Nancy M. Vrechek, Ph.D.
125 W Indiantown Rd, 203A
Jupiter Fl 33477
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Welcome to My Practice

We appreciate the opportunity to work with you and support your decision to enter into counseling and/or psychotherapy. Please read the following basic information regarding our policies. This information is provided to assist you in making informed decisions regarding our services. Please feel free to ask questions at any time.

Appointments:
Individual, couples, or family sessions are for 45 minutes (known as the "clinical hour"). If you must re-schedule an appointment, at least 24 hours is necessary to avoid being charged for the sessions, unless it was due to an emergency. **The fee for cancellation without a 24-hour notice or for a "No Show" is $75.00.** This fee cannot be billed to your insurance company.

Fees:
Psychotherapy:
The fee for individual, couples, or family sessions is $150 per session. If more than your scheduled time is needed, and if the time is available, the charge is $75 per half session. Cash or check only.

Psychological testing:
Fees for psychological testing are charged on a per test basis and vary according to the usual time required to administer, score, and interpret the specific test(s) used. Psychological tests often provide important Diagnostic information that is an aid in treatment planning. Even when a diagnosis seems clear, psychological testing is often beneficial, as it can provide greater understanding in a much shorter time. If I believe testing would be helpful or is needed, I will discuss this with you in advance and the discussion will include the nature of the test(s) to be utilized, the rationale for the testing, and the fee(s). Usually results are discussed with clients. A written report can also be provided, but the preparation time required will increase costs to you.

Other services:
Fees for court ordered evaluations; appearances, depositions, telephone consultation, travel, communications or mediated agreement evaluations and out of office services are billed on an actual time and expense basis ($250.00/hr.) Please note that these non-therapy services are not billed through your insurance. You are solely responsible for their payment. (In the event that a summary report is requested on your behalf, the fee is based on the preparation time needed at the rate of $250.00/hr) Copies of documents are provided at $1.00 per page. There are limits to confidentiality and privilege for non-therapy services which will be explained to you at your first visit. Payments are due for these services on a retainer basis and before a report is issued.

Payment Methods:
Payment for services is required *at the time services are provided.* If this is a financial hardship for you, please discuss this with me. If needed, I will bill your insurance company for payment of their portion of the charges. However, you are responsible for any portion of the fee not covered by

them. We cannot guarantee that your particular insurance carrier will cover services provided. It is your responsibility to verify your specific contractual requirements and/or exclusions of your policy. You are responsible for any deductible due and co-pay, if applicable, at the time of each visit. Should we file for you, *payment in full for the initial session is required, and your co-payment and any subsequent unreimbursable portions of fees will be made when services are provided.* If your carrier makes payments to you directly, you are responsible to pay each session in full at the time of service and we will be happy to file for your or provide you with a receipt for filing for reimbursement. Medicare patients with supplementary insurance should be aware that, as a rule, secondary carriers only pay a portion of the patient's Medicare co-payment. Therefore, patients with supplementary carriers should be prepared to pay their co-payment in full at the time of the visit until payments received reflect full coverage for these services. Payments are accepted by CASH or CHECK ONLY.

Emergencies:
If you have an emergency, please call our office and identify as such. Because of our other patient commitments, we may not be available immediately. In such a case, here are some alternative numbers to call:

Police/Fire/Poison Control: 911 Jupiter Hospital ER: 744-4460
Oakwood Mental Health Center-Crisis and Stabilization: 844-9741
Crisis Line: Palm Beach/Martin/St. Lucie Counties: 211
Child Abuse Registry: 1-800-342-9152

Client's Rights:
You may question or refuse any suggested therapeutic or diagnostic procedure or methods at any time. If we are unable to agree on treatment methods, a referral can be given, or therapy can be discontinued. Clients are also assured of confidentiality. There are exceptions to confidentiality that are legally mandated. In general terms, these exceptions are (1) the law requires that I notify relevant others if I judge that a client has intention to harm another individual; (2) I am also obliged by the law to report an incident of suspected child abuse, neglect, or molestation in order to protect the children involved; (3) in legal cases, I or my records may be subpoenaed by the court; (4) if you are requesting my services as the parent or guardian of a minor, I may not release specific information but do feel it is appropriate for me to discuss with you your child's progress and your participation in the treatment. I may need a copy of a divorce decree to verify guardianship. Otherwise, confidentiality will be maintained unless you have a signed a completed "Release of Information" form giving me permission to discuss or provide information with specified others. HIPPA laws also protect you. A copy is in the office for your review at your initial appointment and you may ask for a clarification of these protections at any time.

Agreement:
By signing below, I acknowledge having read and understood the above information and agree that my medical information may be released to my health insurance carrier and its agents in order to access my health insurance benefits. Further I agree to any and all stipulations in this document as to receiving services from:

PATIENT NAME/RESPONSIBLE PARTY_____DATE_____

Nancy M. Vrechek, Ph.D.

Lic. Psychologist and Marriage and Family Therapist

Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the "Information for Clients" brochure and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that devel-oping a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call to cancel an appointment at least 24 hours (1 day) before the time of the appointment. If I do not cancel and do not show up, I will be charged $75.00 for that appointment.

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s), and providers of any services or treatments I receive. I understand that if payment for the ser-vices I receive here is not made, the therapist may stop my treatment and that I am responsible for unpaid services.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of client (or person acting for client) Date

_____ _____

Printed name Relationship to client (if necessary)

I, the therapist, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

❑ Copy accepted by client ❑ Copy kept by therapist

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

FORM 13. Form for generic consent to treatment of an adult. From *The Paper Office*.

