Philip J Fauerbach, LMHC

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Office: (813) 651-1221 Fax (813) 657-0850
Web address: pfauerbachtherapy.com

New Client Packet

For "Couples Therapy,"
Each Person Please Complete a Packet

I invite you to read through the material contained on the website pfauerbachtherapy.com before you proceed. Important information about my policies regarding insurance and my fee schedule is contained on the "New Patient" page on the website. Please be sure to read this if you have not already done so.

After you have read the information on the website, feel free to call me if you have any questions or concerns; or to schedule an appointment at 813-651-1221. Once we schedule I am requesting that you ***print out*** and ***complete*** all the forms in this New Client Packet and ***bring with you*** to the initial session. You may also fax them to (813) 657-0850. By providing these forms to you for completion in advance, it will allow you to complete them at your convenience and comfort without the pressure of filling out forms in the waiting room. (If you cannot print them out, we will arrange for you to come to the initial session 30 minutes early to complete, in the waiting room, copies provided for you.)

I know there are many forms in this packet and it may seem like quite a lot to do. Much of this is required by state and federal law and I must comply with these legal requirements. Some of the other forms are designed to give me the most information possible at the very beginning so I can best understand your concerns and begin assisting. Your time spent providing this information will allow us to spend more time in our initial session talking about your concerns and needs rather than addressing, in detail, each of the questions asked here. Providing this information and bringing it all with you to the initial session helps me focus on ***you*** during that session.

Thank you,

Philip J Fauerbach, MS, LMHC

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Tel: 813-651-1221
Fax: 813-657-0850
philip@pfauerbachtherapy.com

Registration Sheet for Therapy

Date: _____

Patient Name: _____
Last First M.I.

Date of Birth: _____ /_____ /_____ Age: _____ SSN: _____-_____-_____

Gender: **[ ]** Male **[ ]** Female Last School Grade Completed: _____

How do you prefer to be addressed (Name/Nickname)?_____

Single	Married	Partnered	Separated	Divorced	Widowed
□	□	□	□	□	□

Ethnicity:_____ Religion:_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (___) ____-_____ can a message be left at this number?_____yes_____no

Work Phone: (___) ____-_____ can a message be left at this number?_____yes_____no

Mobile Phone: (___) ____-_____ can a message be left at this number?_____yes_____no

Personal Email address: _____

How do you prefer to be contacted? _____

Occupation: _____ Employer: _____

Referred by: _____

In Case of Emergency, Contact:

Name: _____ Relationship: _____

Phone: _____

Medical/Mental Health History Self Report

Current Primary Care Provider: _____ Contact # _____

Psychiatrist: _____ Contact # _____

Please describe any medical problems you have been or currently experiencing, or medical problems you believe I should know about:

Please describe:

_____

_____

_____

Have any family members had any of the following?

	Yes	No	Who
Depression	□	□	_____
Bipolar Disorder	□	□	_____
Suicide or Suicide Attempt	□	□	_____
Eating Disorder	□	□	_____
Anxiety Disorder	□	□	_____
Alcohol/Drug Problems	□	□	_____
ADHD	□	□	_____
Other mental Health issues	□	□	_____
Stomach Problems	□	□	_____

Current Mental Health Medications (including any *over the counter* or *herbal preparations*):

Name of Medication	Dosage	For what reason?	How Long?	Side effects(if any)

Continue on back of this sheet, if needed.

Mental Health Care in the past? (such as psychiatrist, psychologist, social worker, nurse, counselor, or psychological testing)

By Whom?	When?	Diagnosis	Type of Treatment	Were you hospitalized?

How often do you have the following problems?

