BETHEL OLENTANGY PSYCHOLOGICAL SERVICES
An Association of Independent Practitioners
4949 Olentangy River Road Columbus, OH 43214Phone:
(614) 451-6606 / Text: (614) 450-2927
admin@bethelolentangy.com

Client Information

To Our Clients:
Welcome to our office. Enclosed you will find information regarding fees, billing practices, office policies, and other procedures. If you have additional questions or concerns that are not addressed within this packet, pleaseask your therapist or the administrative staff.

Appointments and Fees: *(*Fee is per appointment)*

First 1 to 3 appointments, Intake (53-60 minutes)_____	$ 290.00	
Established Patient, Individual (53-60 minutes - insurance claims)_____	$ 250.00	
Established Patient, Individual (38-52 minutes)_____	$ 190.00	
Family or couples therapy (45 minutes)_____	$ 205.00	
Established Patient, Individual (16-37 minutes)_____	$ 125.00	
Missed appointments (see Cancellation Policy)_____	$ 190.00	
Psychological Testing (per 45-minute session)_____	$ 205.00	
(Fees are based on time spent in administration, scoring, interpretation, and write-up time.)	$ 6.00	/minute
Assessment forms for evaluations (forms priced up to)_____	$ 15.00	/form
Phone calls or emails longer than 5 minutes (to client or family)_____	$ 5.00	/minute
Phone calls or emails for any court-related matters_____	$ 7.00	/minute
Letters, formal reports, travel time for "out-of-office" services _____	$ 7.00	/minute
Testifying in court, depositions and court-related work including travel time_____	$ 400.00	/hour
(Payable in full in advance including if subpoenaed, or called by another party)		
Executive coaching, consulting, mediation (not billable to insurance)_____	$ 270.00	

Billing:

- Payment is expected at the time of services rendered. A valid form of payment on file is required for all patients.
- Our office verifies insurance benefits and bills insurance companies as a courtesy to the client. Benefit verification is not a guarantee of coverage or reimbursement. It is ultimately the client's responsibility toknow their policy and for payment in full for any portion of services that insurance does not cover.
- Please note that there is a $45 service charge for all returned checks.

Cancellation Policy:

- 24-hour notice/one business day is required for appointment cancellations. Cancellations given with less than 24-hour noticeand no-shows for appointments are subject to a fee of $190 (not billable to insurance).
- Monday appointments must be cancelled by noon on Friday and appointments scheduled for the day after aholiday must be cancelled by noon the previous business day

_____ _____ **INITIALS OF BOTH PARTIES** indicating policy/procedure agreement

After Business Hours/Emergencies:

- Voicemails left after business hours, on the weekends or during holidays will be returned the followingbusiness day.
- For situations that cannot wait until the office reopens, phone numbers for on-call psychologists are providedin the office voicemail message.
- If the situation is life threatening call 911 or proceed to the nearest emergency room.

Confidentiality:

- Information disclosed during therapy sessions is confidential and will not be released without the client's permission.Exceptions to this include the following:
  - The client is actively suicidal.
  - The client is threatening to harm another person.

  In these instances, the therapist is legally bound to protect the client and other parties and thereforeconfidentiality may have to be broken.
- Treatment information will be released to the client's insurance company in order to pay for services rendered.
- Confidentiality for teenagers and children will be discussed to clarify their rights and the rights of the parents.
- Confidentiality for couples and families can be discussed with the therapist.
- A General Release of Information form may be signed for the therapist to communicate with other familymembers, medical professionals or other persons of the clients choosing.

Health Insurance Portability and Accountability Act (HIPAA):

This office practices and complies with all policies and procedures occurring under the HIPPA guidelines. Acopy of the HIPPA policies is available to the client upon request.

Ethics and Professional Standards:

As psychologists licensed by the State of Ohio and as members of the Ohio and the American PsychologicalAssociations, we agree to abide by and uphold the most responsible ethical and professional standards possible. We accept responsibility for the consequences of our acts and make every effort to protect the welfare of our clients and to ensure that our services are used appropriately.

