ViewPoint
Psychological Services

New Client Information

Client's Full Name: _____ Date: _____
Form completed by (if someone other than client)/relationship: _____
Name of Legal Guardian (if client if a minor under 18): _____
Client's Date of Birth: _____ Client's Age: _____ Gender: ❑ M ❑ F ❑ O
Client's Address: _____
City: _____ State: _____ Zip: _____
Phones: ❑ Cell: _____ ❑ Home: _____ ❑ Work: _____
**Check box(es) to indicate where voice mails can be left.*

Email Address: _____
❑OPT IN to our email subscription for: ❑ Mental Health Tips/Resources ❑ Self-improvement/Self-care ❑ Groups
❑ Wellness/Consulting ❑ Relationships ❑ Parenting Young Children ❑ Parenting Teens/Teen Issues ❑ Other/All

❑Please check box indicating if you DO NOT want text or email reminders about your upcoming appointments.
***IMPORTANT**: DO NOT rely solely on text and/or email reminders. Text and email reminders are being offered as a courtesy only, it is ultimately the client and/or guardians' responsibility to keep track of appointment dates and times.*

Primary Care Physician: _____ Physician's Phone Number: _____

Primary Insured's Information if Using Insurance (if different from client's name)

Full Name: _____ SS#: _____

Relationship: _____ Phone Number: _____ Date of Birth: _____

Address (if different from client's address): _____

Employer: _____ Employer's Phone Number: _____

Employer's Address: _____

Primary Insurance: _____ ID#: _____ Group # _____

I, _____, am hereby providing authorization for the professionals and support staff of Viewpoint Psychological Services to release any required information to the designated insurance company and the listed Primary Care Physician. I understand that I am responsible for any cost not covered by the insurance and for the services I or my dependent receives from this office.

_____ _____
Signature of Client or Legal Guardian Date

ViewPoint
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Practice Policies

Thank you for choosing Viewpoint Psychological Services. We are committed to your treatment being successful.

Please take a few minutes to review the policies of Viewpoint Psychological Services. We have created these policies so that we can maintain consistency and inform clients of various situations at the onset of treatment.

If you have any questions regarding any of the following policies, please see a member of the office staff who will be happy to answer any questions you may have.

Please initial each policy indicating that you have read, understand, and agree to the policy.

_____ MISSED APPOINTMENT/LATE CANCELLATIONS. Your appointment time is reserved exclusively for you. If you fail to show up for a scheduled appointment OR if you do not provide 24 HOURS NOTICE, you will be charged $95 per missed appointment or late cancellation. **Please note: For appointments scheduled for Monday, you must notify the office prior to 5:00 pm on Friday to cancel. Please see the Attendance Agreement on the following page.**

_____ INSURANCE CHANGES. Clients are responsible for monitoring their own insurance benefits, such as co-pays, deductibles, insurance limits, etc. Clients agree to notify Viewpoint whenever there is a change in insurance. If the client fails to do so and the service is not covered, the client assumes all financial responsibility. Payment is due at the time of service. **Please see the Financial Policy and After Hour Appointments Policy on the following pages.**

_____ CONSENT TO PROVIDE TREATMENT. I hereby provide my consent to Viewpoint Psychological Services to provide psychological, counseling, and/or consulting services to me or my dependent. I verify that I have the right to provide such consent. I understand that I can withdraw my consent at any time with the provision of such in writing to the treatment provider(s). This consent will remain in effect until such time as I revoke it. **Please see the Informed Consent & Permission for Treatment on the following pages.**

_____ CHARGES. All clients must maintain an active credit card on file so payments can be charged at the time of service. Please see Credit Card Authorization form for details.

_____ NO SMOKING. We strive to provide a healthy and clean environment for all clients and employees. For this reason, no smoking is permitted within the office, waiting area, parking lot, or outside the building.

_____ CHILD SUPERVISION. I understand that Viewpoint Psychological Services cannot accept responsibility for unattended children. It is the responsibility of the parent/caregiver to arrange for proper supervision. We recommend not bringing children who are not being seen. Note: Parent will be held responsible for any damages that may occur.

