Patient Registration Form

Name (Last)_____ (First)_____ (Middle)_____

Address:_____ Phone # ( )_____-_____

City: _____ State:_____ ZIP:_____

Date of Birth:_____/_____/_____ Soc. Sec #_____-_____-_____ Gender : _____ Marital Status : _____

Parent/Spouse's Name:_____ Date of Birth:____/____/____ Soc. Sec #_____-_____-_____

Emergency Contact: _____ Relationship: _____ Phone # ( )_____-_____

Do You Have Medical Insurance? Yes No (If Yes, Please Answer **ALL** Questions Below)

Primary Insurance Company_____

Policy #_____ Group#_____

Does your insurance require authorization prior to the first session? _____ If yes, have you contacted the company? _____

Policy Holder's Name & Relationship_____

Policy Holder's Date of Birth:_____/_____/_____ Policy Holder's Soc. Sec #_____-_____-_____

Policy Holder's Employer's Name_____ Employer's Phone # ( ) _____-_____

Employer's Address_____

Secondary Insurance Company_____

Policy #_____ Group#_____

Does this insurance require authorization prior to the first session? _____ If yes, have you contacted the company? _____

Policy Holder's Name & Relationship_____

Policy Holder's Date of Birth:_____/_____/_____ Policy Holder's Soc. Sec #_____-_____-_____

Policy Holder's Employer's Name_____ Employer's Phone # ( ) _____-_____

Employer's Address_____

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature of this document authorizes my physician to submit claims for benefits for services rendered for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I authorize and assign payment of all/any insurance benefits to my provider, that is otherwise payable to me for his/her services as described on the assigned payment forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to my provider, will be credited to my account in accordance with the above assignment.

_____ _____ _____

(Print Name of Patient) (Authorized Signature of Patient/Parent/Guardian) (Date)

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

By signing this form, you acknowledge that you have received a copy of the Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us after April 14, 2003. If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true:

[ ] I have received a copy of the Privacy Notice. [ ] I have had the chance to discuss my concerns and questions about the privacy of my health information.

_____ _____ _____

(Print Name of Patient) (Authorized Signature of Patient/Parent/Guardian) (Date)

Note: If the patient is under the age of 19, their parent or guardian must sign all legal documents provided.

3801 Union Drive, Suite 206, Nebraska 68516
PHONE: 402-489-2218 FAX: 402-489-3666

Diane C. Marti, Ph.D., LP, LLC

Children, Adolescents, Families, Individuals, School Consultation, & Autism Spectrum Disorder

CONSENT TO THERAPY AND CONFIDENTIALITY STATEMENT

In compliance with the ethical and legal guidelines delineated by the American Psychological Association and the American Counseling Association, my psychologist/counselor has explained that my participation in therapy is completely voluntary and confidential. In signing this document, I provide my voluntary consent to participate in therapy/counseling for myself and/or my minor child. I understand that I may refuse and/or terminate services for myself and/or my minor child at any point during the counseling process, without adverse repercussions between this agency and myself.

I also understand that Diane C. Marti Ph.D., LP, LLC, will maintain protected health information records relevant to therapy, as well as information obtained through consultation with other professionals. I understand that these records are restricted to the internal use of Diane C. Marti Ph.D., LP, LLC. and their confidentiality will be strictly maintained at all times. I understand that Diane C. Marti Ph.D., LP, LLC has employed administrative assistants who manage the transcription, billing, scheduling, filing, and other miscellaneous office duties and that these individuals have been bonded to uphold the state and federal guidelines with regard to maintaining confidentiality. Diane C. Marti Ph.D., LP, LLC will release the written or verbal information regarding my intake or counseling sessions only upon receipt of my written consent and only to those specified by myself, except in unusual circumstances. In circumstances where there is risk of danger and/or impending harm to myself or others, child abuse, and/or certain legal situations (for example, court subpoena of your records), Diane C. Marti Ph.D., LP, LLC would be mandated by law to disclose such information for my protection and/or that of others. In such situations, my psychologist will make reasonable attempts to discuss the situation with me and enlist my participation in resolving the matter, if possible. If I have any questions, I understand that I can discuss them freely with Diane C. Marti Ph.D., LP, LLC

I have had these rights explained to me and by my signature, I indicate my understanding and agreement. I also understand that I have the right to refuse to sign this consent form. By my signature, I authorize that a photocopy or facsimile (FAX) copy shall have the same effect and authority as the original copy of this document.

Client/Parent/Guardian_____ Date_____

Witness_____ Date_____

Children and adolescents may need to discuss information with their counselor in confidence. Often, such information is important for the purposes of providing your child with appropriate assessment and treatment services, but would not be provided to the parent. Diane C. Marti Ph.D., LP, LLC requests that you support your child's need for privacy, excluding situations in which there is a risk to the health and welfare of your child. I provide my permission to my child's counselor to maintain the confidentiality of my child _____, except in circumstances in which there is a risk to her/his health or welfare.

