# FAMILY TREATMENT ASSOCIATES

## PERSONAL INFORMATION

**NAME: _____**

**ADDRESS: _____**

**CITY: _____ STATE: _____ ZIP CODE: _____**

**DATE OF BIRTH: __/____/____ TELE # (h) _____ (C) _____ (B) _____**

**NUMBER TO CALL : HOME _____ CELL _____ BUSINESS _____**

***MAY WE LEAVE A MESSAGE AT THESE NUMBERS? HOME _____ CELL _____BUSINESS_____***

***WHOM MAY WE CONFIRM APPOINTMENTS AND/OR LEAVE MESSAGES WITH OTHER THAN YOURSELF? _____***

**PLACE OF EMPLOYMENT HOW MANY YEARS? JOB TITLE**

_____

**INSURANCE INFORMATION**

Plan Name _____ ID # _____ GROUP# _____

Phone # _____ INSUREDS NAME _____

**IS THERE ANOTHER INSURANCE?** yes no

IF YES: PLAN NAME _____ ID # _____ GROUP # _____

PHONE # _____ INSUREDS NAME _____

Who will be responsible for your bills? _____

Reason for seeking treatment: _____

Previous counseling or psychiatric treatment? _____

Referred by: _____

**117 BROAD STREET, STROUDSBURG, PA 18360 * (570) 424-6049 * FAX (570) 424-0917**

# *MEDICAL INFORMATION*

**NAME AND ADDRESS OF PERSONAL PHYSICIAN**

_____

**DATE OF LAST PHYSICAL** _____

***Have you ever been treated or ever had any known indication of:***

| | | |
|---|---|---|
| Disorder of eyes, ears, nose or throat? | Yes | No |
| Dizziness, fainting, convulsions or headache, paralysis or stroke? | Yes | No |
| Shortness of breath, persistent cough, chronic bronchitis, asthma or Any other respiratory disorder? | Yes | No |
| High blood pressure, heart murmur, chest pain, heart attack, phlebitis or Any other disorder of the heart or blood vessels? | Yes | No |
| Ulcer or hernia, disorder of the stomach, intestines, rectum, liver, Spleen, pancreas or gallbladder? | Yes | No |
| Disorder of the kidney, bladder, reproductive organs or menstruation? | Yes | No |
| Diabetes, goiter, thyroid problems? | Yes | No |
| Arthritis, disorder of the back, muscles or bones? | Yes | No |
| Allergies? | Yes | No |
| Anemia, disorders of blood? | Yes | No |
| **ARE YOU RECEIVING TREATMENT NOW?** | **YES** | **NO** |

List ALL medications that you are currently taking (over the counter as well as prescribed):

_____

_____

How many alcoholic drinks do you have weekly? _____

How many cups of coffee and/or tea do you drink daily? _____

Other caffeinated beverages: _____

Do you smoke cigarettes? _____ How many packs per day? _____

Do you use other drugs? (such as marijuana, cocaine, speed, etc.) _____

*MEDICAL INFORMATION CONTINUED*

**Other than the above, have you in the past 5 years?**

| | | |
|---|---|---|
| Had any mental or physical disorder? | Yes | No |
| Had a checkup, consultation, illness, injury or surgery? | Yes | No |
| Been a patient in a hospital, clinic or other medical facility? | Yes | No |
| Had any diagnostic tests? | Yes | No |
| Been advised to have any diagnostic test, hospitalization or surgery? | Yes | No |

---

| | | |
|---|---|---|
| Have you had any change in your weight in the past year: | Yes | No |
| If yes specify loss or gain _____ | | |
| Have you experienced any change in your sleeping patterns? | Yes | No |
| Is there anything else with regard to your health that is significant? | Yes | No |

If yes please specify:

_____
_____
_____
_____

| | | |
|---|---|---|
| **HAVE YOU NOW OR IN THE PAST BEEN SUBJECT TO PHYSICAL/SEXUAL/PSYCHOLOGICAL ABUSE?** | **YES** | **NO** |
| **AT THE PRESENT TIME, DO YOU FEEL THAT YOU ARE IN DANGER OF BEING HARMED?** | **YES** | **NO** |
| **HAVE YOU NOW OR IN THE PAST HAD THOUGHTS OF EITHER HURTING YOURSELF OR OTHERS?** | **YES** | **NO** |