_____ TERMINATION OF TREATMENT. Viewpoint Psychological Services maintains the right to terminate treatment for any reason at anytime, including, but not limited to, verbal or physical abuse to any staff or clients of Viewpoint Psychological Services, physical assault or threat to assault any staff or other clients, or refusal to comply with essential treatment recommendations that could result in harm to self or others.

Client/Legal Guardian Signature: I have read each of these polices and I realize that I am responsible for informing and making sure that anyone who accompanies me to the office also complies with these policies. By initialing each policy, I am indicating my agreement to follow them, without deviation. I am also acknowledging that I have been provided with a copy of the privacy policies of Viewpoint Psychological Services.

Client Name (printed): _____ **Client DOB:** _____

Parent/Guardian Name for Minor Client (printed): _____ **Date:** _____

Signature of Client/Guardian Responsible: _____

Relationship to Client (if signing for minor client): _____

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Attendance Policy

Failure to Keep Appointment and Late Cancellation Agreement

Please understand that your specific appointment time is reserved exclusively for you. We regularly have clients on a waiting/cancellation list and we need time to fill open appointments. We ask that if you need to cancel or reschedule your appointment you contact us as soon as you can. We require at least 24 hours notice to cancel an appointment. **If you fail to cancel within 24 hours or fail to keep your appointment, there will be a $95 fee. For appointments scheduled for Monday, you must notify the office prior to 5:00 pm on Friday to cancel.** Our providers are reimbursed based on collection of payment; therefore, they reply on your payment(s) and payments from insurance for their income. The fee serves to offset loss of income.
**This charge will be billed to you directly, not through your insurance company. A $10 per month late fee is assessed on all unpaid balances, including missed appointments and late cancellation fees.*

Payments for missed/late cancelled appointments will be automatically charged to your credit card on file. Payments can be made by calling the office, on our website www.viewpointpsych.com using our convenient "Pay Your Bill Online" link or in person at any one of our three locations.

Please note that after any instance of 2 consecutive missed/late cancelled appointments, no further appointments will be made until the issue is addressed. Excessive missed appointments for any reason may result in termination of services.

By signing below, you are attesting you understand and agree to the attendance agreement.

Client Name (printed): _____ **Client DOB:** _____

Parent/Guardian Name for Minor Client (printed): _____ **Date:** _____

Signature of Client/Guardian Responsible: _____

Relationship to Client (if signing for minor client): _____

Financial Policy

All clients must complete our client information and insurance form (if using insurance) before they see a provider. As a courtesy, we will verify your mental health coverage and bill your insurance company on your behalf. We cannot be held responsible for any inaccurate benefit information that is given to us in any form, whether it be by phone, fax, mail or online.

You are ultimately responsible for the payment of your bill. Your insurance policy is a contract between you and your insurance company and plans vary from one to another.

Regarding Your Insurance Co-Payment

We require your co-payment at the time services are rendered. If the co-payment is not paid at the time of service, a $10 late fee will be assessed. It is your responsibility to know your benefits. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, "usual and customary" charges, etc., other than to supply factual information as necessary. If you receive payment from the insurance company for services rendered by Viewpoint Psychological Services, you must reimburse Viewpoint Psychological Services in full at the time of receipt of such payment. If you have secondary insurance we will provide you with a statement for you to submit to your secondary insurance company. We will not bill your secondary insurance company. The client agrees that if he or she defaults on any balance owed to Viewpoint Psychological Services and it becomes necessary for Viewpoint Psychological Services to engage the services of an attorney, collection agency or other lawful method of collection, the client will pay the original balance owed and reimburse Viewpoint Psychological Services for all cost incurred by the collection of said debt.

Regarding Your Deductible

If you have a deductible and Viewpoint Psychological Services is considered "in network" with your insurance company, we require payment of services at the time of treatment. Because we are in-network with your insurance company, we typically know in advance the "allowed amount" of services rendered. We accept the allowed amount from your insurance company. If you have met your deductible or maximum out of pocket amount, you must bring proof of this from your insurance company to your appointment. If you do not supply this information to Viewpoint Psychological Services, you will be responsible for payment at the time services are rendered. If we are considered "out-of-network" with your insurance company, you are responsible for the full out of pocket amount at the time services are rendered.