Nancy M Vrechek, Ph.D. – Licensed Psychologist and Marriage and Family Therapist

Your cooperation in completing this questionnaire will be helpful in planning our services for you. Please fill each item carefully or ask your therapist for clarification if you do not understand an item.

Full Name:_____ Date:_____

Address: _____

Street City State Zip

Telephone:_____EMAIL_____

Home Work Cell

Age: _____Birth Date: _____Marital Status:_____

Occupation: _____Social Security Number:_____

Education:_____Are you working now? Y N Where?_____

Briefly Describe Your Reason for Seeking Help:_____

_____

Who referred you to our Office?_____Can I contact you via phone? Y N; e-mail Y N;

Who is your physician /primary care physician?_____Phone:_____

Whom have you previously consulted about your present problem?

_____

Please check any of the following that apply to you:

Worry	Sexual difficulties
Headache	Over Anxious
Palpitations	Inferiority feelings
Bowel disturbances	Memory problems
Nightmares	Can't keep a job
Feeling tense	Weight loss gain
Depressed	Anger
Unable to relax	Fainting spells
Don’t like weekends	Loss of appetite
Can’t make friends	Insomnia
Financial problems	Alcoholism
Sad	Tremors
Dizziness	Take drugs
Stomach Trouble	Can’t make decisions
Fatigue	Home conditions bad
Feel panicky	Unable to have a good time
Suicidal ideas	Other
Concentration Difficulties	

Are you taking any medication for these? Yes No If yes, name:_____

Prescribed by: _____Dosage:_____

Any current side effects?_____

In order to coordinate your care, may I contact your Primary Care Physician or Psychiatrist?

Please Initial Here to agree_____

Family History

Father:
Living or deceased:_____If alive, father's present age:_____ Occupation:_____
Health:_____
If deceased, your age at time of his death____ Cause of death:_____

Mother:
Living or deceased? _____If alive, mother's present age:_____ Occupation:_____
Health:_____
If deceased, your age at the time of her death:____ Cause of death:_____

If you have a stepparent give your age when parent remarried:_____ How is (was) your relationship with your parents and or
stepparents?_____

Siblings:
Number of brothers: _____Ages:_____
Number of sisters: _____Ages:_____
Has any member of your family suffered from Alcoholism or Drug Addiction?_____
Give details:_____
Has any member of your family suffered from anything which can be considered a mental disorder? Give details:_____
Are there any other members of the family about whom information regarding illness, etc. is relevant?_____

Marital/couple History:

Are you or ever were in a significant relationship including marriage? Please give details of when and length of each union including children from each relationship.

Current Partner's age: _____Occupation of partner:_____First Name:_____
If single, are you dating'? _____How long with this person?_____
Any relevant details concerning miscarriages or abortions?_____

If you have children, please state their age/gender/Name:_____
Do any of your children present special problems?_____

General Questions
Are you too emotional or too unemotional?_____
Are you able to express your emotions?_____
What makes you nervous? _____
Any history of significant, negative events in your life? Explain:_____
_____

Additional Information You Think I should know:

Medical History

Have you ever abstained from or "quit' anything?_____
What and why?_____
For how long?_____
Have you ever craved that which you have curbed?_____When?_____
Have you ever had a psychiatric treatment?_____
When?_____ Where?_____
Have you ever attempted suicide?_____
When?_____Where?_____
Have you ever overdosed from a drug?_____
Have you ever been hospitalized?_____
When?_____Where?_____
What medicines are you taking now? List dosage and name:_____
What diseases run in the family?_____

Do you smoke? If so, how much daily? Cigarettes:_____ Marijuana_____Other_____
Do you us: alcohol?_____ If so, how much daily?_____ Weekly?_____
Have you ever had or do you now have any of be following: (please check)

Hepatitis	Convulsions
Rheumatic fever	Venereal Disease
Anemia	Headaches
Tuberculosis	High blood pressure
Asthma	Blood in urine
Pneumonia	Kidney trouble:
Allergy	Accidents
Skin problems	Surgery
Arthritis	Stomach trouble
Diabetes	Other

List any major health problems for which you currently receive treatment:_____
_____
What other serious disease or symptoms have you had that are not on this list?_____
_____

CLIENT SIGNATURE:_____DATE:_____

THERAPIST SIGNATURE:_____DATE:_____

AGREEMENT

PATIENT'S
NAME:_____DOB_____

The undersigned agrees whether he, signs as an agent or as a patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to promptly pay the account of Dr. Vrechek in accord with her office policies. In the event of default, the undersigned will pay all cost of collections including court costs and reasonable attorney's fees.

UNLESS CANCELLATIONS are made 24 HOURS prior to the time of appointment a $75 charge will be made for the time allotted. Patient/responsible Person is solely responsible for this fee.
The undersigned certifies that he/she has read the foregoing and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms.

DATE: _____SIGNED:_____
Patient
DATE:_____ SIGNED:_____
Responsible Person
DATE:_____SIGNED_____
Witness

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize Dr. Vrechek to submit Medicare or insurance claims without my signature. I authorize the release of any medical information necessary to process this claim and related claims that may be necessary in order to access my health insurance benefits. I request payment of Medicare or insurance benefits either to myself or to the party who accepts assignment of the claim. I authorize payment of medical benefits to the physician indicated above for services described on claim form.
DATE:_____ SIGNED:_____

PRIMARY INSURANCE INFORMATION

_____
Insurance Company Telephone (to verify coverage)
_____
Insurance Company Address City/state Zip
_____
Insured's Name (policyholder) Date of Birth Policy/social Security #
_____
Place of employment Group Name/Number
_____
Employment Address City/state Zip