# CONTRACT FOR SERVICES

**THE FOLLOWING CONDITIONS SHALL APPLY:**

1. All sessions will be by appointment only
2. A session is 45-50 minutes in length, unless otherwise negotiated
3. Payment is expected at the time of service
4. There will be an additional charge for work pertaining to legal services, should such a service be necessary
5. **Cancellations must be made 24 hours in advance of the scheduled appointments. There will be a $100.00 charge for "last minute" cancellations and "no shows" that must be paid before the next scheduled appointment. In the case of extenuating circumstances, this will be handled on an individual basis**
6. Collection Services or Small Claims Court will be utilized if "normal" payment retrieval is not sufficient
7. Taking an active part in his or her treatment planning and therapy.
8. Keeping appointments and cooperating with the clinician.
9. Reporting changes in his or her condition, asking for clarification if there is a misunderstanding about issues related to ones care and complying with policies that relate to care and treatment expectations.
10. Being considerate and respectful of the rights of privacy and confidentiality of other clients.
11. Communicating concerns and complaints through appropriate channels
12. **Your mental health records are the property of Family Treatment Associates. If copies of records are needed for insurance purposes or legal issues the proper Authorizations to Disclose must be signed. Your mental health privacy is very important to Family Treatment Associates; information will be released at the therapist/psychologists discretion. This is done to protect your privacy.**

*******IMPORTANT REGARDING INSURANCE*******

**YOUR AGREEMENT IS WITH YOUR INSURANCE COMPANY AND YOU. FAMILY TREATMENT ASSOCIATES AS A COURTESY TO CLIENTS WILL SUBMIT CLAIMS AND WILL DO EVERYTHING POSSIBLE TO OBTAIN PAYMENT. IF A PROBLEM ARISES - AS NON PAYMENT BY YOUR INSURANCE COMPANY, YOU ARE RESPONSIBLE FOR ANY CHARGES INCURRED.**

**EACH CLIENT HAS A RIGHT TO RECEIVE SERVICES:**

- Regardless of cultural and ethnic identify, religion, disability, age or sexual preference.
- From clinicians who are qualified, competent, focused on each individual's care and are reasonably accessible to the client.
- Free of unprofessional involvement with providers and staff.
- That emphasize patient participation in developing a treatment plan which is specific to his or her needs and includes the clients agreement to work toward defined goals.
- Their diagnosis, recommended treatment and alternatives in terms they can reasonable understand and to have this information addressed and discussed.
- If the therapist is not available, you can call MH/MR Emergency Services at 570-421-2901 or go to the Emergency Room at Pocono Medical Center.

**I certify that I have read and truthfully answered to the best of my ability and fully understand the CONTRACT FOR SERVICES and CLIENTS RIGHTS**

**SIGNATURE _____ DATE _____**

**SIGNATURE OF PARENT OR LEGAL GUARDIAN IF UNDER 18 YEARS OF AGE:**

**_____ DATE _____**

# FAMILY TREATMENT ASSOCIATES
# NO SHOW/LATE CANCELLATION POLICY

**YOU WILL BE CHARGED $25.00 FOR THE FIRST NO SHOW/LATE CANCELLATION THAT IS NOT AN EMERGENCY.**

**NO SHOW/LATE CANCELLATIONS AFTER THE FIRST TIME WILL BE CHARGED $100.00 PAYABLE PRIOR TO OR ON YOUR NEXT APPOINTMENT.**

**THE APPOINTMENT THAT YOU ARE GIVEN IS BEING RESERVED IN YOUR NAME, IF YOU HAVE A NEED TO CANCEL PLEASE CALL THE DAY BEFORE SO THAT THIS OFFICE CAN SCHEDULE FOR THAT TIME SLOT.**

**THERE IS AN ANSWERING SERVICE AVAILABLE 24 HOURS A DAYAT 570-424-6049.**

**IN CASE OF AN EMERGENCY, EACH SITUATION WILL BE HANDLED ON AN INDIVIAUL BASIS.**

**_____ _____**

**SIGNATURE DATE**

**BY SIGNING ABOVE YOU ACKNOWLEDGE THAT YOU AGREE AND UNDERSTAND FAMILY TREATMENT ASSOC POLICY**

**New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations**

I, _____, understand that as part of my health care, FAMILY TREATMENT ASSOCIATES, LTD. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that FAMILY TREATMENT ASSOCIATES, LTD. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that FAMILY TREATMENT ASSOCIATES, LTD. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should FAMILY TREATMENT ASSOCIATES, LTD. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

_____
_____
_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

_____
Patient's Signature

_____
Date

---

FOR OFFICE USE ONLY
[ ] Consent received by _____ on _____.
[ ] Consent refused by patient, and treatment refused as permitted.
[ ] Consent added to the patient's medical record on _____.

___ **I HAVE RECEIVED A NOTICE OF PRIVACY POLICIES FOR FAMILY TREATMENT**