Regarding Insurance Billing

We will bill your primary insurance company as a courtesy to you. However, if repeated billing of your insurance company does not satisfy your balance for services rendered, **you will be responsible for payment of your account** and your credit card on file will be charged.

If paying by check you understand and authorize all dishonored checks plus a processing fee with applicable taxes to be charged to your account.

After Hours Appointment Policy

Our normal business hours are from 9:00 A.M. to 5:00 P.M. Monday - Friday. All clients are required to maintain an active credit card on file to be charged appropriate feed, generally billed the next business day after the appointment. If you request a receipt for your payment, it will be emailed or mailed to you the next business day.

Minors – The adult accompanying the minor is responsible for payment. We do not get involved in custody or other financial arrangements between parents. We will provide a receipt so you can collect from another party, if needed.

I have read and agree to the above Financial Policy and After Hour Appointments Policy and understand that regardless of insurance status, I am ultimately responsible for the balance of my account for any professional services rendered by Viewpoint Psychological Services, PLLC.

Client Name (printed): _____ **Client DOB:** _____

Parent/Guardian Name for Minor Client (printed): _____ **Date:** _____

Signature of Client/Guardian Responsible: _____

Relationship to Client (if signing for minor client): _____

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Informed Consent, Confidentiality, and Permission to Treat

I hereby certify that the Viewpoint Psychological Services, PLLC, clinician providing services has informed me of his/her professional qualification, licensures, etc., and I have been provided with an explanation of and a copy of the client's rights and responsibilities. I have been informed of the clinician's assessment, diagnosis and treatment plan. By signing below, I agree to participate in treatment at Viewpoint Psychological Services as it has been explained to me and as recommended by the clinician. I recognize and agree that information concerning my treatment may be shared with other Viewpoint Psychological Services clinicians should such consultation be deemed useful to my treatment.

I also understand that Viewpoint Psychological Services utilizes electronic medical records for communication with the practice and for storage of all medical information. The electronic medical records system used is Theramanager, which meets HIPAA compliance criteria to safeguard protected health information (PHI).

By opting to receive email or text reminders of appointments, I recognize that email is not considered a secure/confidential form of communication. Also, as a patient, if I choose to contact a clinician or support staff via email, I acknowledge and assume the risks associated with non-secure electronic forms of communication and hold Viewpoint harmless for any unintentional breaches related to this communication.

As a patient at Viewpoint Psychological Services, I recognize that my information, including my status as a client, is kept strictly confidential. Identifying information will not be released without my permission and a consent form will be required for the release of specific information. All records will be maintained in a confidential manner. State (Kentucky Revised Status, KRS) and Federal laws may require the release of information without written or verbal consent in the following exceptions to confidentiality:

1. Medical or mental health emergencies
2. Patients who pose a specific danger to themselves (KRS 202A)
3. Patients who pose a danger to the safety of others (in which case, the person who is threatened and the policy must be notified in accordance with KRS 400)
4. Any report of suspected child abuse or neglect (KRS 620)
5. Any report or suspected domestic violence (KRS 209)
6. Any report or suspected abuse, neglect or exploitation of the elderly, or adult with mental illness or who cannot care for themselves (KRS 209)
7. A court order directing specific release of information
8. Any litigation initiated by the patient (or patient's legal guardian) related to treatment

I consent to release any personal or clinical information required to process my claim to my insurance provider. I also authorize any payments made for services made by my insurance provider to be paid directly to Viewpoint Psychological Services.

I understand and agree to the limits of confidentiality as indicated above. I agree to hold Viewpoint Psychological Services, PLLC, harmless for any loss, cost, and/or damages sustained by my spouse, child, or myself. By signing below, I hereby authorize Viewpoint Psychological Services clinicians to assess, diagnose and treat mental health, and/or substance abuse problems. I acknowledge that I have received, read and understand the above and my rights as a patient as well as the privacy practices of Viewpoint Psychological Services. PLLC.

