

# BEYOND THERAPY

119 Cheshire Drive, Greensburg, PA 15601-5934

724 331 3930

Fax: 724-832-1821

**CONFIDENTIAL: PROTECTED HEALTH INFORMATION- Authorized Personal Only**

Evaluation (first appointment) Date: \_\_\_\_\_

Client Name: \_\_\_\_\_ Your Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
(H) Phone: \_\_\_\_\_ (W) Phone: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_  
Email (for appointment reminder only) \_\_\_\_\_ (GenBook)  
May we contact you at home? Yes no May we call you at work? Yes no  
Your Employer Name/Address \_\_\_\_\_

Marital Status: Single Married Divorced Separated Widowed

Spouses Name: \_\_\_\_\_ Employer \_\_\_\_\_

Parents Names (if client under 18 Years): \_\_\_\_\_

Address (if different than yours): \_\_\_\_\_

Primary Current Insurance: Insurance \_\_\_\_\_ Co-payment: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group#: \_\_\_\_\_

Deductible Amount? \_\_\_\_\_ Has your yearly deductible been met? \_\_\_\_\_

Primary Insurance Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Their complete address: \_\_\_\_\_

Their place of Employment \_\_\_\_\_

Secondary Current Insurance: Insurance \_\_\_\_\_ Co-payment: \_\_\_\_\_

Insurance ID #: \_\_\_\_\_ Group#: \_\_\_\_\_

Deductible Amount? \_\_\_\_\_ Has your yearly deductible been met? \_\_\_\_\_

Primary Insurance Member Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Their complete address: \_\_\_\_\_

Their place of Employment \_\_\_\_\_

**Clients must obtain EAP authorization prior to their first appointment (if applicable)**

EAP ONLY Employee Assistance Company: \_\_\_\_\_

Employee Work Start Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Authorization for How Many Sessions: \_\_\_\_\_ Authorization number: \_\_\_\_\_

## Medical Information

Current Medication Dosage and times per day Medication start date Doctor Name

\_\_\_\_\_

\_\_\_\_\_

COMPLETE OTHER SIDE

COMPLETE OTHER SIDE

# BEYOND THERAPY

125 Hartman Road

724-832-7157

Fax: 724-832-1821

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I agree to allow Beyond Therapy to bill my Insurance Company for all services I receive at Beyond Therapy.

I agree to pay to Beyond Therapy any **co payments or deductibles** that my insurance company does not cover for my services at Beyond Therapy.

I agree to provide to Beyond Therapy my current insurance information and notify Beyond Therapy of any changes to my insurance for Behavioral Health Services.

I am responsible for any charges that are **not** paid for by my insurance company.

**If I fail to show up for or cancel a scheduled appointment, I will be billed directly the current rate for my services. As stated now, the current rate of \$90.00 for the initial evaluation and \$70.00 per follow-up session applies.** I have received or been offered a copy of HIPPA.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ today's Date: \_\_\_\_\_

# Beyond Therapy

## Limits of Confidentiality

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### **PLEASE READ & SIGN**

Contents of a therapy, intake, or assessment session are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of my practice not to release any information about a client without a signed release of information. Noted exceptions are as follows \_\_\_\_\_

#### **Duty to Warn and Protect**

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

#### **Abuse of Children and Vulnerable Adults**

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

#### **Prenatal Exposure to Controlled Substances**

Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

#### **In the Event of a Client's Death**

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child or spouse's records.

#### **Minors/Guardianship**

Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

#### **Insurance Providers (when applicable)**

Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes type of services, dates/times of services, diagnosis, and description of impairment, and progress of therapy.

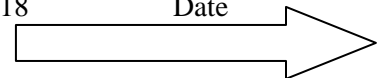
*I agree to the above limits of confidentiality and understand their meanings and ramifications.*

\_\_\_\_\_  
Client's Name (please print)

\_\_\_\_\_  
Client's (or Guardian's) Signature if under 18

\_\_\_\_\_  
Date

**PLEASE COMPLETE OTHER SIDE**



# Beyond Therapy

125 Hartman Road

Phone: 724/832-7157 Fax: 724/832-1821

## CLIENT CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

### Authorized Personnel Only

This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary. If I do not sign this form, my doctor may not receive information that is important to my treatment. This disclosure is to coordinate my diagnosis and my treatment. I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire 1 year from the date of signature, unless another date is specified. This release is required by all insurance companies. **Insurance companies consider all treatment to be medically necessary.**

I, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, for the  
(Patients Name – Print) (Patients Date of Birth.) (Patients Social Security #)  
purpose of coordinating care, authorize Beyond Therapy: \_\_\_\_\_, to  
(Provider Name – Print)  
release information indicated in the "Consent" portion of this form to be sent or faxed:

PCP Name: \_\_\_\_\_

PCP Phone: (\_\_\_\_) \_\_\_\_\_ PCP Fax: (\_\_\_\_) \_\_\_\_\_

PCP Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

### **Patient please check one:**

( ) To release any applicable mental health/substance abuse information to my primary care physician.

( ) I do not give my consent to releasing any information to my primary care physician. (This may affect insurance approval benefits for additional session requests)

|X|

\_\_\_\_\_  
Patient Signature (Patients over 18) Date

\_\_\_\_\_  
Parent/Guardian Signature (Patients Under 18) Date

\_\_\_\_\_  
Witness Date

**Notice To Recipient Of This Information:** This information has been disclosed to you from records, which are protected by federal (42 CFR Part 2) and state laws regarding confidentiality. Such laws prohibit you from making any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose

### **. CONFIDENTIAL: PROTECTED HEALTH INFORMATION- Authorized Personal Only**

Below is the only Information Released to Your PCP:

This patient was seen on (date): \_\_\_\_\_

(Diagnosis) \_\_\_\_\_

Treatment Plan or Recommendations: \_\_\_\_\_

\*\*\*PROVIDER: Fax to Primary Care Doctor and keep original in client file.