LIZA C. MERMELSTEIN, PhD
BEHAVIOR THERAPY ASSOCIATES, LLC
9426 Indian School Road NE, Suite #1
Albuquerque, NM 87112
505-345-6100

NEW PATIENT INFORMATION: CHILD AND ADOLESCENT FORM

Today's Date: _____

Name: _____ DOB: _____/_____/_____ Age : _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone #: _____ Alternate Phone #: _____

Email Address: _____ Referred By: _____

If you are under 18 years of age, please provide the following information:

Guardian Name & Relationship to you: _____

Phone _____

PRIMARY INSURANCE POLICY - **Please have your card ready to copy.**

Insurance Company: _____ Co-pay: _____

Insured's Name: _____

Policy ID: _____ Group Number: _____

SECONDARY INSURANCE POLICY - **Please have your card ready to copy.**

Insurance Company_____

Policy ID: _____ Group Number: _____

EMERGENCY CONTACT INFORMATION

Name & Relationship to you: _____

Phone _____

INTAKE INFORMATION

Education (current grade in school): _____ School: _____

Who lives in your home with you?_____

_____

Occupation of Parent in Household: _____

Employer: _____

Occupation of Parent in Household: _____

Employer: _____

Marital Status of Parents: _____ If Divorced or Widowed, year: _____

Names and ages of siblings or other children in home: _____

_____

Briefly describe the problem(s) or concern(s) that you would like to address in therapy:

_____

_____

_____

_____

Have you seen a psychologist, psychiatrist, or counselor in the past? NO YES

If YES, please provide the names and approximate dates seen: _____

_____

Are you currently seeing another psychiatrist, psychologist or counselor? NO YES

If YES, please provide their Name & Phone Number: _____

Please list CURRENT health conditions or problems:

_____

_____

Please list PAST health problems - major operations and hospitalizations:

_____

_____

Please list ALL medications and doses (including homeopathic) you are currently taking:

_____

_____

_____

Primary Care Physician (family doctor) _____

Telephone: _____ Fax: _____

List any other doctors you are seeing: _____

Please describe any current, past, or future legal problems or concerns: _____

_____

Please describe any problems with at school: _____

_____

Please describe your hobbies, special interests, and talents: _____

_____

OUTPATIENT PSYCHOTHERAPY CONTRACT AND INFORMED CONSENT

Liza C. Mermelstein, PhD, LLC

This document contains important information about my professional services and business policies. Please read it carefully and ask me any questions that arise. Your signature indicates that you understand and accept the terms of treatment.

PSYCHOLOGICAL SERVICES

Psychotherapy varies depending on the particular problems being treated and the theoretical approach practiced by the providing psychologist. It is therefore important that you take care in selecting a therapist that fits your style and treatment goals. Our first few sessions will involve an evaluation of your current problems, concerns, and needs. By the end of the evaluation period, I will offer you my clinical impressions and a recommended approach to treatment. During this time, it is important that we both consider whether I am the best person to provide the services you need to meet your specific treatment goals. If indicated, a referral to a more appropriate therapist will be provided (e.g., your presenting problem is outside the scope of my clinical expertise). As therapy involves a commitment of time, energy, and money, it is important that you feel comfortable working with me. The goals of therapy are arrived at by mutual collaboration between us. The goals we establish will be reviewed during the course of our work in order to assess and/or modify the focus of therapy according to your needs. If any questions or concerns about our work together arise at any point during treatment, please bring them to my attention.

PROFESSIONAL FEE INFORMATION

INSURANCE: Dr. Mermelstein is considered "in-network" for Medicaid, Medicare, Presbyterian Health, Blue Cross Blue Shield and New Mexico Health Connections insurance plans. If you are covered under a different plan, we will submit claims to your insurance if you have "Out of Network Benefits" for behavioral health services. In this way, you may receive reimbursement for what you pay Dr. Mermelstein. However, if submitting as out of network, you will be responsible for paying the "SELF-PAY" fees described below at the time of service.

