# Prime Behavioral Health, LLC

ADULT INTAKE PACKET

**Client Name** ____________________________________________________________

Street Address ______________________________________________ PO Box ____________________
City/State/Zip ______________________________________________________________________
Home Phone # ___________________________ **May we call this #? Yes No, May we leave a msg? Yes No**
Daytime Phone # _________________________ **Can we contact you here? Yes No Leave msg? Yes No**
Cell Phone # ____________________________ **May we call this #? Yes No, May we leave a msg? Yes No**
Client Date of Birth ____________________ Age: ______ Social Security # __________________________
Primary Care Physician & Phone #:____________________________________________________________
If we may email you, please provide your address below. *Bear in mind that email* ***IS NOT SECURE. NO <u>PRIVATE INFORMATION</u> OTHER THAN YOUR NAME, EMAIL ADDRESS AND/OR APPOINTMENTS WILL BE INCLUDED.***
_________________________________________@_________________________________________
**Emergency Contact Name (required):**_________________________________ **Phone #:**________________
**Address (required):**________________________________________________________________

## Insurance Information (Copy of Insurance Card and ID is Required)

**• This section is required to be filled out in full •**

**1) <u>Primary</u>** Insurance Company ____________________________Ins Co Phone # ______________________
**Employer of Subscriber** ______________________________________________________________
Name of Subscriber __________________________________________Date of Birth ___________________
Address of Subscriber (if different from Client) ____________________________________________
Subscribers Social Security # ______________________________ Relationship to Client__________________

**2) <u>Secondary</u>** Insurance Company ____________________________ Ins. Co Phone # ___________________
**Employer Name** ____________________________________________________________________
Name of Subscriber __________________________________________Date of Birth ___________________
Address of Subscriber (if different from Client) ____________________________________________
Subscribers Social Security # _________________________ ___Relationship to Client ___________________

***<u>WE DO NOT FILE CLAIMS TO ANY THIRD INS.</u>***

**CLIENT AGREEMENT**

**<u>The above information is current and correct to the best of my knowledge</u>.**

**I understand my insurance coverage as noted above and that I am responsible for paying the co-pay, if required, and/or the amount not covered by my insurance policy. This agreement also grants authorization to PBH to release such information as may be necessary for completion of my insurance claim with payment of benefits to PBH for services rendered.**

______________________________________ ______________________________ ______________
Client Name (please print) Client Signature Date

____________________________ ______________

Witness Date Revised 01/2020


**Prime Behavioral Health, LLC**

647 Hill Rd. North, Unit B
Pickerington, OH 43147
614-833-6900

711 North Columbus St., Ste. 100
Lancaster, OH 43130
740-653-6500

# Client Intake Form

**Instructions:** To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank.

**Identifying Information**

**Name:**_________________________________ **Date of Birth:** ________________ **Age:**________
**Gender:** ❑ Male ❑Female **Race:** _____________ **Height:** ______________ **Weight:**____________
**Hair Color:**______________ **Eye Color:** _______________

**Behavioral Health**

**Why are you seeking counseling?**

**What issues or circumstances do you believe contribute to your problem(s)?**

**How long has this problem(s) persisted?** ___________

**Under what conditions do the problems usually get worse?**

**Under what conditions do the problems usually improve?**

**Have you previously been involved in counseling?** ❑No ❑ Yes **If yes, describe the reasons for counseling, who provided the counseling, and the outcome.**

**Counselor** _____________________________

**Reason:**

**Outcome:**

**List your greatest strengths:**

**List your greatest weaknesses:**

**Psychiatric Hospitalizations:** **❑None** **❑Past** **❑Recent**

| Dates of Service: | # of Days | Where & Reason (suicidal, depressed etc.) |
|---|---|---|
| Dates of Service: | # of Days | Where & Reason (suicidal, depressed etc.) |

