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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 \$175 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.

Parent Coordination: Services are provided according to the terms of your court order referral.

Forensic 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.* For Medicare, 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. It is your responsibility to verify your specific

contractual requirements and/or exclusions of your policy. 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 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.

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? _____

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? _____

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 your relationship with your stepparent? _____

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:

How long married? _____ If cohabitation, length of time: _____

Is this your first marriage? _____ If not, length of each union: _____

How long did you know your partner before marriage/cohabitation? _____

Partner's age: _____ Occupation of partner: _____ 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 use alcohol? _____ If so, how much daily? _____ Weekly? _____

Have you ever had or do you now have any of the 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

Medicare only: 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