STEVEN KATKIN AND ASSOCIATES, INC.

All Matter Discussed Is Confidential Except As Required By Law, As In Cases Of Abuse Or In Cases Of Declared Intention Of Harm To Others Or Self.

Patient Information

Patient's Name: ____ SSN: _____-____-_____ Date of Birth____________

If 18 years or older

Address: ______________________________________ City: ___________________ State: ____ Zip: ____________

Home Phone: _____________________________________ Cell: ____

Employer: ___________________________________ Work Phone: ____

Marital Status: (Select one) Married Single Separated Divorced Widowed

If this Patient is a child, please indicate with whom the child resides: Mother Father Both Other ______

Custodial Parent/Guardian: ____

If you are not the parent or guardian, we will require a "Permission to Treat" form to be completed by the custodial parent.

Who referred you to us? ____

Insurance Information

Policy Holder's Relationship to patient: (Select one) Self Spouse Parent Step Parent

Policy Holder's Name: _________________________________SSN_____-____-_____ Date of Birth____________

Address: _____________________________________ City: _______________________ State: ____ Zip: __________

Phone: ____________________________________ Employer: ____

If you are using an Employee Assistance Program (EAP), please provide the following:

Authorization #: ________________________________ Number of visits authorized: _____________

Phone Number you called to obtain this authorization: _______________________________________

WE REQUIRE A COPY OF YOUR INSURANCE CARD TO BILL FOR SERVICES

Insurance billing is provided as a courtesy; however, you are responsible for all charges from the date the service is rendered. All co-pays and deductibles are to be paid at the time of service unless prior arrangements have been made. Clients will be charged a Late Cancellation Fee of $75.00 for any appointments cancelled without 24 hours' notice.

I have read the above information. I understand that regardless of insurance status, I am ultimately responsible for the balance of my account.

Signature: ____ **Date:** _________________________

STEVEN KATKIN AND ASSOCIATES
5720 A Signal Hill Court   Milford, Ohio 45150

Authorization for Communication

I am not required to provide explanations for my requested forms of communication as listed below:

Please contact me using the following phone number(s): 1.____________________ 2. ____________________

Please follow these directions when calling (if any): ____

Emergency Contact: ____________________________ Relationship: __________ Phone: ________________

If this office should need to contact me via mail or email, I instruct them to use the following addresses:

Mail: ____________________________________

____________________________________ Email: ____

____

Please *do not send* correspondence to the address: ____

- [ ] I understand that a copy of my Rights and Responsibilities is available to me both in the office and online at www.katkintherapy.com

- [ ] I understand that a brief version of the Privacy Practices of Katkin and Associates is also available to me both in the office and online at www.katkintherapy.com

____ ___________

Signature of client or legal representative Date

STEVEN KATKIN AND ASSOCIATES, INC.

Informed Consent for Treatment

I ____ (Or Parent/Guardian) agree and consent to participation in mental health services offered by Steven Katkin and Associates, Inc. As a client, I understand that I am consenting and agreeing only to those services that my provider is qualified to provide within: (1) the scope of the provider's license, certification and training; or (2) the scope of the license, certification and training of those mental health providers directly supervising the services received by the patient. If the patient is under the age of eighteen, I attest that I have legal custody of this child and am therefore able to give consent for and initiate treatment.

____ ________________

Signature of Patient or Legal Guardian Date

Relationship to Patient (Select One) Self Mother Father Other:____________________

Patient Care Communication Form/Release of Information

I hereby authorize my provider(s) within **Steven Katkin and Associates, Inc.** to release the following information to: _____________________________ _________________ _________________

Doctor's Name Phone Number Fax Number

(Please check all that apply)

_____ Any applicable mental health information.
_____ Any applicable substance abuse information.
_____ Only medical information.

I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. If I do not revoke this authorization, it will expire one (1) year after I have terminated treatment.

____ _______________

Signature Date

Notice to recipient of information: This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation 42 CFR Part 2 prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2.

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HEALTH QUESTIONNAIRE

Please List Any Allergies: ____

____

____

____

____

Medications you are currently taking: ____

____

____

____

____

Medical Conditions/Disorders: ____

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FINANCIAL AGREEMENT/CONTRACT

Between you and your therapist at Steven Katkin and Associates, Inc.

Your appointment is reserved for you and/or your family. If you do not show up for this appointment or you do not cancel within 24 hours in advance, this appointment time often cannot be filled. Therefore, you will be responsible for payment of the Late Cancellation/No Show charge of $75.00.

We provide insurance billing as a courtesy, but the overall account remains your responsibility. We strongly encourage you to contact your insurance company prior to, or shortly after your first visit to assure that you fully understand your financial responsibility for these services. We will bill your secondary insurance, providing you present your proof of insurance at the time of service.

All Co-Payments are due at the time of service. If your insurance plan has a deductible, you are required to pay the full amount due for each session at the time of your appointment.

All unpaid balances are due within 30 days. Balances past 90 days will be turned over to a third party collections agency. Steven Katkin and Associates reserves the right to deny services based upon unpaid account balances.

Additional fees will be charged for services rendered outside of the scheduled appointment. This could include, (but is not limited to) telephone contacts with the patient or collateral sources which exceed 10 minutes and paperwork such as forms pertaining to work, disability claims, etc.

Appearances for court or court related activities are billed at the initial rate at $100 per hour which includes travel to and from court. Final fees will vary according to extent of preparation and duration of legal proceedings. Any documentation written for court requiring preparation outside of the scheduled session time will carry a minimum fee of $75.00 per page.

***Please note:* In the event that the patient is a minor, the parent who brings the child to the appointment is responsible for any co pay or deductible due for the appointment, regardless of any legal understanding between the parental parties.**

I understand and agree with the statements and stipulations as listed above.

____

Patient, Guardian of Patient or Legal Representative Date