If you have insurance coverage for behavioral health services, check with your insurance company to find out the type of coverage you have and whether you have a co-payment or a deductible. You are responsible for the amount that is not covered by your insurance company, which may include services that are not covered, a co-payment or the result of an unmet deductible.

SELF-PAY: For patients who do not have insurance that will cover services or do not wish to bill insurance for services, the fee for an initial evaluation with Dr. Mermelstein is $175 and the fee for ongoing sessions is $150.

ASSESSMENT FEES: The fee for psychological assessment is $250.00 for the first hour and $200 for each additional hour, including time required for scoring and report writing.

PAYMENT: Payment is due at the time services are rendered. Accepted methods of payment are cash, check, or credit card. Checks should be made payable to Liza C. Mermelstein, PhD. If you have a health plan with which I am contracted, I will bill them directly, and am reimbursed by them directly. Depending on your coverage, you may be responsible for a deductible and/or co-payment. It is your responsibility to inform me of any changes to your insurance coverage. Failure to do so may result in your liability for the total account balance. If you pay by check and the bank refuses it, a charge of $25.00 will be assessed in addition to the original amount of the check. If your account has not been paid for more than 90 days and terms of payment have not been arranged with me, your account may be sent to a Collection Agency and its cost added to the amount you owe.

MISSED SESSIONS: If you must cancel an appointment, please provide at least 24 hour notice - by Friday if you have a Monday appointment. The fee for a missed session that is not canceled with 24 hour notice is $50. Insurance does not cover charges for missed appointments.

Initial here _____ to indicate that you understand the late cancelation/no-show fee.

INFORMED CONSENT

I have chosen to receive psychological services from Liza C. Mermelstein, Ph.D., a provider at Behavior Therapy Associates. My choice has been voluntary, and I understand that I may terminate therapy at any time.

I understand that there is no assurance that I will feel better. Because psychological treatment is a cooperative effort between me and my therapist, I will work with my therapist to the best of my ability to resolve my difficulties.

I understand that during the course of my treatment, material may be discussed that is upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that the ability of my therapist to provide useful feedback and guidance to me is dependent upon the accuracy of the information I provide about myself.

My rights include:

- The right to be informed of the steps and activities involved in receiving services
- The right to confidentiality under federal and state laws relating to the receipt of services
- The right to humane care and protection from harm, abuse, or neglect
- The right to make an informed decision whether to accept or refuse treatment
- The right to contact and consult with counsel at my expense
- The right to select practitioners of my choice at my expense

I understand that records and information collected about me will be held or released in accordance with state and federal laws regarding confidentiality of such records and information.

I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or vulnerable adults.

I understand that state and local laws require that my therapist report all cases in which there exists a

danger to self and/or others.

I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand that my therapist may contact me to ensure continuity and quality of my treatment and/or after the completion of treatment, to assess the outcome of treatment.

I understand that my therapist will be required to provide basic clinical information, including diagnoses, to my insurance company in order to receive payment for services, and that my therapist has no control over how my insurance company handles my private information and that my therapist cannot be held liable for the actions of the insurance company.

If you have questions about fees, payment plans, insurance, or other financial concerns, please discuss these with me. Please be sure, as well, to read the **Notice of Privacy Practices** available in the waiting area.

Your signature below verifies that you have read, understand, and agree with the information provided in the section titled "**OUTPATIENT PSYCHOTHERAPY CONTRACT AND INFORMED CONSENT".** This also verifies that you have read and understand the Notice of Privacy Practices and have been offered a copy for your records. Your signature also authorizes the release of any medical or other information necessary to process this claim with your insurance company.

Signature of patient: _____

Print patient name: _____Date: _____

If patient is under the age of 15, parental consent for treatment is required.

Signature of Parent or Legal Guardian: _____

Print name of Parent or Legal Guardian: _____

Date: _____

Signature of Parent or Legal Guardian: _____

Print name of Parent or Legal Guardian: _____

Date: _____