**Behavioral Health Symptom Checklist**

***Please indicate the degree to which you have experienced any of the following symptoms in the last 4 weeks***.

0 = Never 1 = Occasionally 2 = Regularly 3 = Frequently

_______ 1. Trembling, or feeling shaky
_______ 2. Shortness of breath or smothering sensation
_______ 3. Racing heart, heart palpitations or chest pain (circle which)

| | |
|---|---|
| _______ | 4. Moist palms or excessive sweating |
| _______ | 5. Dizziness, lightheadedness, unsteady or faint (circle which) |
| _______ | 6. Nausea, diarrhea, or other abdominal distress (circle which) |
| _______ | 7. Frequent headaches or other muscle aches |
| _______ | 8. Startle easily |
| _______ | 9. Irritability (loses temper easily) |
| _______ | 10. Worrying a lot |
| _______ | 11. Trouble swallowing, “lump in throat”, or choking sensation |
| _______ | 12. Fearful of or embarrassed by being watched or being the focus of attention |
| _______ | 13. Avoid talking to strangers |
| _______ | 14. Fear of embarrassment |
| _______ | 15. Persistent fear of an object (snakes) or situation (high places) considered excessive or unreasonable |
| _______ | 16. High levels of anxiety in the presence of an object or situation |
| _______ | 17. Regular and disturbing thoughts about a past traumatic experience |
| _______ | 18. Regular and disturbing dreams about a past traumatic experience |
| _______ | 19. Avoidance of thoughts feelings, or conversations associated with a traumatic experience |
| _______ | 20. Excessive hand washing or fear of germs |
| _______ | 21. Excessive checking (i.e., doors, locks, stove) |
| _______ | 22. Excessive need for order or neatness or counting ritual(s) |
| _______ | 23. Unusual and persistent sad feelings |
| _______ | 24. Diminished interest or participation in enjoyable or important activities |
| _______ | 25. Difficulty concentrating or poor memory (circle which) |
| _______ | 26. Tire easily or low energy level |
| _______ | **27**. Thoughts of suicide |
| _______ | 28. Increased or decreased sleep (circle which): avg. hrs per night ____ |
| _______ | 29. Feelings of hopelessness |
| _______ | 30. Persistent and abnormally elevated mood |
| _______ | 31. Over inflated feelings of self-worth |
| _______ | 32. Decreased need for sleep |
| _______ | 33. Rapid or racing thoughts |
| _______ | 34. Excessive involvement in pleasurable activities |
| _______ | 35. Excessive and/or reckless spending |
| _______ | 36. See or hear things that others around you are unable to perceive |
| _______ | 37. Hold ideas or beliefs that are not shared by others |
| _______ | 38. Self induced vomiting |
| _______ | 39. Excessive exercise |
| _______ | 40. Use of laxatives or diuretics to lose weight |
| _______ | 41. Dieting (very strict, women consuming less than 1400 daily calories or men less than 2000 calories) |
| _______ | 42. Careless mistakes in school work, work, or other activities |
| _______ | 43. Can only pay attention for short periods at school/work/home |
| _______ | 44. Failure to complete schoolwork, chores, duties |
| _______ | 45. Hyperactive: fidgets, squirms, talks excessively |
| _______ | 46. Acts without thinking of consequences |

## Drug and Alcohol History

*Indicate the level of use for each substance by checking the appropriate box.*

| Use | No Use | Past use | Current | Use | No Use | Past use | Current |
|---|---|---|---|---|---|---|---|
| **Alcohol** | ❑ | ❑ | ❑ | **Hallucinogens** | ❑ | ❑ | ❑ |
| **Marijuana** | ❑ | ❑ | ❑ | **Inhalants** | ❑ | ❑ | ❑ |
| **Hashish** | ❑ | ❑ | ❑ | **Cocaine** | ❑ | ❑ | ❑ |
| **Stimulants** | ❑ | ❑ | ❑ | **Heroin** | ❑ | ❑ | ❑ |
| **Sedatives** | ❑ | ❑ | ❑ | **Other**: ______________ | ❑ | ❑ | ❑ |

*If current or past use is indicated to any of the above items compete the following questions?*

| Drug/Alcohol Type | Age of 1st use | Date of last use | Frequency | Amount Used | Method ❑Oral ❑Smoked ❑Nasal ❑Injection |
|---|---|---|---|---|---|
| Drug/Alcohol Type | Age of 1st use | Date of last use | Frequency | Amount Used | Method ❑Oral ❑Smoked ❑Nasal ❑Injection |
| Drug/Alcohol Type | Age of 1st use | Date of last use | Frequency | Amount Used | Method ❑Oral ❑Smoked ❑Nasal ❑Injection |

