Peoples Counseling
& Consulting

"Improved relationships with oneself & others"

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Jay Peoples MS, MSW, LCSW

Intake Form

Name

Address

City **State**

Zip code

Cell Phone

Home Phone

Work Phone

Birthday

Social Security #

e-mail

Insured's Name

Address

City **State**

Zip code

Cell Phone

Home Phone

Work Phone

Birthday

Social Security #

e-mail

Primary Insurance Company

Policy # **Group #**

Insured's Name **Insurance Company Phone**

Employed By

Secondary Insurance Company

Policy # **Group #**

Insured's Name **Insurance Company Phone**

Employed By

In Case of Emergency Call

Relationship **Phone #**

FEE AGREEMENT

If you find you cannot keep your appointment, please contact me as soon as possible so that the appointment time can be offered to another client. You will not be charged for canceled sessions if I am given 24 hours notice. Otherwise, you (and not your health plan) will be billed for the session. In the event that you are called away for an emergency or have a sudden illness or an accident, please make every effort to contact me or have someone else contact me as soon as possible. I will be concerned about you and will want to know the circumstances. I will want us to reschedule our appointment as soon as possible.

FEE POLICY and AGREEMENT

My office is committed to providing the most effective and efficient social work treatment and services possible. To do so, I need your understanding of our fee policy and the reasoning behind it, as well as your cooperation.

PAYMENT SCHEDULE

Payment is due at the time of service, unless other arrangements have been approved in advance by me. By having you pay at each session, this eliminates the need to bill you. This helps keep costs as low as possible, prevents the accumulation of large debts on your part, and avoids possible risks to your privacy that may occur when invoices for services are mailed to you. The fee for service is: *Initial Assessment* $200 (Diagnostic Interview Examination, to cover additional setup costs), *One hour session* $150, *50 minute session* $125, *30 minute session* $90. A sliding fee is available to those meeting certain criteria. Please feel free to talk with me regarding this. I encourage you to contact me immediately for assistance if temporary financial problems affect the timely payment of your account.

SERVICES NOT COVERED

Regardless of your third-party payer, some of the services you receive may not be covered under your mental health benefit. Responsibility for the payment of those services rests with you. It is your responsibility to discuss with your insurance provider the benefits of your policy so as to understand what your policy will and will not cover.

MANAGED CARE PROVIDER NETWORKS

I also belong to some managed care providers. These third party payee systems usually require a referral from your primary care physician and or authorization from the networks themselves and a co-payment for each session. Under no circumstances can the co-payment be waived and must be paid at the time of each visit. In this instance, my relationship is with the provider network as well as with you.

EAP PROGRAMS

In addition to my private practice, I also contract with companies to provide assessment and/or brief counseling for their programs. If you are working with me in this capacity, I will discuss the nature of your individual program with you. There is no charge to you for any difference between what I charge and what your program pays me.

PRIVATE PAY ARRANGEMENTS

Payment is due at the time of service, unless other arrangements have been approved in advance by me. By having you pay at each session, this eliminates the need to bill you. This helps keep costs as low as possible, prevents the accumulation of large debts on your part, and avoids possible risks to your privacy that may occur when invoices for services are mailed to you. The fee for service is $_____/session. I encourage you to contact me immediately for assistance if temporary financial problems affect the timely payment of your account.

I have read and understand all of the above information.

Signature _____ **Date** _____

Working AGREEMENT for Individuals/ Couples

I / We, (name of person(s) receiving services), _____

hereby agree to begin service with Jay Peoples, MS, MSW, Licensed Clinical Social Worker in the state of Oregon. I have discussed with him the operating policies and procedures of this practice setting, the role and responsibilities of him as my therapist and the role and responsibilities of me as his client. I understand my rights to receive and refuse services, to privacy and confidentiality, to respectful treatment, to be informed about all aspects of my treatment, to read and amend my clinic record in the event of a misunderstanding between myself and my therapist and to file a grievance if I feel I have been unfairly or unethically treated. I have asked all questions that have occurred to me.
If we mutually decide that, in your best interest, I should provide part of your information to another professional, your insurance company, or even you, you will be asked to sign a specific and time-limited authorization for release of information. You will know exactly what is to be released, to whom, and how the information will be used. There is only one open-ended release I will ask you to sign and that is your permission to provide information about you to my professional back-up colleague in the event that you have an emergency, need to be seen and I cannot be reached.

I would be required by law to reveal confidential information about you without your consent in four circumstances. The first situation would be in learning that you were in serious danger of harming yourself or another person. The second would be if I learned you were abusing or neglecting a child, an elderly person, or a disabled person in your care. The third would be in the event of a court order compelling me to release your record to a court of law. The fourth would be Oregon state law mandating me to report criminal acts.

I understand the purposes of this setting, the service approaches, and methods used, and the qualifications of my social worker. I understand that after my situation is assessed, I, and my therapist will develop a treatment plan and contract.

