Karen K. Bardenstein, Ph.D.
Marilyn Berger, Ed.M., M.A.
12429 Cedar Road, Suite 18
Cleveland Heights, Ohio 44106

CLIENT INFORMATION FORM

Referred by:_____ Today's Date_____

Client Data:
Client's Name_____ Date of Birth_____ Age_____
Address_____ Home Phone_____
City_____ State___ Zip_____ Work Phone_____
E-mail_____ Cell Phone_____

Adults:
Gender: M F Marital Status: S M D W Client's S.S. #_____ Partner/Spouse _____
Name(s) of Child (Children)_____
Current Health Problems_____
Medications Taken_____
Physician_____

Children: (For clients under 18 years of age)
School name_____ Grade_____ Teacher_____
Father's Date of Birth_____ Mother's Date of Birth_____
Father's Work Phone_____ Mother's Work Phone_____
Place of Employment (Father)_____ (Mother)_____
Physician_____ Siblings (Name, Age)_____

Billing Information:
Send bills to: (check one)_____ Self _____ Spouse _____Parent/Guardian
Responsible Party's Name_____ S.S. #_____
Address_____ Home Phone_____
(Street Apt. # City State Zip)
Employer's Name_____ Work Phone_____
Address_____

As a courtesy to our clients, we accept credit cards as a form of payment. If you wish to utilize this payment option, please complete the following information:
Card Type (Please check one): ____ Visa _____ MasterCard ____Discover _____ American Express

Card Number:_____ Exp. Date:_____

3 Digit V-Code number on back of card (or 4 digit number on Front of Card for American Express):_____

The credit card billing address must match billing address above. If it does not, please enter the correct address here:

_____

I hereby declare that all of the information listed above is true, complete and accurate.

X_____/_____
Date_____ Signature of Patient or Responsible Party / PRINT YOUR NAME

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CONSENT TO EVALUATION AND TREATMENT

Psychotherapy is not easily described in general statements. It varies depending on the training of the therapist, the personalities of the therapist and the patient, as well as the particular problems or challenges you may be experiencing and goals you wish to achieve. Many different methods may be used to evaluate and/or deal with the problems or issues you hope to address. It is not like a visit to your medical doctor. Instead, therapy often calls for an active effort on your part, such as working on things at home that have been discussed during the sessions.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. On the other hand, psychotherapy has also been shown to have many benefits, and can often lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees about what you will experience.

The first few sessions will typically involve an evaluation of your needs and circumstances. By the end of the evaluation, you will be presented with a treatment plan to follow if you decide to continue with therapy. Your therapist shall keep you fully informed about the purpose and nature of any evaluation, treatment, or other procedures, and shall provide a truthful, understandable, and reasonably complete account of your condition to you or to those responsible for your care. You should evaluate that information and make your own opinion about the potential benefits of continuing. You should also consider your level of comfort with your therapist. You should ask any questions you have about the therapist's procedures and the proposed treatment plan and discuss them whenever they arise. You have a right to freedom of choice regarding any services provided. If you would prefer a second opinion or would like a referral to another therapist, we will be happy to assist you in making these arrangements at any time. You have the right to revoke your consent to treatment without prejudice unless there is a legal or judicial restraint on that right.

By signing this form, you are giving your consent to evaluation and/or treatment for either yourself or for an individual for whom you have the legal right to provide this consent.

Patient's name_____
(Please print)

Patient's date of birth_____ Social Security No._____

I have read, understood and consent to evaluation/treatment as outlined above.

_____ _____
(Signature of Patient/Parent/Legal Guardian/Legally Authorized Representative) (Date)

Please PRINT your name here_____

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FINANCIAL POLICY

Thank you for choosing us to provide your care. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.
All clients must complete our information and insurance form before seeing the counselor.
CO-PAYMENT OF THE PORTION OF YOUR BILL NOT COVERED BY INSURANCE IS DUE AT THE TIME OF SERVICE.

Regarding Insurance (All insurance is billed under Karen Bardenstein, Ph.D.):
We may accept assignment of insurance benefits. However we do require your co-payment of the bill not covered by insurance to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not parties to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services under medical insurance. If we do not accept assignment of benefits from your insurance company, then we will require the full payment at the time of service by cash, check or credit card and we will be happy to assist you in filing for your insurance benefits.

