SUFFOLK DBT J.L., LCSW

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Date:_________________

PATIENT INFORMATION

Name: ____

Date of Birth: __________________________ Social Security #: ______________________________

Address: ____

____

Home Phone #__________________________ Cell Phone # __________________________________

Work Phone # __________________________ email: _______________________________________

May we call you at home to confirm your appointments? Yes ( ) No ( )

If not, please indicate the best number to reach you: _______________________________________

Patient Status: ( ) Single ( ) Married ( ) Other ( ) Employed ( ) Disabled
( ) Full-Time Student ( ) Part-Time Student

Sex: ( ) Male ( ) Female

Name of Referral Source: ____

Other Source (please state): ____

EMERGENCY CONTACT INFORMATION

Full Contact Name: _________________________________ Relation to Patient: _____________

Home #: _____________ Cell #: ____________________ Work #: ____________________

INSURANCE INFORMATION

Please Note: You are responsible for all amounts not paid by your insurance plan; this includes any deductible required. X____

In order to facilitate prompt insurance claim processing, kindly fill in **all** requested information on this form.

PRIMARY INSURANCE INFORMATION

Insurance Company Name: ____

ID#: ________________ Deductible Amount: ___________ Already met? ______

Patient's Relationship to the Insured: ( ) Self ( ) Spouse ( ) Child ( ) Other

Policy Holder's Name: ______________________________ Date of Birth: ___________

Policy Holder's Social Security #: _______________________ Sex: ( ) Male ( ) Female

Policy Holder's Employer: ____

Plan or Group #: ____________________ Insurance Company Phone #: ______________

SECONDARY INSURANCE INFORMATION:

Insurance Company Name: ____

ID#: ________________ Deductible Amount: ___________ Already met? ______

Patient's Relationship to the Insured: ( ) Self ( ) Spouse ( ) Child ( ) Other

Policy Holder's Name: ______________________________ Date of Birth: ___________

Policy Holder's Social Security #: _______________________ Sex: ( ) Male ( ) Female

Policy Holder's Employer: ____

Plan or Group #: ____________________ Insurance Company Phone #: ______________

MEDICAL INFORMATION

Primary Care Doctor's Name & Contact Number:____

Medications Prescribed & Dosages: ____

Psychiatrist's or Psychiatric Nurse Practitioner's Name:_____________________________________

Medications Prescribed & Dosages: ____

Vitamins, Herbs, or any other Over-the-Counter Medications:________________________________

Allergies to Medications: ____

******PLEASE READ CAREFULLY AND SIGN THE FOLLOWING******

I understand that I am responsible for any fee amounts not covered by my insurance carrier, including the deductible.

Signature: X____________________________ Date: ______

ASSIGNMENT OF BENEFITS

I, ______________________________ hereby assign to my treating therapist at **Suffolk DBT J.L., LCSW** all major medical benefits to which I am entitled including Medicare and other government-sponsored programs, private insurance and any other health plans.

I understand that I am financially responsible for any charges which are not paid by any aforementioned insurance carrier. I hereby authorize said assignee to release information necessary to secure the payment of said benefits. This assignment will remain in effect until revoked by me in writing.

Signature: X____________________________ Date: ______

Your signature above authorizes the therapist treating you to furnish any necessary information regarding your case to your insurance carrier and to be assigned all benefits and fee amounts not covered by your insurance company.

*******IMPORTANT NOTE*******

You agree to be billed $180.00 for appointments cancelled less than 24 hours before your scheduled appointment as well as for scheduled visits for which you do not show. We provide confirmation calls the evening before your appointment as a courtesy reminder. If you cancel your appointment at the time of the courtesy confirmation call, and it is less than 24 hours before your scheduled visit, you will still be assigned the late cancellation fee. X_____

In the event that your account is not paid in accordance with this agreement and turned over to our collections agency, you agree to pay all additional fees assessed in the collection of the debt. These fees may include collection agency fees and attorney fees.

CONFIDENTIALITY

Your treatment at ***Suffolk DBT J.L., LCSW*** is kept in the strictest of confidence. No one will be permitted access to your treatment information unless you specifically put in writing that you authorize release of such information to a specific party, at a particular time.

Times when confidentiality must be breached pertain to your safety, the safety of others who may be in imminent danger, or when your records are subpoenaed by a court of law. In any situation requiring a breach of confidentiality, attempts will be made to contact you beforehand. If you have any questions regarding this policy, or have vague concerning situations, please ask one of our staff members for clarification. Please understand that it is important for you to immediately address this policy if you require clarification.