**Are you currently pregnant?** ❑ No ❑ Yes **Are you an IV drug user?** ❑ No ❑ Yes

**Have you ever received inpatient drug and/or alcohol treatment?** ❑ No ❑ Yes

**If yes, When?** ________________________ **Where?** ____________________________

**Have you ever received outpatient drug and/or alcohol treatment?** ❑ No ❑ Yes

**If yes, When?** ________________________ **Where?** ____________________________

**Are you involved in any community self-help groups such as AA** ❑ No ❑Yes

## Family History

**Marital status:** ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed
❑ Living with a Significant Other but Never Married

If married: how long have you been married? _________ Spouse's age: ___________

Are you presently experiencing any serious marital conflicts?

❑ No ❑ Yes If yes, explain:________________________________________

If you have ever been divorced: How many times were you previously married? _______

Date of divorce(s) _________________________________________

Prior to the divorce(s), how long were you married? _______________________________________________

Reasons for divorce(s)______________________________________________________________________

________________________________________________________________________________________

**Living Situation:** ❑Own Home ❑ Parent's Home ❑ Relative's Home ❑Homeless ❑Group Home
❑Residential ❑ Other ____________________________________________

| Household Member's Names (if client lives in more than one household list household 1 – 2) | Relation to the Client | Age | Race | Occupation or School | Level of Education |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| Significant Family Members/Others not listed above: | Relation to the Client | Age | Race | Occupation or School | Level of Education |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

**Briefly describe any problem areas that occur between yourself and people you live with.**

## Medical History

**Physician Name:** __❑ No ❑ Yes ______________________________________________ **Phone:** ______________________________

**Address:** _______________________________________________________
Street & Number City State Zip

**Date of most recent physical exam:** ________________ **By Whom:** _____________________

**Results:** ____________________________________________________________

**Immunizations -** Check the immunizations for the following diseases: ❑ Chicken Pox ❑Diphtheria ❑ German Measles ❑Measles ❑Mumps❑Polio ❑ Small Pox ❑Tetanus

**Drug Allergies:**
*

**List any major illness and/or operations**

**Have you had any medical hospitalizations in the last three years** ❑ No ❑ Yes, if yes, complete below:

| Hospital | City | Date | Reason |
|---|---|---|---|
| | | | |
| | | | |

**List any *current* physical concerns (e.g. high blood pressure, headaches, dizziness, etc.):**

**List any *past* physical concerns:**

**Have you ever had head trauma that resulted in loss of consciousness and/or required medical treatment?** ❑ No ❑ Yes

***What medications are you now taking?*** *List all medications including over the counter and herbal therapy, dose (if known), how long taken, and the doctor who prescribed the medication.*

**Prescription/Over the Counter Medication:** ❑No ❑ Yes

**Current Medication:** ___________________
**Total Daily Dosage:** ____________
**Reason:** _____________________
**Compliance** ❑ No ❑Yes ❑Partial ❑Unknown

**Current Medication:** ___________________
**Total Daily Dosage:** ____________
**Reason:** _____________________
**Compliance** ❑ No ❑Yes ❑Partial ❑Unknown

**Current Medication:** ___________________
**Total Daily Dosage:** ____________
**Reason:** _____________________
**Compliance** ❑ No ❑Yes ❑Partial ❑Unknown

**Out of Medication:** ❑ No ❑ Yes

**Current Medication:** ___________________
**Total Daily Dosage:** ____________
**Reason:** _____________________
**Compliance** ❑ No ❑Yes ❑Partial ❑Unknown

**Current Medication:** ___________________
**Total Daily Dosage:** ____________
**Reason:** _____________________
**Compliance** ❑ No ❑Yes ❑Partial ❑Unknown

**Current Medication:** ___________________
**Total Daily Dosage:** ____________
**Reason:** _____________________
**Compliance** ❑ No ❑Yes ❑Partial ❑Unknown

**Do you think these medications help you get better**? ❑ N/A ❑ No ❑ Yes ❑ Unknown

**Do you use caffeine?** ❑ No ❑ Yes from (coffee, tea, soda)___________________ Daily Use____________
**Do you use tobacco?** ❑ No ❑ Yes from (cigarettes, snuff, snus) _________________ Daily Use____________

