**Janet Borden, LCSW PLLC**

3010 S Harvard Ave, Suite 110

Tulsa, OK 74114

918-749-1840

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# Demographic Sheet for Children/Adolescents

Patient’s Name \*\*SS#

Birthdate Age Gender

Religion Ethnicity

Address County

City/State/Zip

Phone Email

School Name Current Grade Placement

Parent/Guardian \*\*SS#

Birthdate Age \*\*Employer

Address City/State/Zip

Home Phone Cell Phone email

Parent/Guardian \*\*SS#

Birthdate Age \*\*Employer

Address City/State/Zip

Home Phone Cell Phone email

Parent/Guardian Name, (if applicable) \*\*SS#

Birthdate Age \*\*Employer

Address City/State/Zip

Home Phone Cell Phone email

In Case of Emergency Contact: Phone

# Demographic Sheet for Children/Adolescents (Cont)

Health Insurance Company

Which parent carries the insurance benefits on this child/adolescent?

Not applicable for a child/adolescent with Medicaid/Medicare/Soonercare.

Insured’s ID Number Group or policy number

Is there a secondary insurance? Yes No; If so, Health Insurance Company

Insured’s ID Number Group or policy number

**PLEASE PRESENT YOU INSURANCE CARD(S) AT THE FIRST APPOINTMENT, AS COPIES WILL BE MADE.**

Referred by:

Reasons/expectations for appointment:

Child/adolescent’s Pediatrician or Primary Care Physician:

Address:

City State Zipcode Phone

Names of other health care providers currently involved:

Please list any medications and dosages:

Payment or copay is expected at the time of your appointment. Payment/copays at the time of service allows billing costs to be kept at a minimum. Cash, personal checks, and Visa/MasterCard are accepted. **Please make checks out to Janet Borden, LCSW.**

I have read the above and I accept financial responsibility for services rendered.

Parent/Guardian signature Date

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**CONSENT TO BUSINESS PRACTICES, CONSENT FOR RELEASE OF INFORMATION**

Welcome to my practice. This consent contains important information about my professional services, my business policies, and summary information about the Health Insurance Portability and Accountability Act, (HIPAA). Please read it carefully and bring any questions you might have to our first meeting.

**Please return this consent, insurance information, the health history form, and any other information that you may believe would be relevant or helpful, (previous evaluations, teacher reports, medical reports, etc), to our first meeting.**

# Therapeutic Services

Prior to our first session, I will have reviewed any relevant records or information you have sent. Generally, I will conduct an initial assessment that lasts from one to three sessions. This allows enough time to discuss history and current concerns about your situation or your child. At the end of the evaluation sessions, appropriate goals, the amount of time it might take to accomplish those goals, and whether or not this provider seems to be the appropriate person with whom to work will be discussed. Should therapy begin, we will schedule 45-60 minute sessions at regular intervals, such as weekly or every-other-week, depending on need.

# Insurance

Most health insurance plans or other third-party payers, (such as Medicaid), require the release of PHI in order to process and review claims. This information may include diagnoses, specific treatment plans or goals, details of a patient’s history or symptoms, or even more specific details of evaluation or therapy sessions. These third parties are also governed by HIPAA; however, no responsibility or liability can be accepted for subsequent use of misuse of information released under your authorization for the filing of insurance claims. If you have specific questions or concerns about this, you should discuss them with your specific provider and/or your healthcare administrator.

In recent years insurance benefits have become increasingly complex, and it is sometimes difficult to determine exactly how much mental health coverage is available. Managed care plans often require authorization before they will provide reimbursement for services, and these plans often limit the types of services covered or are limited to short-term treatment approaches. You should be aware that your insurer might decline to authorize reimbursement even if it is preauthorized or they may limit the services authorized. *If insurance declines payment, you are ultimately responsible for your bill.*  Please clarify your questions as needed with your individual insurance provider before treatment begins. As a courtesy to you, your insurance will be billed if you have provided needed information. We request insurance co-pays at the time of service unless other arrangements have been made.

# Contacting your provider

I frequently will not be immediately available by telephone. When unavailable, the telephone is answered by voice mail that is monitored frequently. If you have an emergency or crisis, please seek assistance at the emergency room of the nearest hospital or call 911. If I must be away from the office for an extended time, the voice mail will reflect this and will give further instructions.

If you have questions about any of these policies, please bring these to your first session or call the office and we can discuss any concerns you have. Otherwise, please sign the following:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read the preceding information and have asked questions about issues that I do not understand or that need to further clarification.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient, Parent, or Guardian Signature Date

**Consent for Treatment**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request and authorize my provider, Janet Borden, LCSW, to provide professional clinical social work services to my child, family and/or myself. These services may include assessment or evaluation, counseling, and/or psychotherapy in individual, group, or family formats, psychoeducational counseling or training, behavioral intervention, professional consultation, and any other additional services or procedures discussed and agreed upon.

I understand that the fees for services are covered by Medicaid or Soonercare. Extended telephone contacts will be prorated at $125.00 per hour charge if the phone contact exceeds 10 minutes and this is **not** a covered expense. I understand that I may be liable for payment of lengthy time spent talking with my provider outside of the scheduled appointments.

I understand that I will personally assume financial responsibility for all fees or charges arising from the services provided by my provider if I allow coverage to lapse or am no longer eligible for coverage. This includes service requested by me or necessitated by other circumstances including but not limited to subpoena or other court process. Formal payment arrangements, if I cannot pay in full, may be made by calling Janet Borden at 918-697-4117, and negotiated. Unless another formal payment agreement is arranged, I understand that any balance unpaid for greater than 60 days, excluding insurance payments, may be subject to additional monthly charges of $15.00 for maintaining and billing the account. If my account is more than 90 days in arrears and suitable arrangements for payment have not been agreed to, I understand that billing procedures automatically forwards my overdue account to a collection agency or small claims court. If such legal action is necessary, the attorney and court costs will be included with my full account balance. A monthly statement on my account and a single insurance billing for each session or service provided will be made as a courtesy to me.

**I understand that I may be charged $20.00 for appointments I miss unless I notify my provider or the offices of Janet Borden, LCSW PLLC at least 24 hours in advance**. I understand that Soonercare, Medicaid, or insurance do not cover such charges and that I may be personally liable for the charges. I also understand that if I fail to come to an appointment, someone else waiting to my provider could have been seen. **I understand that the office policy is to cancel subsequent appointments until I have called, acknowledged the missed appointment, and clarified my intention to attend any further scheduled appointments.**

I acknowledge receiving an explanation of the limits to confidentiality. I authorize Janet Borden, LCSW to submit bills and to furnish confidential information including but not limited to diagnoses and financial information to any insurer, third party payer, or welfare agency providing financial assistance for the services rendered. A photocopy of this authorization is to be considered as valid as the original.

I certify that I have legal standing to authorize these professional psychological services or that I have legal custody and/or other required legal standing to request and authorize professional psychological services for myself or my child or children.

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Patient, Parent, or Guardian Signature Date