We may use or disclose protected health insurance (PHI) for treatment, payment and health care operations purposes without your consent under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). However, Ohio Law requires that you provide informed consent regarding the purposes of the services, limits to the services due to legal requirements, relevant costs, reasonable alternatives, your right to refuse or withdraw consent, and the time frame covered by the consent. We also ask for your consent to submit your information for payment purposes, which may include submission of claims to third party payors, for collection purposes, including providing claims information to the Ohio Department of Insurance Prompt Payment purposes, and for other uses and disclosures as described on my Notice of Privacy Practices form.

Usual and Customary Rates:
This practice is committed to providing quality treatment for patients and charge standard fees for this area. In most instances, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
If you become involved in legal proceedings that require our participation, you agree to pay for all professional time, including preparation and transportation costs, even if we are called to testify by another party. We will be happy to provide you with a current fee schedule for participation in legal proceedings.

Responsibility for Payment:
Adult patients are responsible for payment at the time of service. For minor patients, the adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an insurance plan, or payment by cash or check at time of service has been verified. You are responsible for all fees which are not paid by your insurance company within 60 days. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option to use legal means to secure payment, including use of a collection agency or pursuing small claims court. Patient/guardian agrees to pay all legal and collection costs.
This practice accepts payments via credit/debit card. You agree to pay by credit card by completing the credit card payment section on the CLIENT INFORMATION FORM. If you have agreed to pay for services and/or insurance co-pays via credit card, you agree and give authorization for the card given to be used for any and all outstanding fees due. Further, you also authorize your credit card company to accept and to charge to your account for all future sessions. Your authorization also permits this practice to retain and continue to use your credit card information and this authorization shall remain in full force and affect unless you revoke such authorization in writing.

Missed Appointments:
Unless canceled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit.
Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. You have a right to revoke this consent at any time in writing. That revocation will be binding unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

I have read the Financial Policy. I understand, agree to the terms and give my consent to this Financial Policy.

X_____/_____ Date_____
Signature of Patient or Responsible Party / PRINT YOUR NAME

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HEALTH INSURANCE DATA SHEET

Please fill out this sheet as completely as possible. Contact your health insurer(s) for information which you don't have and supply it to us as soon as possible.

PRIMARY INSURANCE COMPANY NAME: _____

_____

Street Address City State Zip Code Phone #

_____

Policy Holder Name: First Middle Last

_____

Policy or Certificate # Group # Plan # Plan Name

Policy Holder Data: Sex: Male □ Female □ Date of Birth: _____/_____/_____

Client's Relationship to Policy Holder: Self □ Spouse □ Child □

Does this insurer require any evaluation or treatment to be certified or authorized in advance? Yes □ No □
If pre-certification or preauthorization is required, please complete the information below.

Name of Authorizing or Certifying Party_____
Street Address_____

If you have another health insurance policy, please complete this section so that we may bill it for any fees not covered by your primary health insurance.

SECONDARY INSURANCE COMPANY NAME:_____

_____

Street Address City State Zip Code Phone #

_____2_____

Policy Holder Name: First Middle Last

_____

Policy or Certificate # Group # Plan # Plan Name

RELEASE OF INFORMATION: I AUTHORIZE KAREN K. BARDENSTEIN, PH.D. TO RELEASE THE MINIMALLY NECESSARY PROTECTED HEALTH INSURANCE INFORMATION THAT IS PERTINENT TO AND REQUIRED FOR THE PURPOSE OF FILING CLAIMS ON MY BEHALF WITH MY THIRD-PARTY CARRIER OR ITS LEGAL REPRESENTATIVE. I UNDERSTAND THE INFORMATION OBTAINED BY THIS AUTHORIZATION WILL BE USED TO DETERMINE ELIGIBILITY FOR BENEFITS UNDER MY INSURANCE COVERAGE. NO INFORMATION WILL BE RELEASED EXCEPT TO PERSONS OR ORGANIZATIONS PERFORMING BUSINESS OR LEGAL SERVICES IN CONNECTION WITH THE CLAIM OR CLAIMS SUBMITTED BY THE ABOVE PRACTITIONER OR AS MAY BE OTHERWISE LAWFULLY REQUIRED OR AS I MAY FURTHER AUTHORIZE. I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME IN WRITING, AND THAT MY REVOCATION WILL BE BINDING UNLESS ACTION HAS BEEN TAKEN IN RELIANCE ON IT; IF THERE ARE OBLIGATIONS IMPOSED BY MY HEALTH INSURER IN ORDER TO PROCESS OR SUBSTANTIATE CLAIMS MADE UNDER MY POLICY; OR IF I HAVE NOT SATISFIED ANY FINANCIAL OBLIGATIONS I HAVE INCURRED.