**Describe your appetite?** ❑ Poor Appetite ❑Average Appetite ❑Large Appetite
**Has your weight changed in the last year? ❑ No ❑Yes If yes, by how much?** __________ **❑ weight gain ❑loss**

**How much sleep do you get each night?** _________________ **When you go to bed, how long does it take you to fall asleep?**__________
**Do you awaken in the night and have difficulty returning to sleep?** ❑ No ❑ Yes **Do you awaken before you plan to get up?** ❑ No ❑ Yes

**Has client had any of the following symptoms in the past 60 days?** ***Please check.***

❑ Bedwetting
❑ Blood in Stool
❑ Breathing Difficulty
❑ Confusion
❑Consciousness Loss
❑Constipation
❑Coughing
❑Diarrhea
❑Dizziness
❑Falling
❑Gait Unsteadiness
❑Hearing Loss
❑Lightheadedness
❑Memory Problems
❑Muscle Weakness
❑Nervousness
❑Panic Attacks
❑Pulse Irregularity
❑Sleep Problems
❑Seizures
❑Tingling in Arms/Leg
❑Tremors
❑ Vision Changes
❑ Vomiting

❑ Other: ________________________________________

# Health History Questionnaire

**Health History Questionnaire**: Have you **or any of your relatives (related by blood)** had any of the following health problems? If a blood relative has had the condition, please write down the relationship to the you (parent, brother or sister, aunts/uncles, cousins, children, etc.) in the comment section.

| | | Client | | Family | Comment |
|---|---|---|---|---|---|
| **Problem** | **Now** | **Past** | **Never** | **History** | **(Indicate family member relationship to client)** |
| AIDS | | | | | |
| Alcoholism | | | | | |
| Anemia | | | | | |
| Anxiety | | | | | |
| Arthritis | | | | | |
| Asthma | | | | | |
| Bipolar Disorder | | | | | |
| Bleeding Disorder | | | | | |
| Brain Tumor | | | | | |
| Cancer | | | | | |
| Cirrhosis | | | | | |
| Depression | | | | | |
| Diabetes | | | | | |
| Drug Abuse | | | | | |
| Epilepsy/Seizures | | | | | |
| Eye Disease | | | | | |
| GI Problems | | | | | |
| Glaucoma | | | | | |
| Headaches | | | | | |
| Head Injury | | | | | |
| Hearing Problems | | | | | |
| Heart Disease | | | | | |
| Hepatitis | | | | | |
| High Blood Pressure | | | | | |
| Hyperactivity | | | | | |
| Jaundice | | | | | |
| Kidney Disease | | | | | |
| Learning Problems | | | | | |
| Lung Disease | | | | | |
| Low Blood Pressure | | | | | |
| Menstrual Pain | | | | | |
| Oral Health/Dental | | | | | |
| Schizophrenia | | | | | |
| Sexually Transmitted Disease | | | | | |
| Speech Problems | | | | | |
| Stroke | | | | | |
| Suicide | | | | | |
| Thyroid | | | | | |
| Tuberculosis | | | | | |

**If the client has had any of the above, please write the problem, what treatment was received, and when:**

| Problem and Treatment Received: | When: |
|---|---|
| Problem and Treatment Received: | When: |

## Educational History

**Highest Degree attained**: ❑ High School ❑Associate Degree/2yr tech ❑Bachelor's Degree ❑Master's Degree ❑Ph.D.

**Highest Academic Year completed:_____** **Highest Vocational Year Completed: (if applicable)______**

**Type of school placement:** ❑ Regular ❑ Special Education ❑Home-Schooled ❑Unknown

**Type of Special Education Placement:** ❑ None ❑Cognitive Disability ❑Emotional Disability ❑Learning Disability ❑Multiple Disabilities ❑Other: _______________________________________________________

**Did you have difficulties in school?** ❑ No ❑ Yes. If yes, please explain

**Do you have special communication needs?** ❑ TTD Device ❑Interpreter Services

## Employment History

**Employment Status**

❑Employed Full Time (30 or more hours) ❑ Employed Part Time If part time, number of hours worked weekly _______

Job/Occupation:________________________________

❑Unemployed ❑Unemployed due to disability. Date Last Worked________________

If unemployed, do you want to work? ❑No ❑Yes. If yes, what kind of work would you like to do?____________________________

