

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

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 <input type="checkbox"/>										PICA <input type="checkbox"/>		
1. MEDICARE <input type="checkbox"/> (Medicare #) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid #) <input type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID) <input type="checkbox"/>										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"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		
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"/>			7. INSURED'S ADDRESS (No., Street)				
CITY			STATE		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>			CITY		STATE		
ZIP CODE			TELEPHONE (Include Area Code) ()		Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>			ZIP CODE		TELEPHONE (Include Area Code) ()		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER				
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO			a. INSURED'S DATE OF BIRTH MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>		
b. OTHER INSURED'S DATE OF BIRTH MM DD YY					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			b. EMPLOYER'S NAME OR SCHOOL NAME				
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME				
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE			d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>				
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.												
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 _____ DATE _____						
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						17a. _____		17b. NPI _____		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		20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. _____ 3. _____ 2. _____ 4. _____						22. MEDICAID RESUBMISSION CODE _____ ORIGINAL REF. NO. _____		23. PRIOR AUTHORIZATION NUMBER _____				
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 MODIFIER			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1											NPI	
2											NPI	
3											NPI	
4											NPI	
5											NPI	
6											NPI	
25. FEDERAL TAX I.D. NUMBER			SSN EIN <input type="checkbox"/>		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <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.