Problem	Never	Rarely	Frequently	Always
Talking, thinking, and more active than normal; Can't be still or quiet				
Talking, thinking, and less active than normal; Can't do things				
Loss of interest in activities; Hard to have a good time				
Feeling sad or depressed; Feeling like crying				
Wishing I was dead				
Planning ways to kill myself or attempting to kill or harm myself				
Low energy, fatigue				
Trouble making decisions or concentrating				
Feeling worthless or guilty				
Eating and appetite more than normal or gained weight				
Eating and appetite less than normal or lost weight				
Trouble falling/staying asleep or early morning wakening				
Racing heart or chest pain (circle which)				
Lightheadedness, dizziness				
Nausea, vomiting, or diarrhea (circle which)				
Sweating or breathing fast and shallow (circle which)				
Tingling in hands, face, feet				
Hot or cold flashes (circle which)				
Trembling or shaking				
Racing thoughts				
Feeling "I'm going crazy" or losing control (circle which)				
Excessive worrying, fear, dread, feeling out of control				
Dream-like sensations or distortions in vision, hearing, etc.				
Frightening flashbacks to an earlier traumatic event				
Nightmares or frightening dreams (circle which)				
Having lots of aches/pains/physical complaints				
I have to do/say something to prevent bad things from happening				
Frequent, unwanted thoughts or images (circle which)				
Being afraid of certain things such as _____ (fill in blank)				
Mood swings: really down for a time and then really up for a time				
Decreased need for sleep or can't sleep—too wound up				
People telling me "slow down, you are talking too fast"				
Feeling overjoyed with life/ on top of the world/like I can do anything				
Spending or giving away too much money for my financial situation				
Hearing things or voices other people don't hear (circle which)				
Seeing things other people don't see				
Smelling/tasting odd things others don't; things crawling on me				
Feeling that other people are controlling my thoughts				
Being physically or sexually abused (circle which)				
Getting into verbal and physical fights (circle which)				
Thinking about harming others				
Drinking alcohol or using drugs to relax, for pleasure, recreation				

Currently using caffeine? □ Yes □ No If yes, how much, how often_____ If no, past use?_____

Currently using cigarettes? □ Yes □ No If yes, how much, how often_____ If no, past use?_____

Currently using alcohol? □ Yes □ No If yes, how much, how often_____ If no, past use?_____

What is the major reason you are seeking help at this time?

_____

_____

_____

How long have you had these problems or symptoms?

_____

_____

How often do they occur?

_____

Why did you decide to seek help now?

_____

_____

_____

What have you tried, in the past, to help yourself?

_____

_____

_____

Who lives with you at home?

Name of person	Relationship to you	Age	Occupation/School
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____
_____	_____	____	_____

PHILIP J FAUERBACH, MS. LMHC.

CONTACT & EMERGENCY INFORMATION

You are being provided with my contact information that includes my office number **(813-651-1221)** and my cell phone number **(813-759-3278**).

Should you need to contact me between sessions, please leave a message on my confidential voice mail. While I monitor these messages frequently and strive to return calls promptly, I am often not immediately available by telephone. For example, I do not answer any calls when I am with a patient.

I usually return phone calls within 24 if the message is left during normal business hours. Otherwise, I will review and return my messages on the following business day.

If *your call involves a mental health emergency* and I cannot return your call promptly, please go to the nearest emergency room or call 911 immediately and then attempt to contact me again, if needed.

Even the best voice mail systems and attempts to return calls fail at times so please remember that the *emergency room is another resource*.

Please realize that if you are calling with a mental health emergency my response is likely to include use of the local emergency services and the nearest emergency room.

I have carefully read all the terms of the above guidelines and have had an opportunity to discuss any questions.

_____ _____

Signature **Date**

FEE-FOR-SERVICE SCHEDULE* AND PAYMENT AGREEMENT 2013

FINANCIAL AND INSURANCE INFORMATION

* If you have insurance I accept, the insurance rates for my work with you are available from your insurer or you may ask me for them.

PROFESSIONAL FEES

The fee for an initial consultation and any follow-up sessions are due when services are rendered. You may also be charged for additional professional services.. These services include, but are not limited to report writing, telephone conversations that last longer than fifteen (15) minutes, consultations with other professionals that you have authorized and preparation of records and/or treatment summaries. Should you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation for and attendance at these proceedings, even if I am compelled to testify by another party.

