LICENSE PC009298

The Resilience Therapy Group by Robin Pepe, LPC, MA, M. Ed

PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT (PATIENT 14 YEARS OR OLDER)

Welcome and thank you for choosing us. Psychotherapy varies depending on the personalities of the provider and patient, and the problems you are experiencing. There are many different methods your therapist may use to address the issues that you are experiencing. Psychotherapy calls for a very active effort on your part. For therapy to be most successful, you will need to do the work in and outside of our sessions.

Treating Therapist: _____ **Today's Date:** _____

CLIENT CONTACT INFORMATION

Name: _____ **Birthdate:** _____

Address: _____

Email: _____ **Phone:** _____

How Did You Hear About Us? (Circle) Website | Psychology Today | Referral

Referred By: _____

Reason for Seeking Therapy: _____

Past Therapy: _____

EMERGENCY CONTACT

Name: _____ **Phone:** _____

Relationship: _____

INSURANCE

If you have insurance: We are in-network providers with several insurance companies including: Aetna, Cigna, Highmark, Tricare, Blue Cross/Blue Shield (non-personal choice), and United Health Care. Please contact your insurance company if you need pre-authorization or confirmation of benefits and coverage. As a courtesy, in addition to in-network plans, we will provide electronic submissions of out-of-network plans to expedite any reimbursements that your plan may allow.

Insurance Company: _____ IN NETWORK or OUT OF NETWORK

Member ID #: _____ **Rate $:**_____

APPOINTMENT AND CANCELLATION POLICY

Session time with our clients is very important to us. We require 24-hour notice to cancel or change any scheduled appointment. Failure to do so results in a $100 late cancellation or no show fee that will be automatically charged to your credit card on file. This fee is the patient's responsibility and cannot be billed to insurance or paid with an HSF card.

MEDICATIONS

MEDICATION	DOSAGE	FREQUENCY	START DATE

Allergies? Yes/No. If Yes, Describe:_____

Please list any substances you currently use, if any (alcohol, cigarettes, vape, ect.)

SUBSTANCE	AMOUNT	FREQUENCY	AGE/DATE STARTED	DATE OF RECENT USE

NOTICE OF HIPAA CONFIDENTIALITY AND PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

The law protects the relationship between a client and a psychotherapist, and information cannot be disclosed without written permission.

Exceptions Include:

- Suspected child abuse or dependent adult or elder abuse, for which I am required by law to report this to the appropriate authorities immediately.
- If a client is threatening serious bodily harm to another person/s. I must notify the police and inform the intended victim.
- If a client intends to harm himself or herself, I will make every effort to enlist their cooperation in ensuring their safety. If they do not cooperate, I will take further measures without their permission that are provided to me by law to ensure their safety.

My signature below indicates that I am over the age of 14 and have read, understand and agree to the terms of NOTICE OF HIPAA CONFIDENTIALITY AND PRIVACY PRACTICES.

Print Name: _____

Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT

My signature below indicates that I am over the age of 14 and have read, understand and agree to the terms of The Resilience Group by Robin Pepe Psychotherapist-Client Services Agreement.

Print Name: _____

Signature: _____ **Date:** _____