Name (Last) ______________________________ (First) ______________________________ (Middle) ______________
Address: ______________________________ City: ____________________________ State: ____ Zip: ________
Date of Birth: ______________ Soc. Sec#______________________ Gender/Pronouns: ______________________

Race: ________________ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino Preferred Language: ______________
Single: ☐ Married: ☐ Separated: ☐ Divorced: ☐ Widowed: ☐ In a Relationship: ☐

Email Address: ____

Parent/Spouse/Guardian's Name: __________________________
Emergency Contact: ______________________________ Phone:
Primary Care Physician: ______________________________ Phone:

Do You Have Medical Insurance? Yes ☐ No ☐ **(If Yes Please Answer ALL Questions Below)**
Primary Insurance Company____
Member ID #____________________ Group#________________
Does your insurance require authorization prior to the first session? Yes ☐ No ☐ Not Sure ☐
If yes, have you contacted the company? Yes ☐ No ☐
Policy Holder's Name & Relationship____
Policy Holder's Soc. Sec#: Policy Holder's Date of Birth:
Policy Holder's Employer's Name____________________________________ Employer's Phone #
Employer's Address____
Secondary Insurance Co.____
Policy #___________________Group #____________
Policy Holder's Name & Relationship____
Policy Holder's Soc. Sec #: Policy Holder's Date of Birth:
Policy Holder Employers Name: __________________________________ Employer's Phone
Employer's Address____
Responsible Party or Guarantor (if other than patient): ____
Address: ____ Phone:

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature of this document authorizes my physician to submit claims for benefits for services rendered for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I authorize and assign payment of all/any insurance benefits to Angela Hillman, LICSW that is otherwise payable to me for her services as described on the assigned payment forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Angela Hillman, LICSW will be credited to my account in accordance with the above assignment.

_____________________________ ______________________________________ ______________
(Print Name of Client) (Authorized Signature of Client/Parent/Guardian) (Date)

*Note: If the client is under the age of 19, the parent or guardian must sign all legal documents.

Informed Consent

I, ______________________________ (Client/Guardian) hereby give my consent to Angela Hillman, LICSW to provide ______________________________ (Client) with mental health services.

_______ I understand that:

- Angela Hillman, LICSW, will send my medical record information to my insurance company.
- I must pay my share of the costs (e.g., co-pays, amounts until a met deductible, etc.) for mental health services.
- If insurance does not cover mental health services or I am uninsured, I must pay for these services in full.

_______ I understand that:

- I have the right to refuse any treatment.
- I have the right to discuss all treatments with my provider.
- I may be charged for late cancellations or no-show appointments.

_______While I anticipate benefits through treatment, I am aware of unforeseen factors that may hinder my counseling and mental health treatment; I realize that particular results cannot be guaranteed.

_______Counseling and/or mental health treatment may escalate my emotional, mental, or physical conditions and I may experience new stressors during treatment and while attempting to make life changes.

_______If I experience a life-threatening mental health emergency, I am to contact 911 or go to my nearest emergency room. In the event of other emergencies outside of business hours, I am aware that I can contact the crisis line at 800-247-4941.

_______Issues discussed with my clinician will remain confidential, with a few exceptions. There are some special circumstances that limit confidentiality including: a) a statement of intent to harm yourself or others; b) statements indicating harm or abuse of children or vulnerable adults; c) issuance of a subpoena from a court of law; d) when your insurance company is involved; e) when you have signed a Release of Information allowing for your information to be discussed with an identified party.

I know of no reason why I should not or cannot undertake this mental health treatment and agree to participate fully and voluntarily.

Print Client Name: ____ DOB: _________________________

Client/Guardian Signature: _______________________________________ Date Signed: ___________________

*Note: If the client is under the age of 19, the parent or guardian must sign all legal documents.

