ______________ ______________

Signature of Legal Guardian/Legal Representative #2 Relationship to Client Date

Regarding Clients of Divorced Parents

As recommended by the California Board of Psychology, when one parent of a dependent child seeks psychiatric or psychological treatment, clarification in writing is requested regarding the presenting parent's ability to individually authorize the delivery of psychiatric/psychological services.

Thus, your therapist requests a copy of the legal papers permitting the presenting parent to seek psychological/ medical services without the consent of the other parent. If such documentation cannot be presented, the second parent will also need to sign a consent for treatment. Thank you in advance for your kind understanding and compliance.

Jacquelyn J. Bradbard, MSW, LCSW

Notification and Acknowledgement of

Notice of Privacy Practices Regarding Protected Health Information

Our 2-page Notice of Privacy Practices provides detailed information about how we may use and disclose protected health information about you. As a client, you have a right to a copy of that document/Notice. You may obtain a copy of the Notice from your therapist:

Your therapist reserves the right to change the Notice, and if changes are made, you may obtain a copy of the revised Notice from her.

Please acknowledge your receipt of this notification by signing below. Thank you.

____ _______________

Client/Guardian Signature Date

____ _______________

Therapist/Witness Signature as needed Date

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