Parent_____

Dr. Diane C. Marti, Ph.D.,
Of Marti Mental Health Services Inc.,
Children, Adolescents, Families, Individuals, School Consultation, & Autism Spectrum Disorder

BILLING POLICIES

The fees for services provided by Dr. Diane C. Marti Ph.D., Of Marti Mental Health Services Inc., will be in accordance with the reasonable value set forth by the established community guidelines and standards. The following fees are based on a self pay rate and are subject to change at any time. Specific insurance company rates as accepted by this provider may reduce the rate of the aforementioned fees based upon the contractual agreement between the provider and Insurance company.

CPT Code	Cost	Description
90791	$260	Initial Session
90832, 90834, 90837	$165, $180,$280	Individual therapy, vary by session length
90846/90847	$195/$195	Family therapy
90839	$245	Crisis Psychotherapy
90853	$65	Group therapy
90887	$61.25	Feedback session, per 15 minutes
90889	$93.25	Prep. of documentation (e.g., for another agency, attorney, court, school)
96130, 96131, 96136, 96137, 96146	$180, $140, $120, $80	Psychological Assessment Services All services are priced per unit. Units vary depending on service.

Clients are expected to pay fees at the time of service unless other billing arrangements are agreed upon in advance. If payment is not received for two consecutive sessions, the client may not schedule an appointment until the fees owed are paid in full. Those clients whom have met their insurance policy's deductible must pay their co-payment per appointment until the insurance benefits are verified. Diane C. Marti Ph.D., reserves the right to delay, defer, or discontinue services for any reason, including if the balance owed is not paid at the time it is due.

No Show and Late Cancellation Policy

We are sincerely dedicated in assisting you meet your therapy goals. Consistent attendance allows you and your therapist to progress your treatment program which will result in quicker recovery and better outcomes. However, if you are unable to keep your appointment, *please cancel 24-hours prior to your appointment time* and we will be happy to reschedule your visit. Other patients who can be seen during the appointment time will be grateful for your thoughtfulness as well.

You will be charged $50 if you cancel an appointment less than 24 hours before your appointment time or do not show for an appointment. Your insurance does not cover charges for late cancellations or no-shows. We understand that unavoidable situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. In the event of an emergency, the fee may be waived due to notice of these circumstances.

I understand that I am liable ultimately for the balance on my account for any services provided by Diane C. Marti Ph.D., regardless of the status of my insurance situation. With my signature, I agree to adhere to the agency's billing policies and procedures, and to pay any fees that I owe the agency based upon such policies. I hereby authorize direct payment and all benefits due under my insurance policy to Diane C. Marti Ph.D., for services provided. I authorize the release of medical or other protected health information necessary to process insurance claims. I also authorize the release of medical or other protected health information necessary to collect unpaid bills (i.e., forward to a collection agency).

Printed Name: _____

Signature_____

Date: _____

Located at Williamsburg Behavioral Psychology Clinic, LLC
3801 Union Drive, Suite 206, Nebraska 68516
PHONE: 402-489-2218 FAX: 402-489-3666

Diane C. Marti, Ph.D., LP, LLC

Children, Adolescents, Families, Individuals, School Consultation, & Autistic Spectrum Disorder

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, _____
Name of Patient

_____ _____ _____
Street Address City, State, Zip Birth Date

Hereby Authorize:

Diane C. Marti, Ph.D., LP, LLC
3801 UNION DRIVE, SUITE 206,
LINCOLN, NEBRASKA 68516

____ To Receive Protected Health Information From: ____ To Release Protected Health Information To:

_____
Name of Health Care Provider/Agency/Plan/Other

_____ _____ _____
Street Address City, State Zip Code Phone Number

INFORMATION TO BE RECEIVED:

___ Medical History, Examination, Reports
___ Psychological Evaluation
___ Psychiatric Evaluation
___ Laboratory Reports
___ Other (Specify): _____
___ Social History
___ Treatment Plan
___ Termination Summary
___ Prescriptions
___ Academic Records
___ Consultations
___ Hospital Records and Reports
___ Entire Record

SUCH INFORMATION WILL BE USED FOR THE PURPOSES OF: (Check applicable categories)

___ Evaluation and/or Treatment
___ Insurance Eligiblity/Benefits
___ Other (Specify): _____
___ Further Medical Care
___ Changing Physicians
___ Legal Investigation or Action
___ Educational Planning and Programming
___ Follow up
___ Personal

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: **Right to Inspect or Copy the Health Information to Be Used or Disclosed** - I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting **Diane C. Marti, Ph.D., LP, LLC. Right to Receive Copy of This Authorization** - I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization** - I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact: **Diane C. Marti, Ph.D., LP, LLC.** I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good until the following date(s) _____or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes and I am releasing Diane C. Marti, Ph.D., LP, LLC from all liability resulting from this disclosure. By my signature, I authorize that a photocopy or facsimile (FAX) copy shall have the same effect and authority as the original copy.

Signature of Patient or Legal Representative: _____ **Date:** _____
(If signed by other than patient, state relationship and authority to do so.)

Witness: _____

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