Release of Liability:

The client releases the therapist from liability of their psychological counseling/care within one week of amissed appointment or upon canceling an appointment without rescheduling.

Returning Clients:

- Clients absent from therapy for longer than 3 months are considered a returning client and will be billed as anew client.
- Clients absent from therapy for longer than 1 years' time will need to complete updated paperwork.
- Clients with existing balances wanting to return to the practice will not be able to schedule until payment ismade in full.

_____ _____ **INITIALS OF BOTH PARTIES** indicating policy/procedure agreement

Patient Information For Both Parties

Patient Name _____ Date of Birth _____

Home Address _____ City _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

Email Address _____ Employer _____

Emergency Contact _____ Relationship _____

Home Address _____ City _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

Patient Name _____ Date of Birth _____

Home Address _____ City _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

Email Address _____ Employer _____

Emergency Contact _____ Relationship _____

Home Address _____ City _____ Zip _____

Cell Phone _____ Home Phone _____ Work Phone _____

By signing below, I agree to the following:

- ✓ *I have read, understand and agree to the office policies and procedures of Bethel Olentangy Psychological Services as outlined above.*
- ✓ *I acknowledge and understand that the treating psychologist as an independent contractor is solely and legally responsible for my treatment and care.*
- ✓ *I have read or received a copy of the HIPAA Notice Form.*

Both Parties Sign Below:

Patient Signature _____ Date _____

Patient Signature _____ Date _____

Professional Referrals:

Our office sends Thank You cards for referrals from professional sources (other medical professionals etc.). Please indicate below who referred you to our office and if you consent to sending that referral source a ThankYou card.

Whom may we thank for referring you to our office? _____

May we contact them with a thank you note? YES ☐ NO ☐

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Presenting Concerns Questionnaire

Patient Name: _____ Patient DOB: _____
(*Please Print)*

Please read this checklist and select the items that are of concern to you.

☐	Depression	☐	Parental alcohol/drug use
☐	Suicidal feelings/behavior, Self-harm, or Cutting	☐	Childhood physical abuse or Sexual abuse
☐	Anxiety, Fears, or Worries	☐	Domestic violence or Intimate partner violence
☐	Physical stress (Headaches, Stomach pains, Muscle tension)	☐	Physical attack (Mugged, beaten up, Shot, Stabbed, Threatened with a weapon)
☐	Sleep problems	☐	Emotional abuse in past or present relationship
☐	Body image concern	☐	Sexual violence (Unwanted sexual experience, Rape, sexually assaulted, Abused by intimate partner)
☐	Irritable, Angry, or Hostile feelings	☐	Military combat or War zone experiences
☐	Self-esteem or Self-confidence	☐	Learned that self or loved one was diagnosed with a threatening/chronic illness
☐	Loneliness or Homesickness	☐	Gay/Lesbian/Bisexual/Transgender concerns
☐	Compulsions (e.g. Collecting things, Cleaning, Shopping, Gambling, Porn, Internet, Sexual)	☐	Experiencing Discrimination
☐	Alcohol or Drug abuse	☐	Racial identity concerns
☐	Shyness or Being assertive	☐	Decision about career or academic future
☐	General interpersonal problem	☐	Legal issues
☐	Relationship with friend/roommate	☐	Family of origin issue
☐	Relationship with romantic partner	☐	Work stress
☐	Loss of significant person or Grief	☐	Procrastination or Getting motivated
☐	Ended relationship or Divorce	☐	Test anxiety, Speech or Performance anxiety
☐	Sexual issue	☐	Specific issue to discuss with therapist
☐	Weight management issues or Eating disorder	☐	Emotional eating
☐	Relationship with parents/family	☐	Other:

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Please list medications below for both parties:

MEDICATIONS

Name: _____ Patient DOB: _____

Please include all medications you are currently taking.

Medication Name	Medication Dosage	Medication Frequency

MEDICATIONS

Name: _____ Patient DOB: _____

Please include all medications you are currently taking.

