Susan M. Pittenger, Psy.D.
675 Sierra Rose, Suite 102
Reno, Nevada 89511
(775) 432-6399 775-455-4499 (Fax)

PATIENT INTAKE PACKAGE: ADULT

NAME OF PATIENT:_____ M or F

Social Security #: _____ -____ - _____Date of Birth:_____ /____ /____

Mailing Address:_____ City:_____ State:____ Zip:_____

Street Address:_____ City:_____ State:____ Zip:_____

Phone: (Home)_____ (Cell) _____ (Business)_____

Employer: _____ Messages OK? Home: Yes or No Cell: Yes or No

E-Mail:_____ Referred by: _____

Emergency Contact Name: _____

Relationship:_____ Phone: _____

NAME OF PERSON RESPONSIBLE FOR PAYMENT:_____

Address:_____ City:_____ State:____ Zip:_____

Date of Birth:_____ /____ /____ Phone:_____

PRIMARY INSURANCE:_____ Policy:_____

Insurance Address:_____ Phone:_____

Insured's Name: _____ Phone:_____

Social Security #: _____ -____ - _____Date of Birth:_____ /____ /____

SECONDARY INSURANCE:_____Policy:_____

Insurance Address:_____ Phone:_____

Insured's Name: _____ Phone:_____

Social Security #: _____ -____ - _____Date of Birth:_____ /____ /____

HEALTH INSURANCE PAYMENT AUTHORIZATION (Please initial):

_____ I authorize my provider to release any medical or other information required by my insurance company and billing service that is necessary to process this claim. I understand that I am responsible for the full amount of billed services, including any amount not paid by insurance.

_____ I authorize payment of behavioral health benefits to my provider for services rendered.

_____ _____ _____

Signature Print Name Date

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PROFESSIONAL FEES

Fees are as follows, unless I have a contracted rate with your insurance company:

Initial Evaluation $220
Individual, Family, or Couples Psychotherapy $200
Psychological Testing and Report Writing $200 (per hour)

A pro-rated fee may be charged for professional services, such as telephone conversations lasting longer than 5 minutes, consulting with other professionals with your permission, or time spent performing other services.

Unless otherwise stated, it is my policy to avoid being a party to litigation. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am not called to testify by another party.

INSURANCE

As a courtesy service, I bill many major insurance companies. It is important to understand:

1. It may be necessary to release information about your treatment to the insurance company, including a clinical diagnosis, a treatment plan, or a treatment summary. Please be aware that this information will become part of your insurance company's files.
2. Your insurance coverage is a contract between you and the insurance company. My relationship is with you, not your insurance company. Not all services are a covered benefit in all contracts. Any balance that accumulates because of a discrepancy between your payment and the insurance company's is your responsibility. **All charges are your responsibility whether your insurance company pays or not.**
3. It is your responsibility to understand the requirements and coverage of your insurance plan, including determining whether or not your doctor is in-network, if there are referral or pre-certification requirements, and your copayment or deductible responsibilities. If authorization has not been granted, you will be responsible for all charges incurred. If you choose to use your out of network benefits, you will be responsible for the full fee. **Copayments and deductibles are due at the time of each appointment.**
4. Appointments are typically scheduled for 50 minutes, one time per week, or by other agreed upon arrangement. You will be expected to attend each scheduled visit or provide 24 hours advanced notice if you need to cancel. **If you fail to attend without calling or give me less than 24 hours notice you may be charged the full session fee.**
5. **If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, you provide authorization to charge your credit card on file for any outstanding balance.** If you do not provide authorization, I have the option of using legal means to secure payment, including using a collection agency. This will require disclosure of confidential information. You may be held liable for legal and collection charges. I ask for a credit card number to be kept on file in the eventuality that I should need to follow through on the above stated policies.

Card Type: _____ Credit Card #: _____ _____ _____ _____ Exp: ____ / ____ CVV: _____

I have read, understood, and agree to these terms.

_____ _____ _____

Signature of Client or Legal Representative Print Name Date

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THERAPIST-CLIENT SERVICES AGREEMENT

Welcome to the practice of Susan Pittenger, Psy.D. and thank you for choosing me for your behavioral health needs. This agreement contains important information about my professional services and business policies. Please read it carefully. If you have any questions, please feel free to ask.

PHILOSOPHY
I expect to do everything within my professional competencies to be helpful to you. The best gains in therapy are achieved by cooperation between you and your provider. I welcome your active participation in planning therapy and encourage you to ask questions whenever they arise.