**Current Employment**

Name of employer: _________________________

Job Position:__________________________ How long have you been in this position __________

Date Last Worked________________

Have you been disciplined by your supervisor? ❑Yes ❑No
Have you had frequent tardiness? ❑Yes ❑No
Have you had frequent absences? ❑Yes ❑No
Are you satisfied with your job ❑Yes ❑No

**Family Financial History**:

Amount of Monthly Income____________ Source(s) of income: ______________________________________________________

Loss of Income due to: ___________________________________

Financial Problems ❑ No ❑Yes If yes, explain: ___________________________________________________________________

## Military History

Are you currently in the military? ❑ No ❑Yes If yes, what branch? _______________________ How long? _________________

Rank:___________________ What work did you do for the military?____________________________________________________

Have you recently been deployed to a combat zone? ❑ No ❑Yes If yes, have you experienced any psychological or physical difficulties because of this deployment? ❑ No ❑Yes explain?______________________________________________________

Have you ever been in the military? ❑ No ❑Yes If yes, what branch? _______________________ How long? ______________

Rank:___________________ What work did you do for the military?____________________________________________________

When were you discharged?________________________ Type of discharge:____________________________________________

Have you ever been deployed to a combat zone? ❑ No ❑Yes If yes, when?__________ Have you experienced any psychological or physical difficulties because of this deployment? ❑ No ❑Yes explain?________________________________________________

## Interests and Community Involvement

**What meaningful activities, including leisure and recreational activities to you engage in?**

**What community activities, including volunteer work are you involved in?**

**What religious or spiritual activities do you participate in?**

**List any cultural or family traditions you have?**

**Legal History**

**Do you have a Legal Guardian/Custodian?** ❑ No ❑Yes If yes, Name: ___________________________________Phone:________________

**Civil Proceedings:**_______________________________________________________________ ❑ Current ❑ Past When? ___________

**Domestic Relations Court**
**(Custody, Protective Services, Restraining Orders):** _____________________________________ ❑ Current ❑ Past When? ________

**Child Support Enforcement Orders:**________________________________________

**Job and Family Service Involvement with Family:**_____________________________________________________

**Caseworker assigned to Family:**___________________________________**Phone:**________________________

**Juvenile Court Involvement (for Child Abuse, Neglect or Dependency):** ❑ Current ❑ Past When? ____________

**Current Legal Status:** ❑ **None** ❑ **Awaiting Charges** ❑ **On Probation/Parole** ❑ **Conditional Release**
❑ **Outpatient Commitment** ❑ **Incarcerated**
❑ **Other:** _________________________________________________________

**Legal Charges: Juvenile** ❑ No ❑Yes If yes,
❑ Felony ❑Misdemeanor Charge:_______________________________ ❑ Current ❑ Past When? ____________
❑ Felony ❑Misdemeanor Charge:_______________________________ ❑ Current ❑ Past When? ____________

**Legal Charges: Adult** ❑ No ❑Yes If yes,
❑ Felony ❑Misdemeanor Charge:_______________________________ ❑ Current ❑ Past When? ____________
❑ Felony ❑Misdemeanor Charge:_______________________________ ❑ Current ❑ Past When? ___________

**Incarcerations:**
**From** ________ **To** _________ **Where**___________________________ **Conviction:**__________________________
**From**________ **To** _________ **Where**____________________________ **Conviction:**__________________________

**Probation/Parole Officer:** _________________________________________ **Phone:** ___________________________

| **Print Name** (Person completing questionnaire): | **Signature:** | **Date:** |
|---|---|---|
| **Reviewer Name/Degree** (if applicable) | **Signature:** | **Date:** |
| **Comments:** | | |

To the best of my knowledge, all the information I have given is accurate. I understand the information contained in my chart kept at Prime Behavioral Health, LLC, may not be released to anyone without my written consent, with these exceptions:

- If the law mandates disclosure
- If you have placed yourself or someone else in clear and imminent danger
- For the purposes of therapist supervision & consultation, within the ethical guidelines of the American Counseling Association.

