JANICE SULTENFUSS, PH.D.

CLIENT INFORMATION

Welcome! I would like you to know about some very important aspects of the services I will be providing to you. I would also like you to signify your acceptance of these arrangements by signing this form and returning it to me at the time of your first visit.

Your first consultation session will give you the opportunity to determine if you are compatible in treatment with me and for me to determine whether a therapeutic relationship can be established.

CONFIDENTIALITY: Your identity and any information shared by you will be held in the strictest confidence. The right to release information about you belongs to you. No information, including the fact that you are being seen by me, will be released to anyone without your written permission.

Exceptions to this confidentiality policy are made as a result of a legal requirement to report:
The abuse or neglect of a child or dependent adult. * Imminent danger of hurting yourself or someone else. * In cases of court involvement, your treatment record (if it is court ordered). * Dates of treatment and billing record if legal collection action becomes necessary. * Information regarding treatment, date of service, diagnosis, and treatment plan if you should submit claims for these services to your insurance company and your insurance company requires this information.

APPOINTMENT: I will see you on an appointment basis. We will establish a regular time for your appointments that works for both of us. Please NOTIFY ME AT LEAST 24 HOURS PRIOR to your appointment if you need to cancel or you may be charged the full fee for the missed appointment. I do not charge for missed appointments due to snowy or icy roads. (If the Staunton Schools are closed, my office will be closed.) If you cancel your appointment within 24 hours of the appointment you may still be charged if you had a significant number of late cancellations or missed appointments due to situations that were not emergencies. You will be responsible for missed appointment fees as they are not billable to your insurance.

TELEPHONE CONSULTATIONS: I will talk to you as soon as possible if you need to talk between appointments. If it is a psychiatric emergency, call 911 or go to the Emergency Room. Otherwise, if you get my voice mail, please leave a message and your call will be returned as soon as possible. Telephone consultations of more than five minutes may be billed to you on a prorated basis. Insurance does not cover this service.

PAYMENT FOR SERVICE: You agree to pay in full for services not covered by your insurance and for your portion (co-pay) of covered services, including any legal or other costs incurred in the collection of your account if it becomes delinquent. I will file your insurance, but your co-pay is due at time of service. If you wish to file your own insurance or opt not to use insurance (preserves privacy), you agree to pay the full fee at the time of service. If you have difficulty paying for on-going services or have a significant outstanding balance, I may develop a budget plan with you, adjust the frequency of your visits, or assist you in obtaining alternative services.

Would you like for us to communicate with your Primary Care Physician?

I agree ___________________ I refuse ___________________ I do not have a PCP _________________________

Physician's Name ____

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Physician's Phone # ________________________________Fax # ______________________________

Physician's Address ____

I authorize services for myself. I agree to everything stated above and acknowledge that I have been given an opportunity to review and/or receive a copy of the Client Bill of Rights and the Notice of Privacy Practices.

Signature____

Please PRINT your name ____

Social Security Number of responsible party _________________________ Date __________________________

In case of emergency, notify _______________________________________ Phone # _______________________

Therapist Signature ____ Date __________________________