PARTICIPATION AGREEMENTS FOR DBT SKILLS GROUP

I agree to attend my assigned weekly DBT Skills Group at ***Suffolk DBT J.L., LCSW*** understanding that it will take approximately 12 months to cover all of the skills in the manual.

As a participant in group, I agree to attend all sessions free from the influence of drugs and alcohol.
X____

I agree to be an active participant in the weekly DBT Skills Group. I also agree to practice the DBT skills taught in the group and to complete weekly homework assignments. **X____**

In addition to participating in the weekly DBT Skills Group, I agree to attend regular weekly individual DBT therapy sessions. **X____**

To abide by ***Suffolk DBT J.L., LCSW*** attendance rules, I agree to arrive on time for group as well as individual sessions. Furthermore, I understand that missing **4** consecutive weeks of either individual therapy or DBT Skills Group means that I have "dropped-out" of DBT treatment for the remainder of my contracted period. **X____**

PARTICIPATION AGREEMENTS FOR DBT SKILLS GROUP CONTINUED

I understand that the DBT skills group fee is $90.00 per session and said fees if not paid by insurance are payable on a weekly basis. Being that weekly group participation is expected and considered part of the DBT program commitment, I understand that payment is due regardless of attendance.
X____

I understand that if my insurance company normally covers my DBT Skills Group but I am absent from any group session/s then I, as the participant, **will be** responsible for the missed group session/s fee because my insurance company cannot be billed for sessions not attended. **X____**

****IMPORTANT NOTE****

If you miss a group session you will be charged the full $90.00 for the session, even if you do call 24 hours in advance. **X____**

CREDIT CARD INFORMATION

Cardholder's Name:____
Patient's Relationship to Cardholder: ( ) Self ( ) Spouse ( ) Child ( ) Other ____________
Card Type: Visa___ MasterCard___ Discover___ American Express___
Card #: ____
Exp. Date: __________________ **Code:** ________ **Billing Zip Code:** _________

*This card will be charged on the date of service for all the group therapy sessions which are not covered by insurance. **X____**
*This card will also be charged for any outstanding balances over $180.00. **X____**
*This card will also be charged for any missed individual or group appointments. **X____**

***Please be advised – if you are over 18 and the card on file is not your own, you are allowing us to disclose financial information regarding your attendance to the cardholder.** **X____**

CREDIT CARD INFORMATION CONTINUED

If you DO NOT want your card charged:

- You must bring in a payment ***BEFORE*** the first of the month;
- You must remit payment at the time of your next visit if you have missed a session the week prior, otherwise this card will be charged and
- You must not accrue a balance in excess of $180.00, or else this card will be charged.

MULTI- FAMILY DBT SKILLS GROUP AGREEMENT

To participate in the *Suffolk DBT J.L., LCSW* program, I understand that family involvement is **REQUIRED** as empirical research has clearly indicated that it predicts treatment success in DBT. To fulfill this program requirement, I understand that at least one family member/friend must attend all 16 group sessions that review 5 skills modules: Mindfulness, Distress Tolerance, Emotion Regulation, Interpersonal Effectiveness, and Middle Path Skills. The cost of each Family Skills Workshop is $150.00 and is covered by most insurance that are accepted by our practice. **Please note: If a Multi-Family DBT Skills group session is missed, you will be charged the full $150.00 for the session, even if the practice is notified 24 hours in advance.** Failure to fulfill this program requirement within the first year of treatment will constitute the patient in treatment having "dropped-out" of the DBT program for the remainder of the contracted treatment period. **X____**

TREATMENT/CONSULTATION TEAM AGREEMENT

It is possible that your treatment may involve more than one practitioner housed within this practice. Your signature below provides consent for communication between said practitioners for consultative purposes and for optimal coordination of care. Kindly understand that although team collaboration may be part of the DBT treatment approach, ultimately each individual therapist involved in your care is held independently responsible for any of his/her treatment decisions made on your behalf.

Our contract is designed to reflect an active interest in your concerns for we are dedicated to assisting you in reaching mutually agreed upon goals.

By signing below, you are indicating that you have read, understand, and are in agreement with all points of this contract in its entirety.

Signature **X____** **Date** __________

Witness **X____** **Date** __________