ACCOUNT BALANCES

Unless otherwise agreed, fees are due and payable when services are rendered. Cash, credit cards and personal checks are accepted. A $25.00 fee will be assessed for all returned checks. Services will be discontinued if proper payment is not received in a timely fashion.

INSURANCE

It is important for you to evaluate resources available to pay for treatment. If you have a health insurance plan, it will usually provide some coverage for mental health treatment. Please read the section in your insurance coverage booklet that explains mental health benefits and call your plan administrator if you have questions about coverage. At the present time, I am a contracted provider for ***BlueCross/BlueShield*** only. Prior to your appointment, we will contact your insurance company to verify eligibility and benefits. It is your responsibility to pay the full co-pay at the time service is rendered. As a condition for reimbursement, insurance companies require me to provide them with certain information: diagnosis and dates of service. They may also request additional clinical information, including but not limited to treatment plans and/or summaries. This information will become part of the insurance company's file. In such situations, I will only release the minimum information that is necessary to accomplish the stated purpose. Please remember, however, that you have the option to pay for my services personally to avoid having any information released to your insurance company.

Please initial

_____If Philip J Fauerbach, M.S., LMHC, **does not** accept my insurance, I understand that fees are due as stated and are payable *at the beginning of the assessment or evaluation session* (this allows him to focus entirely on my problems, needs, and concerns during the session). I understand that I am responsible for paying my **co-pay** amount at the time the service is rendered. If, after being billed for the services I receive, my insurance company refuses to pay Philip J Fauerbach LMHC, *the amount allowed by them per his contract with them* (because, for example, I have not yet met my insurance deductible.) I agree that I am responsible for payment of any difference to make up that allowed amount.

_____ When you schedule an appointment with me, I am reserving that time exclusively for you. **If you need to cancel an appointment, please let me know at least two business days (48 hours) in advance**. Understanding this, I agree to accept financial responsibility for any missed appointment/"no show" and I understand that my insurance company will not be billed for nor will they reimburse me for missed appointments. **Late cancellations or "no show" will result in your being charged for a full session.**

_____I understand and agree that fees for services provided me by Philip J Fauerbach, MS., LMHC. are due and payable when services are rendered.

***Payment in the form of cash, personal check, debit or credit card is accepted at the time services are rendered unless I accept your insurance in which case you will need to pay your co-pay portion at the time of service. If I accept your insurance I will file the claim for the portion beyond your co-pay. If I do not accept your insurance, I will provide you with the documentation you need to file your own insurance claim. *At this time I am a participant BlueCross/Blue Shields plans* and, if I am not a participant in yours at the time I see you, your insurance plan may consider me "out-of-network." Please contact your insurance company ahead of time to determine if they will reimburse you for any portion of my services.

INFORMED CONSENT

PSYCHOTHERAPY SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychotherapist and the client and the particular problems you are experiencing. There are many different methods that may be used to deal with the problems, you hope to address. Psychotherapy is not like a visit to your medical doctor. To be most beneficial, therapy calls for an active effort on your part both during our sessions and at home. Psychotherapy can have risks and benefits. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. However, 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. But there are no guarantees of what you will experience. Our first few meetings will involve an evaluation of your needs. At the end of this process, we will work together as a team to establish clear goals and formulate a treatment plan. If you have questions about my procedures, I will discuss them with you in detail.

THERAPY SESSIONS

Services are available by appointment. Initial consultations are scheduled for one hour. Thereafter, we will usually meet once a week for a 45-50 minute session. The law protects the privacy of all communications between you and your psychotherapist. In most situations, information about you and your treatment can only be released to others with your written consent. There are, however, limits to confidentiality. Please consult the Notice of Privacy Practices (below) for the requirements of legal disclosure of information about you.