I have read, understood, consent to and agree to the above terms.
Insured's Signature_____ Date_____

I authorize that payment of medical benefits be made to Karen K. Bardenstein, Ph.D.
Insured's Signature_____ Date_____

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OFFICE POLICIES

The Office Policy statement is designed to acquaint you with our current office policies. We are always willing to listen to unusual circumstances and discuss our office policies with you.

CONFIDENTIALITY:

Normally, we do not communicate with anyone or send any records about our clients without their written authorization to release the information. There are some situation, however, in which we are permitted – or even legally required – to disclose information without your consent. A complete description of the exceptions to confidentiality is available in our Notice of Privacy Practices.

1. **We may use or disclose protected health information (PHI) for treatment, payment, and health care operations purposes without your consent under the Health Insurance Portability and Accountability act of 1996 (HIPAA). However, Ohio Law requires that you provide informed consent regarding the purposes of the services, limits to the services due to legal requirements, relevant costs, reasonable alternatives, your right to withdraw or refuse consent, and the time frame covered by the consent. We also ask for your consent to submit your information for payment purposes, which may include submission of claims to third party payors for collections purposes, including providing claims information to the Ohio Department of Insurance Prompt Payment purposes, and for other uses and disclosures as described in my Notice of Privacy Practices form.**

2. **We may be required to disclose protected health information if we receive a court order, if we receive a request from a government agency, or in order to defend ourselves against a complaint or lawsuit.**

3. **The privilege if confidentiality does not apply when you are being evaluated for a third party or in situations in which the evaluation is court ordered. If this is the case, you will be notified in advance.**

4. **If you waive the privilege of confidentiality in order to allow your counselor to present information about you in a legal proceeding (i.e., divorce personal injury lawsuit, child custody, etc.), you may not be able to reclaim it to prevent other confidential information from being disclosed.**

5. **In certain circumstances, we are legally obligated or permitted to take actions we believe are necessary to protect you or others from harm. We may have to reveal protected information in the process. These types of situations can include: (1) a person who poses a clear and substantial risk of imminent serious harm to him/herself or another person; (2) in Ohio, in most instances, suspected child abuse; (3) elder abuse or abuse involving a mentally retarded/developmentally disabled person; (4) a person filing a Worker's Compensation claim; and (5) suspected domestic abuse and/or violence, for which we are required to make a note in our records.**

6. **Parents or guardians of minors are entitled, in most instances, to information communicated by their children in counseling unless a court order blocks such access. Of course, all actions taken under these provisions will be discussed with you fully and in advance, whenever possible.**

FEES:

A. **Our standard fee for a 50 minute session is $150.00. The initial session constitutes a clinical interview and is billed at $175.00. Payment is expected at the time of service, unless other arrangements are made. As a rule, the fee remains constant over the course of treatment. If it becomes necessary for us to raise our fees, we would inform you about three months in advance.**

B. **A charge of $35.00 will be assessed on all returned checks.**

C. This practice accepts payments via credit/debit card. You agree to pay by credit card by completing the credit card payment section on the CLIENT INFORMATION FORM. If you have agreed to pay for services and/or insurance co-pays via credit card, you agree and give authorization for the card given to be used for any and all outstanding fees due. Further, you also authorize your credit card company to accept and to charge to your account for all future sessions.

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Your authorization also permits this practice to retain and continue to use your credit card information and this authorization shall remain in full force and affect unless you revoke such authorization in writing.

I. Under unusual circumstances, payment arrangements may be altered during the course of treatment. Please feel free to discuss these issues if the need arises.

II. Psychological testing is usually offered at additional cost. A psychological evaluation is billed at $150.00 per hour; billed time includes administering the tests, scoring, and any requested report writing. School or home observations, school conferences, and phone conferences may be requested; these services will be billed at $150.00 per hour, including any required travel time.

III. You are responsible for all fees which are not paid by your insurance within 60 days. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option to use legal means to secure payment, including use of a collection agency or going through small claims court. If legal action is necessary, its costs will be included in the claim.

OTHER MATTERS:

When I am not personally available to answer the telephone, your call will be transferred to voice mail. In the event of an emergency, you may page me at 216-707-7244. Enter the pager number: 33104, followed by the telephone number at which you can be reached, followed by the # sign. One of my colleagues or I will return the call as soon as possible. For non-emergency calls, we will contact you as soon as we can. Excessive, odd-hour calls are subject to fees comparable to office visits. Please let us know if you have any difficulty contacting us.

_____ _____

Date

I have read and understood this document, and I consent and agree to the office policies and terms outlines above. (Your signature is required on the above.)

_____

_____

Please print your name here.

Thank you.

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