For Office Use Only Appt Date/Time: _____ Therapist: _____

CLIENT INFORMATION

First _____ Middle _____ Last _____

Address _____ City _____ State _____ Zip _____

Phone - Cell _____ Phone – Home _____ Email _____
Ok to Call and Leave Message (Y or N) _____ OK to Call and Leave Message (Y or N) _____

DOB _____ SS# _____ Marital Status _____
(S - Single, M - Married, P - Partnered, W - Widowed, D - Divorced, SP - Separated)

Gender _____ What Pronoun Do You Prefer _____ Employer _____

Emergency Contact _____ Relationship to Patient _____

*Phone - Cell*_____ Phone - *Home*_____
Ok to Call and Leave Message (Y or N) _____ Ok to Call and Leave Message (Y or N) _____

RESPONSIBLE PARTY

Name: First _____ Middle _____ Last _____

Address _____ City _____ State _____ Zip _____

Phone _____ DOB _____ SS# _____

INSURANCE INFORMATION

Insurance Carrier _____ ID# _____ Group # _____

Primary Person on the Policy _____ DOB _____

Include images of a drivers license/photo ID and the front and back of your insurance card

PRIMARY CARE PHYSICIAN: _____ Phone: _____

REASON SEEKING THERAPY: _____

REFERRAL INFORMATION

Individual/organization who referred you to this practice/therapist _____

Phone _____

I am aware this office is HIPAA compliant and have ☐ received or ☐ declined a copy of the Practice Privacy Statement _____
Initial here

My signature indicates that I am in agreement with providing the above information.

_____ _____
Client / Guardian of Legal Equivalent if Minor Date

I allow Antone F. Feo, PhD & Associates, Inc. to have my email address for billing statements and scheduling reminders from Schedulicity.com. I understand I am not to depend on these reminders, that they are being sent as a courtesy, and if a reminder is not received it is not an excuse for not keeping an appointment. The use of emails is NOT for the canceling/rescheduling of appointments. Please do not reply to reminder emails. Canceling / Rescheduling of appointments must be done by phone.

Please complete, save and email this form to afeo1755@gmail.com

Antone F. Feo, Ph.D. & Associates, Inc.
OFFICE PROCEDURES

(440) 899-1300 (phone)

Thank you for choosing Antone F. Feo, Ph.D. & Associates, Inc. We are dedicated to assisting you with your concerns and promoting your personal growth. To assist in this process the following information is listed for your reference.

1. The office is open Monday through Friday, 8:00 a.m. to 9 p.m., and Saturday 8 a.m. to 4 p.m. We are closed Sundays.

2. The initial interview is charged at $200 a professional hour (60 minutes). Individual psychotherapy sessions are $180 a professional hour (60 minutes) and family sessions are $130 a professional hour.

3. ***We require your payment at the time of service*** and accept check, cash, VISA, MasterCard, Discover, and American Express for payments; however, there is a $10 minimum when charging. There is a $30 fee for all returned checks.

4. We complete and file all insurance claims for primary insurance. ***While we extend this service as a courtesy, you are ultimately responsible for the account.*** **In the event of specific custody regarding minor children, the individual signing this Office Procedure is ultimately responsible for the account.** In the case of blended families, custody paperwork *must* be brought in at the initial visit.

5. If you need to contact the practice after hours call 440.899.1300 to leave a message, including your phone number. In the case of an ***emergency***, go to the nearest emergency room or leave a message on the voice mail at 440.864.4798. We will return calls at the earliest possible time.

6. We require 24 hours notice if you must cancel or reschedule an appointment. Cancellations that **occur less than 24 hours of the appointment time may be charged a $50 Late Cancel Fee. If an appointment is missed without the courtesy of a phone call, we charge $100 for the No Show Fee. These charges are not covered by insurance and will need to be paid prior to your next appointment.** If an appointment can be rescheduled within the week of the missed appointment, the fee may be waived.

7. Payment in full is required before ***any*** psychological report will be sent out from this office. Also, there is a fee for letters written, correspondence sent, and/or copying of files based on the work involved and at the discretion of the counselor. All fees must be paid in advance.

8. It is the responsibility of the client, or the client's parent/guardian, to keep the office updated with correct insurance information. Failure to do so could result in the client, or client's parent/guardian, being totally financially responsible for all services provided.

9. In most cases there are no fees when utilizing **EAP (Employee Assistance Program)** benefits.

STATEMENT OF CONFIDENTIALITY

Any and all information and/or records that we have about you are kept in strictest confidence. Your confidentiality is protected by law and by standards of good practice. Under normal circumstances, we can release information about you only if you have completed, signed and dated authorization documents. Law and standards of good practice allow us to disclose information without your authorization under the following circumstances:

- You are a risk to yourself or other(s).
- We suspect child/elder abuse or neglect.
- Medical personnel request information during a medical emergency.

