

KY RESH LCSW
1122 North Olsen Ave.
Tucson, AZ 85719
(520) 320-9996 FAX(888) 313-2802.

NEW PATIENT INFORMATION NEEDED

DATE: _____ REF. DR: _____ APPT DATE: _____
TIME: _____

PATIENT NAME: _____

DOB: _____

PATIENT'S SOCIAL SECURITY#(SSN): _____

PATIENT ADDRESS: _____

CITY: _____ Email: _____

ZIP: _____

HOME PHONE#: _____ WORK PHONE #: _____

EMPLOYER: _____

INSURANCE CO:

PRIMARY POLICY HOLDER:

ID#: _____

GROUP #: _____

SECONDARY INSURANCE CO:

PRIMARY POLICY HOLDER:

ID#: _____

GROUP #: _____

REASON FOR COMING IN?

TO CALL INSURANCE CO.TO OBTAIN BENEFITS FOR OUTPATIENT MENTAL
HEALTH**

General Consent to Treat

Patient Name _____

Date of birth _____

Social Security# _____

I voluntarily consent to psychotherapeutic care of a routine/emergency nature from the authorized professional staff of Tucson Psychotherapy, LLC., for myself or the above mentioned minor for whom I am the parent/guardian. I authorize the release of any and all medical records and information obtained through my assessment to those individuals that my doctor feels appropriate for my continued medical care.

I understand that I have the right to a full disclosure of the nature of any medical treatment received or proposed to be rendered and the risks, if any, involved and alternative means available. It is understood that I may withdraw this consent at any time by contacting any member of the professional staff in writing.

Financial Agreement

I authorize payment to _____ of any medical benefits, which would otherwise be payable to me and which were established by my insurance company.

The amount paid to _____ shall not exceed the practice's regular charges for the services. We agree to pay all fees left unpaid by our insurance-company after 90 days.

Clients are responsible for coordinating their benefits from their insurance company.

Any fees unpaid after 30 days will be charged 1.5% monthly interest. Any fees left unpaid after 90 days will go to collection and the client are charged for collection fees. There is a \$35 charge for any returned checks. Cancelled appointments require at least 24 hours notice will be billed a \$45 broken appointment fee. This is because the time you schedule is reserved to provide services to you. Less than 24 hours is not enough time to schedule services for another client.

Therefore, this agency incurs a financial loss if you fail to show, or give adequate time to change a scheduled appointment. Three broken appointments in a row will result in termination of services.

I also authorize the release of my medical records to my insurance company/companies or other third party payers or my employer as required for the collection of payments.

I understand that I am responsible for the payment of charges that are not paid by my insurance company.

Limitations of treatment. I understand that over all that Mr. Resh's treatment recommendations represent the options he believes will help me to benefit the most from my treatment. I am also aware that he will explain his opinions about what might happen if I refuse treatment or do not follow his recommendations. I know that Mr. Resh cannot guarantee that my condition will improve, even if I follow his recommendations. I can expect his to discuss with me his ideas about what I can realistically expect from treatment.

I understand that I may decide to discontinue treatment altogether or transfer my care to another psychotherapist at any time. Should I decide to terminate our therapeutic relationship, I will notify Mr. Resh or his office staff as soon as possible.

Outside clinical consultation. I understand that Ky S. Resh may seek outside clinical consultation and may discuss aspects of my therapeutic work with a consultant, but will strive to keep identifying information about me/my work confidential.

Limits of confidentiality. I understand this counseling is confidential and the information discussed cannot be disclosed without my consent unless: (1) It is determined that I am in danger to others or myself. (2) Disclosure is court ordered,

(3) Information is disclosed regarding child abuse or neglect 4.) I give my consent in writing.

If you are using Medicare:

Medicare Agreement The information provided by me in applying for payment of Social Security benefits is true and correct.

I also authorize the therapist to initiate a complaint to the insurance commissioner for any reason on my behalf.

I request that the payment of benefits be made for me. The benefits due to me for services provided by my therapist shall be paid directly to _____. In the event the therapist does not receive such payment, I authorize such therapist to submit a claim to Medicare on my behalf.