Client Name (printed): _____ **Client DOB:** _____

Parent/Guardian Name for Minor Client (printed): _____ **Date:** _____

Signature of Client/Guardian Responsible: _____

Relationship to Client (if signing for minor client): _____

ViewPoint
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Divorced/Soon to be Divorced/Separated Parent Policy

_____ INITIAL HERE IF THIS DOES NOT APPLY TO CLIENT

The professionals and employees of Viewpoint Psychological Services seek to provide a high quality of care to our clients and their families. Divorce can sometimes complicate the services being provided. The following is our policy regarding Divorced/Soon to be Divorced or Separated Parents:

1. A copy of the custody agreement is required prior to your child's first appointment.
2. Court- related evaluations require a court order.
3. We require that the parent requesting treatment and/or evaluation through our office notify the other parent (birth or adoptive) that treatment is being sought.
4. We ask that both parents schedule an appointment to provide important information regarding the child and to receive periodic treatment updates. Exceptions may be made on an individual basis with legally-bound reasons being provided (ex. potential for danger, etc.). It is the responsibility of the treatment-seeking party to request consent from the other parent. If we are informed that a parent with decision-making rights does not consent to treatment, services will be terminated immediately.
5. Our office does not accept responsibility for seeking payment from the non-treatment seeking parent, regardless of your arrangement. Payment for service is due at the time of service, regardless of the custody arrangement. The following are the options for payment of services:
    a. both parents can sign the New Client Packet in full and divide cost and pay together at the time of service, or
    b. the treatment- seeking parent is responsible for paying for the services and gaining reimbursement from the other party.

    Both options requires that monies due be paid at each appointment, or in advance. We recommend credit cards are kept on file to be charged at each appointment, to reduce conflict around this issue.
6. Viewpoint Psychological Services **does not agree** to keep information provided by one parent from the other parent when you share joint legal custody. Information important to the well-being of the child will be openly shared and discussed as appropriate. Step-parents may be asked to participate in evaluation and treatment, if deemed in the best interest of the child. This is in addition to the limits of the confidentiality policy provided.

I, _____, (parent or legal guardian) have read the divorce policy provided. I understand the policy and agree to its terms and provisions. I provide my consent from the provider(s) to speak to my child(ren)'s other parent and related parties regarding the treatment and/or evaluation provided.

_____ _____
Signature of Parent/ Legal Guardian A Date

_____ _____
Signature of Parent/ Legal Guardian B Date

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Credit Card Authorization Form

Our practice policy is that all clients maintain a valid credit card on file to charge payments at the time of service, especially for any after hour appointments or appointments where minor clients will come alone. Cards on file will be used:

1. To pay any **unpaid charges** that may accrue as a result of having a deductible, co-payment, or any other fees agreed upon that were not paid at the time-of-service, and to collect fees for assessment procedures/protocols that were not paid in full at the time of service or that were not paid by your insurance company.
2. To pay any **missed appointment** or **late cancellation** fees ($95 per missed appointment).
3. To pay any **Non-Sufficient Funds/Returned Unpaid Check** amount plus returned check fees.
4. As part of your payment plan for amount agreed upon (if applicable).

By signing below, ***I am certifying that I am an authorized signer*** on the card below and have permission to authorize charges. I am hereby providing my authorization and permission for Viewpoint Psychological Services, PLLC to charge my credit card for services rendered, co-payments/deductibles, or missed/late cancellation fees, non-sufficient funds or returned unpaid checks. I acknowledge that it is my responsibility to maintain an active, valid card on file.

I understand that no credit card information is stored within the practice. Once the information on this form is entered into the secure site initially, the card information will be redacted. When my card is electronically charged, staff at Viewpoint Psychological Services is only able to see the last 4 digits, not having access to the full card information to ensure privacy and security.

CLIENT'S NAME (Account to be credited): _____

PRINT NAME ON CARD:_____

SIGNATURE OF CARDHOLDER: _____
Note: the signature ***must* be that of the CARDHOLDER, not the client (if different).

LAST FOUR DIGITS OF CARD (if card has been swiped previously at our office)**:**_____

CREDIT CARD NUMBER (if card has not been used previously with us)**:**_____

EXPIRATION DATE:_____ **DATE SIGNED:** _____

Please be aware that timely payment of your account balance is your responsibility and a late fee equal to 2% of the total balance will be assessed per month for all unpaid balances, or in the case of a declined card.

**********FOR OFFICE USE ONLY**********

I have reviewed the forms and verified information in the system/and redacted credit card number:
Signed by (Staff): _____*Date Received:* _____