- Disclosure is required under court order.
- You commit a crime against a staff member or property of our practice.

POSSIBLE RISKS OF TREATMENT

As a consumer of psychotherapy you may experience some level of anxiety, depression, somatic concern, or other discomfort. If any of these symptoms present themselves, please discuss them with your therapist.

TREATMENT OF ADULTS UNABLE TO EXERCISE RATIONAL JUDGMENT OR GIVE INFORMED CONSENT

Since this is an outpatient, private practice facility without case management resources, it would be unusual for an individual who is unable to exercise rational judgment or give informed consent to be seen. If such occasion should arise, the clinician would first attempt to contact the individual's emergency contact person after obtaining a release of information. If unable to accomplish this, the appropriate emergency resources would be contacted – mental health emergency or 911.

If an established client presents with a life-threatening emergency, the clinician will call 911 and stay with the client until the emergency is resolved.

TREATMENT OF MINORS

Minor children are not seen at this facility without the written consent of their parent or guardian. When an appointment is scheduled it is determined that a parent/guardian must accompany the child/adolescent for the first visit to give written consent. **In the event of specific custody regarding minors, the individual signing this Office Procedure is ultimately responsible for the account.** In the case of blended families, custody paperwork ***must*** be brought in at the initial visit. Clinicians actively encourage ongoing involvement of parents or guardians in the treatment of minor children and adolescents. ***Children should not be left unattended in the waiting room*.**

INDEPENDENT CONTRACTORS

There are several independent contractors working at the site of AFF. As an independent contractor, she/he is not associated or affiliated with AFF. If AFF refers patients to an independent contractor within this office or another professional outside this office, AFF is not responsible for the professional services that are provided.

AUTHORIZATION TO FILE INSURANCE/FINANCIAL RESPONSIBILITY STATEMENT

I hereby authorize said assignee to release only information necessary to secure the insurance payment. I hereby assign all medical benefits, including any major medical benefits to which I am entitled including Medicare, private insurance, and any other health plans to: Antone F. Feo, Ph.D. and Associates, Inc. This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my insurance.

I have read and understand all the above information.

Signature _____ Date _____

Circle if Parent or Guardian of minor child

_____

Please print name

NOTE: Digitally "sign" this form by typing in the text boxes where indicated. You can also print the blank form to manually sign it. Once complete, save a copy to your computer and email it to our office at: afeo1755@gmail.com. Please also print a copy for your records.

ANTONE F. FEO, PH.D. & ASSOCIATES, INC.

(440) 899.1300

Patient Rights and Responsibilities Policy

The provider and office staff acknowledges and adheres to the following patient Rights and Responsibilities as related to the patient's care.

PATIENT RIGHTS

- Patients have the right to quality services, appropriate to their health care needs, which are delivered in a timely manner.
- Patients have the right to appropriate Medically Necessary medical care.
- Patients have the right to reasonable access to medical care.
- Patients have the right to confidentiality in regard to medical and social history, individual medical records and medical information.
- Patients have the right to be treated with dignity, respect and consideration.
- Patients have the right to be informed about personal health as it concerns medical conditions, diagnostic tests and treatment plans.
- Patients have the right to change physicians/providers.
- Patients have the right to a second opinion.
- Patients have the right to involvement in decision-making concerning treatment.
- Patients have the right to refuse participation in research. Human experimentation affecting care or treatment shall be performed only with a patient's informed consent.
- Patients have the right to auditory and visual privacy during a visit.
- Patients have the right to approve or refuse the release of information except when the release is required by law.
- Patients have the right to refuse treatment or therapy. Such persons will be made aware of the consequences of their decision and it will be documented in their medical record.
- Patients have the right to create Advance Directives, which let providers, and others know the persons' wishes concerning medical treatment.
- Patients have the right to assert complaints and grievances about the providers and the health care provided.
- Patients have the right to be informed about the role of medical students/supervised practitioners and the right to refuse such care.

PATIENT RESPONSIBILITIES

- To become informed about their insurance plan including benefits available.
- To become knowledgeable of the system to access medical care.
- To keep all scheduled appointments and to notify the provider when unable to keep a scheduled appointment.
- To be on time for all scheduled appointments
- To follow all medically appropriate physician orders and prescriptions.
- To treat all personnel with courtesy and respect.
- To provide complete health status information for accurate diagnosis and appropriate treatment.
- To always call your PCP before receiving Urgent Care and, when possible, Emergency Care.
- To notify your PCP when you receive Emergency care within twenty-four (24) hours, or as soon as possible.
- Regarding couples counseling, both individuals hold privilege, dual signatures are required.

Signature Date

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Print Forms Email Forms