Extended Billing Policy

The fees for services provided by Angela Hillman, LICSW will be in accordance with the reasonable value set forth by established community guidelines and standards. At the present time, the fee for the first initial 45-minute session, code 90791, is $225, after which the billing rate for a Licensed Independent Mental Health Practitioner provider is $150 per 60-minute individual therapy, code 90837, $120 per 45-minute individual therapy, code 90834, $90 per 30-minute individual session, code 90832, and $175 per 45-minute family therapy session with or without client present, code 90847 and 90846. Copays are the client's responsibility and are required to be paid at the time of service. Clients are also responsible for any deductible, co-insurance and or out of pocket balances remaining after insurance benefits have been applied. Client statements are mailed out on the first of the month. Electronic payment is offered as an option and includes a $5.00 convenience fee. To avoid paying this additional fee, please use cash or check made payable to Angela Hillman, LICSW.

If no payment is received within 30 days of the statement date, a payment will be automatically charged to the client's credit card on file. The client will be notified in advanced of the transaction. If payment is not received for two consecutive sessions, the client may not schedule an appointment until the fees owed are paid in full. Balances that are 90 days past due will begin accruing 1.33% finance charges every 30 days. Angela Hillman, LICSW does offer payment plans to those who need assistance with their balances. Uninsured clients, or self-pay clients are required to pay for services in full at the time of their appointment before they can be seen. Uninsured or self-pay clients are responsible for the first initial session fee of $150, followed by adjusted rates on follow up sessions. Angela Hillman, LICSW reserves the right to delay, defer, or discontinue services for any reason, including if the balance owed is not paid at the time it is due. Angela Hillman, LICSW does reserve the right to forward any unpaid accounts to a collection agency to be recovered.

Clients are required to provide a valid credit card at the time of their first initial session for the office to keep in their file. Once uploaded into our secure system, this information is immediately shredded. This information will be updated yearly or when a card has expired.

I understand that I am liable ultimately for the balance on my account for any services provided by Angela Hillman, LICSW regardless of the status of my insurance situation. With my signature, I agree to adhere to the agency's billing policies and procedures, and to pay any fees that I owe the agency based upon such policies. I hereby authorize direct payment and all benefits due under my insurance policy to Angela Hillman, LICSW for services provided. I authorize the release of medical or other protected health information necessary to process insurance claims.

Card Information Must Be Provided to the Front Office Previous to the Initial Session

Print Client Name: ____ **DOB:** _________________________

Client/Guardian Signature: _______________________________________ **Date Signed:** ____________________

*Note: If the client is under the age of 19, the parent or guardian must sign all legal documents.

Consent to Treat

Authorization for Treatment
I acknowledge that I have been given the opportunity to review the Informed Consent and Patient Rights & Responsibilities. I may obtain a current copy upon request. I understand that Catalyst Behavioral Health has the right to change the Authorization for Treatment at any time.

Acknowledgement of Receipt of Privacy Notice
I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices for Protected Health Information. I may obtain a current copy upon request. I understand that Catalyst Behavioral Health has the right to change the Notice of Privacy Practices at any time.

Office hours and Phone calls
Office staff is available Monday through Thursday, 9am-4pm, and Friday, 9am-12pm to address any questions or concerns. Every effort will be made to return a phone call as soon as possible. If my call is urgent, I will note this with the office staff or when I leave a message on Catalyst Behavioral Health's confidential voicemail.

Appointment No-Show Fee
I have been advised that this office requires a 24-hour prior notice on all appointment cancellations and I have reviewed the Catalyst Behavioral Health Extended Billing Policy. I have been advised that there will be a $50.00 no show fee for appointments that are canceled with less than 24-hour notice. This fee is not covered by any insurance plan and must be paid prior to my next visit. I understand that three no-show/late cancellations in one year may be cause for automatic discharge from the clinic.