Medication Name	Medication Dosage	Medication Frequency

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COMMUNICATION POLICY

Please indicate the ways in which the office may reach you:

Email:

Yes ☐ No ☐

Text messages via administrative texting number:

Yes ☐ No ☐

***Automated appointment reminders via text message:**

Yes ☐ No ☐

Name of cell phone carrier (VZW, AT&T, etc) _____

**Text reminders are sent as a courtesy. The client is ultimately responsible for knowing when their appointment is.*

- Clients may choose to communicate with the office by phone, email, or text. Confidential voicemail and HIPAA compliant email are available, so let us know if that is something that you want to utilize, otherwise the electronic communications will be in an unencrypted format. The confidentiality of electronic communications which are not encrypted cannot be guaranteed, and you acknowledge the possible lack of confidentiality when any of these methods are used and agrees to accept the risks involved.

- If you only wish to use **encrypted electronic communications**, please initial here: _____

- Psychologists and office staff do not connect or communicate with clients on any form of social media. This keeps clear and appropriate boundaries within the therapeutic relationship during therapy and afterwards, should the client decide to return to treatment at some point in the future.

Patient Name _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(if applicable)

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INSURANCE

Choose one of the following options below:

1. ☐ **I choose to self-pay for each session and NOT send claims insurance:**

If you choose to not have your therapist, send information to your insurance company, you must select this option before each session and then pay for the session in full. With this option no report of any information will be made toyour insurance company about that session. Although insurance companies say that they maintain confidentiality, oftentimes they report information to a national data bank that may later affect your ability to obtain other types of insurance.

2. ☐ **I choose to use insurance for each session. I have read and understand the following information:**

Because your therapist is a licensed mental health therapist, many health insurance plans will help you pay for therapyand other services he or she offers. Because health insurance is written by many different companies, your therapist cannot tell you what your plan covers. Please read your plan's booklet under coverage for "Outpatient Psychotherapy"or under "Treatment of Mental and Nervous Conditions." Or call your employer's benefits office to find out what you need to know. If your health insurance pays part of your therapist's fee, the practice will help you with your insurance claim forms. However, please keep some things in mind: Your therapist had no role in deciding what your insurance covers. Your employer or you (if you have individual coverage) decided which, if any, services will be covered and how much you must pay. You are responsible for checking your insurance coverage, deductibles, payment rates, copayments, and so forth. Your insurance contract is between you and your insurance company; it is not between your therapist and theinsurance company unless he or she or the practice has signed a separate agreement with that company. You are responsible for paying the fees that are agreed upon. If you ask the practice to bill a separated spouse, a relative, or an insurance company and payment is not received on time, then you agree to pay this amount. In addition, the plan may have rules, limits, and procedures that should be discussed, and your therapist may not be on one of their panels. Please bring your health insurance plan's description of services to one of the early meetings with your therapist, so that you can talk about it and decide what to do. The practice will provide information about you to your insurance company with your consent, and by signing below you agree that it may do that. If the practice or your therapist has a contract with your insurance company, then billing will be sent in accordance with the contract with that company. If your therapist or the practice is not contracted with that insurance company then you will be supplied with an invoice for your therapist's services with the standard diagnostic and procedure codes for billing purposes, the times you met, the charges, and your payments. You can usethis to apply for reimbursement. By signing this form, you agree to assign any reimbursement you receive from your insurance company to the practice.

Policy Information

Please provide the following information so the office can send claims to your insurance company:

Insurance Company:_____

Name of Policy Holder:_____ Policy Holder Date of Birth:_____

ID Number:_____Group Number:_____

If you are NOT the policy holder and you want to utilize your insurance, permission is given to this office to discuss insurance matters with the policy holder, and to send claims to the insurance company. Information available to thepolicy holder could include dates of service, diagnosis codes, and names of providers.