CLIENT'S SIGNATURE ___________________________________ DATE ________________________

PLEASE PRINT LAST NAME _____________________________ FIRST NAME ____________________

## CANCELLATIONS & MISSED APPOINTMENTS

All appointment cancellations require a **24-hour notice** or in the case of illness, a message prior to 8:00 am on the appointment day. Our voicemail is available 24 hours/day to take messages after hours or on the weekends if you need to cancel an appointment. Adequate notification respects the doctor/therapist's time as well as allows availability to others requesting services. Failure to not show at all or to give a less than 24-hour notice on cancellations will result in a $35.00 charge which must be paid prior to scheduling another appointment. In addition, arriving late or leaving early could also result in charges that would be equal to the time you kept your therapist waiting. **Insurance will not be billed for this.**

**Due to the high demand for appointments, two no-show appointments in a row will result in future appointments being removed from our schedule. If you desire to return for services and this is approved by your therapist, you will need to call to schedule new appointments.**

**I HAVE READ THE OFFICE POLICY AND RECEIVED A COPY OR HAD ACCESS TO IT ON THE WEBSITE. I UNDERSTAND AND AGREE TO THE TERMS CONTAINED IN IT.**

____________________________________________

**Client/Legal Guardian Signature Date**

____________________________________________

**Witness Date**

**Prime Behavioral Health, LLC**

**CONSENT FOR TREATMENT AND INFORMATION SHEET**

The decision to begin mental health treatment is one that may have important results for your life. Research has shown that individuals entering therapy achieve more favorable results when they have a good understanding of what to expect. We have developed this sheet to provide you with an overview, but no information sheet can answer all questions, so please feel free to ask us about any questions you have.

Individual sessions usually last 45-60 minutes providing us with time to think about what you have said, make notes, and plan your services. Your first session will usually be devoted to assessing the type and extent of the problems and concerns you have and to plan your services.

Your therapist has a responsibility to ask questions about your history, your life situation, and your current distress. Your therapist also has a responsibility to be open with you and to provide direct information about your treatment.

As a client in our office, you will also have certain responsibilities for payment and for keeping your appointments. Your most important responsibility, however, is to yourself – to work towards the goals we mutually set, and to work toward your goals both during sessions and during days between sessions. This is your time for you.

If you fail to inform our office of any change of insurance (i.e., termination of policy, addition of new policy, or change in a policy) prior to or by the effective date of the change, which results in failure of our office to be able to bill and receive payment for any charges incurred, you will be billed directly for those charges to the extent of the allowed amount for those charges by the most recent insurance policy provided to us.

**There are charges which are not covered by insurance for missed appointments and late cancellations. Please refer to the Canceled and Missed Appointment Policy form for details on these charges.**

**Once any charge has remained on your account for 90 days, the entire outstanding balance will be forwarded to a collection agency. Any fees and/or interest added by the collection agency will be charged to you in addition to the outstanding balance which you owed to Prime Behavioral Health.**

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We place a high value on the confidentiality of your records. Records will be held confidential except as required by law, or as released by your written authorization. In a small number of situations, therapists are legally required to reveal information; for example, if you reveal information that indicated a clear danger of injury to yourself or others. Records may, on occasion, be reviewed for quality and appropriateness of care by the clinic or by your insurance company.

Every effort is made to answer calls during our regular office hours. If we are unable to answer or the office is closed at the time of your call, please leave a message, and we will return your call as soon as we can.

Entering psychotherapy requires a commitment of time, energy and resources, and often also requires some courage to make the first appointment. Your commitment will be honored here and you will be treated with respect. Thank you for choosing our office.

**I HAVE READ THE ABOVE AND UNDERSTAND AND AGREE TO MY RESPONSIBILITIES, AND CONSENT FOR TREATMENT.**

---

| ______________________________ | ______________________________ | __________ |
|---|---|---|
| **Signature** | **Printed Name of Client** | **Date** |

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## COURT FEE SCHEDULE

- All fees charged for court activity are based on portal-to-portal travel.
- A retainer for the estimated full amount of the fee will be required one week before a court appearance.
- If actual fees exceed estimated fees, clients will be responsible for the remainder of the fee within one week of rendered services.
- Fees will be assessed in four-hour blocks.