Billing Policy/Copayments
I acknowledge that I have been given the opportunity to review the Extended Billing Policy for Angela Hillman, LICSW. I understand that co-pays, if appropriate, must be paid at the time of visit. I understand that I am responsible for all fees not paid by my health insurance. Payment is due 30 days after receipt of statement. I understand Angela Hillman, LICSW does offer financial assistance in the form of payment plans. Uninsured clients or self-pay clients are required to pay for services in full at the time of their appointment before they can be seen. Angela Hillman, LICSW does reserve the right to submit any unpaid balances to a collection agency for recovery. **Clients are now required to provide a valid credit/debit card at the time of their first initial session for the office to keep in their electronic file.** Once uploaded into our secure system, the information is immediately shredded. This information will be updated yearly or when a card has expired. Cards will not be charged without prior notification and opportunity to provide an alternate payment will be offered at that time. Please direct any questions about insurance, billing, and payment plans to Gina Pashby, our office manager.

Print Client Name: ____ DOB: ___________________________

Client/Guardian Signature: ____ Date Signed: _____________________

*Note: If the client is under the age of 19, the parent or guardian must sign all legal documents.

Patient Rights & Responsibilities

As a person receiving mental health services here at Catalyst Behavioral Health, you have the right to:

- Be treated with dignity and respect.
- Ask questions and get answers about services offered here to determine the most appropriate treatment program. You can get information about treatment procedures, costs, and risks. You can request a change in your treatment or services as well.
- Participate fully in decisions regarding your health care services. This includes having your family involved in your treatment with your consent.
- Not to be subject to verbal, physical, sexual, emotional, or financial abuse, harsh, or unfair treatment.
- Make complaints, have them heard, get a prompt response, and not receive any threats or mistreatments as a result. You can file a grievance if you are not satisfied with the response to a complaint.
- Be assisted by an advocate of your choice; for example, family, friend, case manager, member of a consumer advocacy committee, or organization, etc.
- Not to be discriminated against on the basis of race, age, gender, religion, national origin, sexual orientation, disability, or martial status.

All clients, to the extent capable, have the responsibility to:

- Pursue healthy lifestyles. Clients should pursue lifestyles known to promote positive health results, such as proper diet and nutrition, adequate rest, and regular exercise. Simultaneously, they should avoid behaviors known to be detrimental to one's health, such as smoking, excessive alcohol consumption, and drug abuse.
- Actively participate in decisions about their health care and cooperate on mutually accepted courses of treatment. Clients should comply with treatment regimens and regularly report on treatment progress. If serious side effects, complications, or worsening of the condition occur, they should notify their providers promptly. They should also inform providers of other medications and treatments that they pursue simultaneously.

Print Client Name: ____ **DOB:** __________________________

Client/Guardian Signature: ____ **Date Signed:** ____________________

*Note: If the client is under the age of 19, the parent or guardian must sign all legal documents.

NEW CLIENT INTAKE FORM

Name: ______________________ **Age:** ________ **Marital Status:** ______________________

Describe the reason for your appointment today?

Have you seen a counselor previously? If yes, please list dates of treatment:	Yes	No
Have you ever had suicidal ideation or attempts? If yes, list approximate dates and if hospitalization was required	Yes	No
Please list any past or current mental health diagnosis.		
Please list any medications you currently are prescribed.		
Who is your primary care physician?		

CURRENT SYMPTOMS CHECKLIST: (check for any symptoms present)

( ) Depressed mood
( ) Unable to enjoy activities
( ) Issues with sleep
( ) Nightmares
( ) Concentration issues
( ) Change in appetite
( ) Excessive guilt
( ) Increased substance use

( ) Anxiousness
( ) Impulsivity
( ) Increased risky behavior
( ) Increased/Decreased sex drive
( ) Angry outbursts
( ) Excessive energy
( ) Increased irritability
( ) Crying spells

( ) Excessive Worry
( ) Panic attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) Loss of Interest
( ) Fatigue
( ) Intrusive thoughts

What hobbies or leisure activities do you enjoy?

Please describe your support system? (family, friends, church, etc.)

What do you hope to gain through your counseling experience?

Do you drink alcohol? Yes No
If yes, how often? Rare Social Occasions Daily Weekly

Do you have any substance abuse history or concerns? Yes No

Angela Hillman, LICSW
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