PSYCHOLOGICAL SERVICES
In psychotherapy there are many different methods I may use to deal with the particular problems you or your family is experiencing. Psychotherapy is not like a medical doctor visit. Instead, it calls for your active participation. In order for therapy to be most successful, I will expect you to work on therapy goals during sessions and at home.

Psychotherapy can have benefits and risks. There are no guarantees of what you will experience. Since therapy often involves discussing unpleasant aspects of you, and/or your family member's, may experience uncomfortable feelings. On the other hand, psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

During our first few sessions I will evaluate yours and/or family members' needs. By the end of the evaluation, I will offer you some first impressions of what treatment will include. Please consider this information carefully and decide whether or not you feel comfortable working with me. At this point, we can decide if I am the best person to help you meet your treatment goals. If you decide to continue with therapy, we will agree on a treatment plan and discuss this during a feedback visit.

Therapy involves a large commitment of time, money, and energy, so you should choose your therapist carefully. If you have questions about my procedures, please discuss them with me whenever they arise. If at any time you wish to stop treatment, I will be happy to assist with a referral to another qualified professional.

Please note that for adults over age 23, all health care records will be kept for 5 years, in compliance with Nevada State Law and then will be destroyed. For children, records will be kept until age 23, then destroyed.

CONFIDENTIALITY
You have the legal right to have your communication with me kept confidential. In general, I will not reveal what you discuss with me unless you sign an “Authorization for Release of Information” form. In my work with children and adolescents, although the parent or legal guardian holds legal privilege to their child’s healthcare information, therapy is most beneficial if your child is allowed to have a confidential relationship with me. Your therapist will inform you if your child is an imminent, severe, physical danger to him or herself or others. By signing this consent, you agree to your minor child holding privilege over his/her healthcare information and agree to allow your provider to determine when it is appropriate to inform you about the content of your child’s sessions. In order to provide our clients with excellent service, I may consult with other professionals. I will not disclose any identifiable information.

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There are certain exceptions to this general rule of confidentiality.

- *Child Abuse:* If I have reasonable cause to believe that a child has been abused or neglected, I must report this and relevant information within 24 hours to the Nevada Division of Child and Family Services or a law enforcement agency.
- *Adult and Domestic Abuse:* If I have reasonable cause to believe that an older or vulnerable person has been abused, neglected, exploited, or isolated, I must make a report within 24 hours to the local office of the Nevada Department of Human Resources Division of Aging Services or a law enforcement agency.
- *Health Oversight:* If I receive a request from the Nevada Board of Psychological Examiners with respect to an inquiry or complaint about my professional conduct, I must make available any records relevant to such inquiry.
- *Judicial or Administrative Proceedings:* If you are involved in a court proceeding and a request is made for information about the professional services that you have received and/or the records thereof, such information is privileged under state law, I will not release this information without written authorization from you or your legally-appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety :*I may disclose confidential information from your records if I believe such disclosure is necessary to protect you or another person from a clear and substantial risk of imminent, serious harm. I may only disclose such information and to such persons as are consistent with the standards of my profession in addressing such problems.
- *Worker's Compensation:* If you file a worker's compensation claim, and if you receive treatment relevant to that claim, then I must submit to your employer's insurer or a third party administrator, a report on services rendered.

CONTACT INFORMATION
You may call me at 775.432-6399 at any time. I may not be immediately available by telephone. When unavailable, please feel free to leave a confidential voicemail. I will make every effort to return your call within 24 hours or during the next scheduled day, with the exception of holidays, weekends, and vacation days. If you cannot reach your provider in an emergency, call 911 or the Crisis Call Center at 775.784.8090. You may also seek help from the nearest emergency room. If I will be unavailable for an extended period of time, I will provide you with the name of a trusted colleague to contact, if necessary.

CONSENT
I have received and read a copy of the Therapist-Client Services Agreement and the Notice of Privacy Policies and Practices. I understand that this office adheres to the regulations mandated by the Health Insurance Portability and Accountability Act (HIPPA, Title II). I understand these policies and have had an opportunity to discuss any questions I have with my provider. I agree to the fees and services as described and understand confidentiality and limits of confidentiality. I hereby authorize Dr. Pittenger to provide me or my legal dependent with behavioral health services. I also understand that at any time during service, I may withdraw my consent to participate.

Signature of Client or Legal Representative	Print Name	Date