PSYCHOTHERAPY ASSOCIATES • NEW PATIENT INFORMATION

To help us meet your needs, please fill out this form completely.
If you have questions or need assistance, please ask and we will be happy to help.

____/_____/____
Today's Date

Patient Information

Name

☐ Male ☐ Female
(binary gender selection for insurance purposes only)

____/_____/____
Date of Birth

Address | City | State | Zip

Telephone, Home
May we leave a message with whomever answers? ☐ Yes ☐ No
May we leave a voicemail message? ☐ Yes ☐ No
Email Address

Telephone, Cell
May we leave a voicemail message? ☐ Yes ☐ No
Social Security #

Telephone, Work
May we leave a message with whomever answers? ☐ Yes ☐ No
May we leave a voicemail message? ☐ Yes ☐ No
☐ Full-time Student
☐ Part-time Student

School/College (if patient is student): | City | State | Zip

Referred By (if applicable) | Primary Care Physician

I ☐ authorize ☐ decline to authorize communication between my psychotherapist and referral source, if appropriate.

I ☐ authorize ☐ decline to authorize communication between my psychotherapist and primary care physician.

Patient Employer | Employer Address

Circle One: Minor Single Married Divorced Separated Widowed

Preferred pronouns: he/him she/her they/them other: _____

Spouse – Parent – Significant Other

☐ Spouse
☐ Parent/Guardian
☐ Other

Name

____/_____/____
Date of Birth

Address | City | State | Zip

Telephone, Home
May we leave a message with whomever answers? ☐ Yes ☐ No
May we leave a voicemail message? ☐ Yes ☐ No
Email Address

Telephone, Cell
May we leave a voicemail message? ☐ Yes ☐ No
Social Security #

Employer | Employer Address

Telephone, Work

May we leave a message with whomever answers? ☐ Yes ☐ No

May we leave a voicemail message? ☐ Yes ☐ No

Person to Contact in Emergency | Telephone

Person Financially Responsible for Patient's Medical Care: ☐ Self ☐ Other (please specify):

Primary Health Insurance

Do you have Medicare? ☐ Yes ☐ No

Do you have Medicaid? ☐ Yes ☐ No

Insurance Company | Name of Insured Individual | Employer

Identification Number | Date of Birth | Social Security Number | Relationship to Patient

Additional Health Insurance

Insurance Company | Name of Insured Individual | Employer

Identification Number | Date of Birth | Social Security Number | Relationship to Patient

Health History

Medication Currently Used:

Name	Dosage	Frequency	Prescribed By:

Sources of Past Mental Health Treatment or Counseling:

Name	Dates

Authorizations and Acknowledgments

- I have received a copy of *Welcome to Psychotherapy Associates* which lists my rights and responsibilities as a patient, including my privacy rights under the Health Information Health Insurance Portability and Accountability Act.

- Assignment of Insurance Benefits: I authorize the release of any information relating to all claims for benefits submitted on behalf of myself or my dependents. My signature on this document authorizes Psychotherapy Associates to submit claims and understand that I will be bound by this signature as though I had personally signed the particular claim. I hereby assign directly to Psychotherapy Associates all benefits otherwise payable to me for services rendered. I understand that any insurance benefits received by Psychotherapy Associates on my behalf will be credited to my account in accordance with the above agreement.

- Authorization to Release Information to Nebraska Medical Assistance Program or Its Designees (if applicable): I authorize the release of confidential information regarding my condition and treatment, or that of my dependent, to Nebraska Medicaid representatives and acknowledge understanding that this is a condition of use of my Medicaid mental health treatment benefits.

- I understand and agree that, regardless of my health insurance coverage, I am responsible for the balance of my account for any professional services rendered.

- **I understand and agree that I may be charged at the discretion of Psychotherapy Associates, for any appointment I do not keep and do not cancel at least 24 hours in advance. I acknowledge that charges for no-show or late-canceled appointments are not covered by health insurance and are my responsibility in full.**

- I understand and agree that failure to pay the balance of my account in a timely manner may result in the release of non-clinical contact and billing information to a collection agency.

- By virtue of providing my e-mail address and/or cellular telephone number, I authorize their use as a means of communication between Psychotherapy Associates and me and acknowledge that Psychotherapy Associates is unable to ensure complete privacy of communication via either means, of via any electronic media through which I communicate with Psychotherapy Associates.

- I authorize the exchange of confidential information regarding my condition and treatment, or that of my dependent, to all Psychotherapy Associates clinicians for the purposes of providing emergency care and treatment continuity.

- Authorization to Treat Minor (if applicable): I authorize treatment of my minor child or ward, named as patient in this document.

- I certify that this information is true and complete to the best of my knowledge. I understand that it is my responsibility to notify Psychotherapy Associates of any changes in the above information.

- *See attachment for Telehealth session permission/release.*

Would you like to receive text message reminders the day before your appointment? ☐ Yes ☐ No

Therapist you see: _____

Phone number to receive text message reminders: _____-_____

Cell phone provider_____

_____ _____

Signature Date

PSYCHOTHERAPY ASSOCIATES

CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my health care provider is offering for me to engage in a telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit, primarily due to not being in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions regarding this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE TELEHEALTH BY SimplePractice, Doxy.me, Zoom, telephone, or other appropriate, adequate, and available audio and/or video conferencing service

Telehealth by Doxy.me and/or Zoom are the technology services we will primarily use to conduct most telehealth videoconferencing appointments. It is simple to use and is accessible by computers or smart phones with a webcam and microphone. If Doxy.me and/or Zoom services are unavailable for reasons that deem other telehealth videoconferencing platforms more appropriate, by signing this document, I acknowledge:

1. Telehealth by any videoconferencing service is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the telehealth videoconferencing platform being utilized, no telehealth service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The telehealth videoconferencing service used during my appointment will only facilitate videoconferencing and is not responsible for the delivery of any healthcare, medical advice, or care.
4. I do not assume that my provider has access to any or all of the technical information for the telehealth videoconferencing service – or that such information is current, accurate or up to date.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- that I have read or had this form read and/or had this form explained to me
- that I fully understand its contents including the risks and benefits of the telehealth videoconferencing used during my appointment.
- that I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Patient, Parent, or Authorized Guardian Signature Date