Patient Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____
(if applicable)

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Informed Consent to *Telehealth* (i.e., Videoconferencing) Services

1. I understand that I must be a new or established client receiving services at Bethel Olentangy Psychological Services (BOPS) inorder to be considered for telehealth sessions. BOPS will conduct initial assessments via videoconference only when the therapist decides that it is appropriate for the patient.

2. I understand that BOPS is making use of telehealth sessions to address the needs for service, and to protect both patients and staff during possible quarantines and/or safety concerns related to Coronavirus. I understand that face to face sessions will resume on a regular basis once the Coronavirus is resolved. I understand that there are potential benefits and risks of telehealth and video-conferencing (eg limits to patient confidentiality) that differ from in-person sessions.

3. I understand that, in order to participate in telehealth sessions, I will need access to a secure, reliable internet connection on a computer or mobile device in a private setting. I will be responsible for making sure that the camera and microphone on my device are accessible to the doxy.me platform used for telehealth sessions. I know that I can request a "set-up" trial with my therapist to be sure the technology works prior to my scheduled session.

4. I understand that, in order to participate in a telehealth session, I must be physically located in the state of Ohio at the time of the session.

5. I understand that it will be my responsibility to assure privacy for myself during the session, and to inform my therapist of a) my location, b) any other persons in the room with me during a session, and c) a way that I can be reached by my therapist if we lose the internet connection. I understand that my therapist will be conferencing with me from a private room and will maintain my confidentiality.

6. I understand, in the event of technology failure during session, my therapist and I might have to revert to a telephone session.

7. I understand that my therapist may choose not to offer telehealth sessions with me, or to cease conducting such sessions, if the therapist deems such sessions to be inappropriate for my circumstances for any reason.

8. I understand that typical session fees, as listed in the general BOPS Informed Consent to Treatment document, will apply to telehealth sessions. If I am using insurance to pay for sessions, claims will be submitted to my insurance company as usual. Every attempt will be made to assure in advance that my insurance company will reimburse for telehealth sessions, but in the event that my insurance company subsequently denies the claims, I understand that I will be responsible for the fees myself. I understand that I must have a credit card on file in advance of a telehealth session.

9. I understand that all other elements of the general BOPS Informed Consent to Treatment document still apply, in addition to these specifications for telehealth sessions.

Patient Name: _____

Legal Guardian Name (if applicable) and relationship to patient: _____

Patient home address: _____

Emergency Contact name and phone number: _____

Address and Phone Number of Nearest Police Department to Residence: _____

Address and Phone Number of Nearest Emergency Services to Residence: _____

I understand that if I might hurt myself or others, or feel that telehealth is no longer meeting my needs, I will either discuss this with my therapist immediately, or I will go to the nearest Emergency Room and/or call the police department to be transported to the Emergency Room.

Client Name Printed: _____

Client or Parent/Guardian (if applicable) Signature: _____

Date: _____

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Patient Name:_____ Patient Date of Birth:_____

The ***cardholder*** agrees to the use of the credit card number (listed below) for fees associated with appointments for the above-named client at the office of Bethel Olentangy Psychological Services. The cardholder understands this may include fees for missed appointments and other fees that are not billable to insurance. This agreement is binding until written notice canceling the agreement is received by the office. Termination will not be effective for previously incurred charges. If there are any changes in the information below, I agree to update the practice immediately.

If Applicable:
I am responsible for_____% of my child's medical expenses. I agree to keep my portion of any medical expenses for my child up to date. I agree that if the other parent involved in my child's medical care defaults on their portion of the expenses accrued at this office, I will be held responsible, and this card may be charged. I understand that Bethel Olentangy Psychological Services requires payment up front for services rendered.

Credit Card Information					
Card Type:	Visa ☐	Mastercard ☐	Discover ☐	American Express ☐	HSA ☐
Credit Card Number:				Expires:	
Name of Cardholder:				CVV Code:	

_____ _____
Cardholder Signature Date

_____ _____
Patient Signature Date
(If applicable and if patient is not the cardholder)

FOR OFFICE USE ONLY
Clinician:
Form reviewed by office staff:
Patient is under 18: