ADVOCATE PSYCHOTHERAPY SERVICES

SERVING ALL OF CENTRAL WISCONSIN — TO HELP YOU FIND WHAT'S MISSING

Toll Free: 800-681-2374 **Mailing Address:** PO Box 959, Stevens Point, WI 54481 **Fax:** 715-952-4995
Email: office@advocatepsychotherapyservices.com **Website:** www.advocatepsychotherapyservices.com

Name:_____

Home Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____ *(circle preferred #)*

DOB:_____ Age:_____ Sex:_____ Marital Status:_____

Employer:_____ Referral Source: _____

Spouse's Name:_____ DOB:_____ Cell Phone:_____

Spouse's Employer:_____ Work Phone:_____

Children: Name_____ Age_____ Name_____ Age_____

Name_____ Age_____ Name_____ Age_____

Email Address: _____ *(please read and sign the email use consent form, too)*

(Your email is also used for appointment reminders and e-bills/statements; any reply to your email may be encrypted for security)

Primary Insurance Coverage

Subscriber Name_____

Subscriber Address_____

City_____ State_____ Zip_____

Subscriber Ph_____DOB_____

Employer_____ Group #_____

Policy / Member ID #_____

Insurance Co Name_____

Insurance Co Phone_____

Secondary Insurance:

Subscriber Name_____

Subscriber Address_____

City_____ State_____ Zip_____

Subscriber Ph_____DOB_____

Employer_____ Group # _____

Policy / Member ID #_____

Insurance Co Name_____

Insurance Co Phone_____

I authorize insurance payments directly to Advocate Psychotherapy Services for services performed.
I authorize Advocate Psychotherapy Services to release any medical information necessary to process claims.
I consent to having my email addressed used to send me my statement electronically and to receive my payment receipts.
I may be charged **$60** for missed appointments and for appointments cancelled less than 24 hours in advance.
If any other payor source denies benefits, I will be held responsible for the amount due.
I recognize and accept personal responsibility for payment of my deductible and / or co-pays.
In the event any unpaid balance is placed for collections – *generally past 120 overdue without any payment plan in place* - with any third party collection agency, and/or placed with an attorney to obtain judgment or otherwise satisfy payment of this account, the maximum monthly interest rate per Wisconsin law will be accumulating against the total amount due until resolved.
A late fee of **$15.00** will be added each month for any account more than 60 days overdue.

Client/Guardian Signature_____ Date_____

Please make sure you read and sign the back of this form

CLIENT RIGHTS and HIPAA INFORMATION

I understand that the following is a summary of my rights as a client of Advocate Psychotherapy Services:

The right to prompt and adequate treatment environment.

The right to be treated with respect and dignity.

The right to confidentiality of conversations and records.

The right to refuse to be filmed or taped.

The right to participate in the development of any treatment plan, including benefits, effects and method of treatment.

The right, upon request, to receive information regarding alternative programs or methods of treatment.

The right to refuse any treatment, including medications.

The right to have access to my treatment record after discharge, during treatment if facility director approves it, and to have access at all times to records of medications or treatment I receive for physical health reasons.

The right to refuse, or to give informed consent, to participate in drastic treatment or in experimental research. Informed consent shall remain in effect until formal discharge from the treatment program, unless revoked by me in writing.

The right to file a grievance.

If I believe that one of my client rights may have been violated, the agency's complaint investigator will investigate the matter and attempt to find a resolution. If I wish to file a complaint, I may request a complaint form from any staff member of the agency.

I am encouraged to contact my therapist regarding any concerns or problems I may have during my treatment and after my discharge. I further understand that I may, at any time, request resumption of services. I understand my therapist may consult with another licensed professional, psychiatrist, or psychologist regarding my case.

Advocate Psychotherapy Services cannot be responsible for children left unsupervised in the waiting room.

Client/Guardian name (print)_____

Client/Guardian Signature_____ Date_____

I acknowledge that I have received written notice of my HIPAA related rights / Notice of Privacy Practices that describe how and for what reasons my protected health information (PHI) may be disclosed to others. I understand its content and I am aware of my rights and responsibilities as a client of Advocate Psychotherapy Services LLC.

_____ Initial Here

(Copy available upon request)