Fee Rates

- Fees for court related activities requested more than two weeks in advance = $120 *per hour (Minimum = $480)*
- Fees for court related activities requested less than two weeks in advance = $240 *per hour (Minimum - $960)*

Cancellation Policy

- If request for court related activities is cancelled at least 2 weeks prior to scheduled appearance, the client will be entitled to a full refund minus any time the counselor used for preparation.
- If request for court related activities is cancelled at least 1 week prior to scheduled appearance, the client will be entitled to a 50% refund minus any time the counselor used for preparation.
- No refund will be given for cancellations that occur within the week of the scheduled activity.
- If a counselor is subpoenaed for court related activity and the subpoena is cancelled, regardless of retainer not being submitted, the client will be responsible for the initial requested fee.

Consideration for modification of this fee schedule will be made on a case-by-case basis.

______________________________________________

Client Signature Date

Your signature states that you are aware of this policy. ***Please sign even if you feel that this will not apply to your situation.***

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**FEE SCHEDULE**
**All Counselors**

| | |
|---|---|
| **Initial Session** | **$160** |
| **Office Visit ~60 Min** | **$150** |
| **Office Visit ~45 Min** | **$120** |
| **Office Visit ~30 Min** | **$ 80** |
| **Family Counseling ~45 Min** | **$130** |

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**I have read and understand the Financial Policy and office procedures at Prime Behavioral Health, LLC. I agree to the cancellation/reschedule policy. I further understand I will need to make my co-pay at each visit. I acknowledge that I have either received a copy of this policy or have it available to me from the website at www.carebyprime.com**

___________________________________
**Client Name (please print)**

___________________________________ ____________
**Client Signature** **Date**

* * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * * *

Revised 10/15

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We like to keep your information current. Please list anyone to whom we may speak or leave a message in regard to appointments or payments/billing along with their relationship to you.

| NAME | RELATIONSHIP |
| --- | --- |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |
| ______________________________ | ______________________________ |

Signature ________________________________ Date______________

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**APPOINTMENT REMINDERS BY PHONE, TEXT AND/OR EMAIL**

We can now send you appointment reminders by email or SMS text. **PLEASE READ THE FOLLOWING:** The appointment reminder will include only the date and time of your appointment and your service provider's name. We will not encrypt the messages. Health care information sent by regular e-mail or SMS text could be lost, delayed, intercepted, delivered to the wrong address, or arrive incomplete or corrupted. If you understand these risks and would like to receive an appointment reminder by email or SMS text, please confirm that you accept responsibility for these risks, and will not hold us responsible for any event that occurs after we send the message.

Failure to receive appointment reminder by call, SMS text, or email does not release the responsible party of any responsibility for a charge that may be incurred for a missed appointment or late cancellation (less than 24 hours). You are responsible for keeping the card that is available for you at the window when you schedule your appointments or for appointments made by phone.

By checking a box below that enables E-mail reminders or SMS text reminders, and entering an email address or phone number, you acknowledge that you have received the information shown above and acknowledge your consent.

☐ Enable email reminders
☐ Enable SMS text reminders
☐ Phone call only

Recipient email: [ ]

Recipient Mobile Number: [ ]

# **Prime Behavioral Health**

## **NOTICE FOR ACCOUNTS WITH BALANCES DUE**

*Please take note of our new policy regarding our scheduling policy due to outstanding balances.*

Beginning immediately, if you have an account with balances from unpaid copays, fees for missed/late canceled appointments, and coinsurance and/or deductibles for claims that HAVE FINISHED PROCESSING through your insurance, the clerical staff have been advised to not schedule any new appointments until the balance is paid in full. Please keep 3 appointments booked at all times so that you will still have at least 2 appointments on the books. We will not cancel any appointments already on the schedule. Please pay the amount requested when you check in for your appointments to avoid this issue. We diligently try to ask for the proper amount we expect to be due after your insurance processes your claim to keep you from getting behind. We adjust the balance accordingly, when needed, after we receive the final decision from your insurance. However, policies with co-pays do require the payment at the time of service. Payment can be made in person, over the phone, or via our website or QR codes on our statements.

**We would encourage you to keep a credit/debit card on file with our office and sign to give us permission to charge your card for balances due (as needed) to be sure that there is no disruption to your care. Would you like to take advantage of this option? _____yes  _____no**

I understand the policy above.

______________________________________________________________

Name　　　　　　　　　　　　　　Date　　　　　　　　　　January 11,2024