



Ellis Evaluation & Consulting Services

Mesha L. Ellis, Ph.D.

Licensed Clinical Psychologist

California . Georgia . Nevada . Tennessee

CA: PSY20263

GA: PSY003274

NV: PY0990

TN: P0000002777

THERAPY INTAKE FORM

BASIC INFORMATION:

Your Name _____ Date ____/____/____

Home Address (including zip code): _____ Email Address: _____

Home # (_____) _____

Work # (_____) _____

Cell # (_____) _____

Fax # (_____) _____

Birth Date ____/____/____

FAMILY COMPOSITION: (List yourself and other members involved in treatment)

Name	Age	Birth Date	Birth Place	Occupation or Current School
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Other important addresses and phone numbers (e.g. other parent, therapist, attorney):

PATIENT AGREEMENT AND NOTIFICATION

This document contains important information about my professional services and business practices. Please read it carefully. It explains many of your rights and responsibilities and will represent an agreement between us, unless it is amended or terminated in writing.

PROFESSIONAL SERVICES

Treatment may include discussion of issues that are uncomfortable for you. While I am using my best professional judgment for your well-being, I cannot guarantee that you will obtain the results you seek. You have the right to challenge any aspect of the treatment I recommend. If you believe I have mismanaged your treatment or your privacy please discuss this with me and you may also report any concerns you have to the Board of Psychology at 800-633-2322 and/or the U. S. Department of Health and Human Services at 877-696-6775.

CONFIDENTIALITY

In general, the confidentiality of all communications between a patient and a psychologist is protected by law and I can only release information about your treatment to others with your written permission. However, there are some situations in which I am legally entitled or even required to release patients' protected health information without their authorization. If applicable, I may release information to your insurance company to obtain authorization for treatment, payment or for other purposes, such as for quality improvement programs. In these cases, I will release only the minimum information necessary to accomplish the specific purpose for which the information was requested. In some situations, I can also be compelled to release patient records by the courts and by the Board of Psychology.

In the following situations, I must take action to protect people from harm, even though that requires revealing some information about a patient's treatment. If I believe that a child, an elderly person, or a disabled person is being abused, I must file a report with the appropriate agency. If I believe that a patient is threatening serious bodily harm to themselves or to another, I am required to take protective actions which may include contacting authorities, family members or others who can help provide protection. I will inform you of these reports.

The standards of my profession require that I record and maintain appropriate treatment records. You are entitled to request a copy of any protected health information or any communication from me in a variety of means and locations. You have the right to request that your information be amended or restricted from certain uses and disclosures. While I will seek to honor your requests, I may decide that it is not prudent for me to agree to your requests.

CONTACTING YOUR THERAPIST

Due to my work schedule, I am not regularly immediately available by telephone. While I am usually in the office between 10am and 5pm, I generally will not answer the phone. My telephone is answered by assistants or by voice mail. I make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform us of some times when you will be available. If you are unable to reach us and feel that you can't wait for us to return your call, contact your family physician or the nearest emergency room and ask for the psychologist on call. If you feel that you need immediate assistance or there is a life-threatening emergency, please call 911 or your local police. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

FEE POLICIES AND PROCEDURES

1. I set and regularly review fees. Periodically, I will increase my fees and will discuss any change with you.
2. You may be asked for a deposit and billed monthly for services during the month. If not, payment is expected at the time of your session.
3. You may pay by credit card, cashier's check, or cash. Payment is due before the start of your session.
4. I do not bill for insurance reimbursement. Statements will be issued once a month. If you are in psychotherapy, these statements should have all the information necessary for you to submit to your insurance carrier. Please inform me if you wish to do this.
5. I will ask you for authorization for credit card payment of any fees not paid at the end of a calendar month or within one month of receipt of the statement. In the event there is any problem with collecting fees, I will charge interest of 1% per month on the outstanding balance. In the event I must incur costs to collect fees, those costs will be the responsibility of the client.
6. If you find an error in your statement, informing me in writing will help me deal most quickly with your concern.
7. Cancellation Policy: If you need to cancel or reschedule an appointment, please call us as soon as possible and not less than 48 business-day hours in advance to avoid a charge (i.e. canceling a Monday appointment on Friday is not sufficient notice). If you do not cancel at least 48 business-day hours in advance, you will be responsible for the fee for the session. I have this policy because a time commitment is made to you and is held exclusively for you.
8. If I am deposed or called to testify in court on any issue regarding this case, I will be treated as expert witnesses, payment will be made seven (7) office days in advance to schedule my testimony time (a minimum of a half-day with no on-call), and I will be paid my hourly fee for the testimony time plus preparation and travel time needed for testimony.
9. By engaging in treatment you are agreeing to pay the fee for each 50-minute session at the time of service. If it is necessary for me to make phone calls, review documents or write documents as part of my services to you, those services will be charged to you at the same rate as for direct treatment.

Your signature indicates that you have received a copy, read, understood, and are willing to abide by the above agreement.

Client Name

Client Signature

Date

Therapist Name

Therapist Signature

Date

Client Information

Your Name: _____

Hourly Fee: \$ 250.00 Date of First Session: _____/_____/_____

Send Monthly Statement? Yes No

Person or Persons Responsible for Payment:

Name: _____ % _____ Name: _____ % _____

Special Billing Instructions or Arrangements (e.g. deposits or alternate address):

Please sign the credit card authorization form. Your card on file will be charged automatically at the beginning of each session.