I have read and have understood the above and I hereby **consent** to psychological treatment by Philip J Fauerbach LMHC. I understand that if he is PARTICIPATING in my insurance plan I agree to undertake full responsibility for securing pre-authorization for the services I seek from him and full responsibility for paying for the services I receive if my insurer does not pay for them. I understand that if he is NON-PARTICIPATING in my insurance plan I agree to undertake full responsibility for payment of the fees incurred at the time of the assessment/treatment. I am seeking treatment from Philip J Fauerbach understanding that if he does not accept my insurance I will be given a zero-balance invoice with the necessary billing codes for the type of treatment I receive which I may then submit to my insurance provider for any reimbursements for which I am contractually eligible. If Philip J Fauerbach is "out-of-network" with my insurer and I submit his invoice to my insurer, I understand that there is a possibility that I may receive no insurance reimbursement for this assessment/treatment.

_____ _____

Signature of Patient or Responsible Party **Date**

NOTICE OF PRIVACY PRACTICES

As of April 14, 2003, the federal government requires us to disclose our privacy policies to all patients (HIPAA 04/14/03). This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice that describes the health information privacy practices of Philip J Fauerbach, LMHC. A copy of our current notice will always be available in our office. You will also be able to obtain your own copy by calling our office at (813) 651-1221 or by asking for one at the time of your next visit. If you have any questions about this notice or would like further information, please contact our privacy officer, Philip J Fauerbach, MS, LMHC.

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing you with healthcare. Some examples of protected health information are:

- information indicating you are a patient of our practice;
- information about your health condition (such as diagnosis);
- information about health care products or services you have received or may receive in the future (such as an operation or diagnostic imaging);
- information about your health care benefits under an insurance plan

When combined with:

- demographic information (such as your name, address, insurance status);
- unique numbers that may identify you (such as social security number, phone number, or drivers license number); or
- other types of information that may identify who you are.

REQUIRED PERMISSION TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We will obtain a one-time general written consent (at the end of this Notice of Privacy Practices) to use and disclose your health information in order to treat you, obtain payment for that treatment, and conduct our business operations. This general written consent will be obtained the first time we provide you with treatment or services. This general written consent is a broad permission that does not have to be repeated each time we provide treatment or services to you.

INITIAL_____

NOTICE OF PRIVACY PRACTICES

Notice to Minors. If you are under eighteen years of age, please be aware that your parents have a right to receive general information on the progress of the treatment. Your parents may also request a copy of your record.

Medical Records. We are required to maintain complete treatment records for approximately 7 years after your last clinical contact with Philip J Fauerbach, MS, LMHC. After that time has elapsed, the record will be shredded, burned or otherwise destroyed in a way that protects your privacy.

PATIENT RIGHTS REGARDING PROTECTED HEALTH INFORMATION

Right to Request Restriction You may request limitations on your mental health information we may disclose, but we may not agree with your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Confidential Communication. You may request communication in a certain way or at a certain location, but you must specify in writing how or where you wish to be contacted.

Right to Inspect and Copy You may request the opportunity to inspect and copy your mental health information regarding decisions about your care. **Psychotherapy notes, however, may not be inspected and copied.** Under certain circumstances, your request may be denied. You may request a review of the denial by a licensed mental health professional designated by Philip J Fauerbach, LMHC. We may charge a fee for supplies, copying and mailing.

Right to Amend the Record Your request to change your protected health information must be in writing and provide a reason to support the requested correction. We may deny your request.

Right to Accounting of Disclosures You may request a summary of certain disclosures of your protected health information that have been made within the last six (6) years.

Right to a copy of this Notice At any time, you may request a paper copy of this Notice even if you have agreed to receive the Notice electronically. Philip J Fauerbach, LMHC reserves the right to change the terms of this Notice. Revised policies will be available in the office and on our website.

INITIAL_____

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY AND CONSENT FOR TREATMENT

By signing below, I acknowledge that I have read, initialed each page of, and have been provided a copy of this **Notice of Privacy Practices** and have therefore been advised of how health information about me may be used and disclosed by Philip J Fauerbach, LMHC and how I may obtain this information. Finally, by signing below, I **consent** to the use and disclosure of my health information to treat me and to arrange for my mental health care, to seek and receive (or help me seek/receive) payment for services given to me, and for the business operations of this practice.

_____ _____

Signature of Patient or Patient's Representative **Date**

Upon request you will receive a copy of this document for your records