I understand I will be asked to furnish the name of someone close to me to be contacted in the event of an emergency. I understand that in contacting that person, my therapist will have to identify his relationship to me and my whereabouts and condition. However I am assured that no details of my service will be provided to that person. My contact person is (name, address, and phone number):

Emergency contact person _____ **Relationship** _____

Address _____ **Phone Number** _____

I understand that the relationship between my therapist and me is now and will continue to be in the future solely a professional one and that we will have no shared interests or activities outside my service. I realize that; although therapy is recommended for me and will probably be helpful, there are no guarantees that any or all of my problems will be remedied. I also understand that my therapy involves possible risks as well as benefits. Hence, I may experience difficulties as a result of the therapy process.

I understand that the service will terminate when the goals of the treatment plan that I agree to have been fulfilled. However I also understand that I may end therapy at any time I wish or feel that I need to and that my therapist has these same rights if we do not make progress, our relationship becomes too strained to continue our work, or if I and/or my insurance company are no longer to afford treatment. If this occurs before the goals of my therapeutic plan are completed, I understand that my therapist will do everything in his power to refer me to an alternative source of care. Finally, I understand that any time I have questions about this setting, the evaluation process, or any policy or procedure; I should promptly bring my questions to my therapist. I may request a copy of this agreement.

Signature _____ **Date** _____

Signature _____ **Date** _____

Legally responsible parent or guardian (as required)

Signature _____ **Date** _____

Therapist Signature _____ **Date** _____

By signing, I, Jay Peoples, am indicating that I agree to begin the process of assessment and therapy with

_____,

who, I believe has read and understands the forms and the working agreement I have asked him/her to read and sign. I have discussed the content of all forms with the client and am satisfied, by his/her statements and questions that she/he understands everything that will be involved in the therapy process and ready to begin.

Notice of Privacy Practices

- The client shall have a humane service environment that affords reasonable protection from harm and affords reasonable privacy.
- The client shall be provided services in a setting under conditions that are least restrictive to the person's liberty, that are the least intrusive to the person and that provide for the greatest degree of independence.
- The client shall receive no services without informed voluntary written consent except as permitted by law.
- The client and others of the client's choice shall be afforded the opportunity to participate in the planning and provision of services with the client's consent.
- The client shall have the right to refuse services, including any specific procedure without suffering any punitive consequences.
- The client shall not be involuntarily terminated or transferred from services without prior notice, notification of available sources of necessary continued services and exercise of a grievance procedure.
- The provider shall maintain written policies and procedures with regard to the client's rights that will assure that the client's right to be treated with respect and dignity is safeguarded.
- All providers are required to report incidents of abuse when the provider comes into contact with and has reasonable cause to believe that a client has suffered abuse or committed abuse on another person.
- All providers shall make reasonable modifications in policies, practices, and procedures to avoid discrimination.
- The provider shall comply with the American with Disabilities Act.
- The client shall have the right to file a grievance or complaint, free from retaliation, and receive assistance when needed in submitting either.
- All requests regarding your records, our privacy policies, any of our forms, or copies of any of these for your own purposes must be in writing and will have a $50.00 fee plus postage.
- You have the right to request that we place additional restrictions on our use or disclosure of your medical information. You also have the right to ask us to send your information to an address other than your home.
- You have the right to ask us to change or amend your records in the event there has been a misunderstanding between you and your therapist. We may deny the request depending on the reasons behind the change or for various other reasons. If we deny your request, we will inform you in writing.

My signature below verifies that I have read this *Notice of Privacy Practices* and have received a copy for my records.

Client Signature **Date**

Notice of Privacy Practices

- The client shall have a humane service environment that affords reasonable protection from harm and affords reasonable privacy.
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- You have the right to ask us to change or amend your records in the event there has been a misunderstanding between you and your therapist. We may deny the request depending on the reasons behind the change or for various other reasons. If we deny your request, we will inform you in writing.

My signature below verifies that I have read this *Notice of Privacy Practices* and have received a copy for my records.

Client Signature **Date**

Client Appointment Log

Client Name

Insurance Company

#	DATE	CODE	TIME	CHARGE	PAYMENT	BALANCE	NOTES

CPT Codes

90791 Diagnostic Interview Examination
90832 Individual Psychotherapy 30 min
90834 Individual Psychotherapy 45 min
90837 Individual Psychotherapy 60 min
90839 Crisis Initial 60 min
90840 Crisis add on additional 30 min
90846 Family Psychotherapy w/o patient present
90847 Family Psychotherapy with patient present
90853 Group Psychotherapy
99404 Preventive Counseling (EAP)

Authorization # **on** **from** **to** **# Units**

Authorization # **on** **from** **to** **# Units**

Authorization # **on** **from** **to** **# Units**