EPIPHANY
BIRTH YOUR BRILLIANCE.

Patient Information

Patient Name _____

Street Address _____

City _____ **State** _____ **Zip Code** _____

Main Phone # (Circle one) _____ **home** **work** **mobile**

Secondary Phone # (Circle one) _____ home work mobile

It is okay to leave voicemails at (check all that apply): □ **Home** □ **Work** □ **Mobile**

Would you like appointment reminders via text? If so, who is your cellular service provider? _____

Date of Birth _____/_____/_____ **Social Security Number** _____-_____-_____

Driver's License # _____ Employer _____

Email Address _____

Who may we thank for referring you to our practice? _____

□ Family □ Friend □ Doctor/Medical Professional □ Coworker

□ Search Engine □ Psychology Today □ School Counselor □ Other

Primary Insurance Information

Carrier Name _____

ID # _____ **Group #** _____

Name of Policy Holder _____

Relationship to Patient_____

Policy Holder's Birthdate _____ **Policy Holder's SSN** _____

Policy Holder's Employer _____

□ I will not be using insurance to pay for services rendered.

□ I have a secondary insurance policy (please specify).

Carrier Name: _____

ID #: _____

Release and Assignment
I authorize the release of any information necessary to process my insurance claims and assign and request payment to my provider. I have received a copy of Epiphany!'s Notice of Privacy Practices.

Signature _____ **Date** _____

☐ I am signing as the legal guardian for the client (aged less than 18 years old).

Note: All bolded fields are required

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Client-Therapist Agreement

Therapist-Client Relationship

I understand that therapy is a commitment between my therapist and me. I agree to be a willing participant in therapy, and to be committed to the therapy process. I understand that the therapist may make me aware of behaviors and patterns I was unaware of, and understand that this at times may be uncomfortable, yet crucial to the therapy process. I understand that the outcome of my treatment will depend heavily on the energy and effort I invest during and between sessions, and I agree to complete assignments and be present in therapy sessions. I understand that there will be times when I do not feel like putting forth the required effort or times when I have the urge to quit therapy. I agree to discuss these openly with my therapist. I understand that attending sessions less often or for shorter durations than recommended will limit my progress.

Financial Agreement

I agree to fully investigate my insurance benefits and take responsibility for paying all amounts not paid by my insurance company. I agree to bring physical payment for co-pays and all services provided at the time of the office visit. **CO-INSURANCE/DEDUCTIBLE**: If my insurance policy only covers a portion of the amount of each session (i.e., I am responsible for co-insurance, or a percentage of the cost of the session), or if my policy is subject to a deductible that has not been met, I agree to bring some form of payment to each session and be prepared to pay for any such outstanding balances before every session. I understand I will not always receive an invoice in the mail from Epiphany! for outstanding balances, and it is my responsibility to know my insurance benefits and financial liability for services. I am aware that I may contact Epiphany! during reception hours to confirm my outstanding balance prior to my session. Even if I do not receive an invoice in the mail for balances owed, I am still responsible for paying any balance that my insurance will not pay, and that this balance must be paid in order to attend my session. I understand that I can consult with my insurance company to better understand my policy benefits.

I agree to forfeit my appointment if I come without full payment (self-pay rate, copay, co-insurance, deductible, or any other past-due balance), and agree to compensate the therapist for his/her reserved time, as outlined in paragraph below. I agree that if I am using out-of-network benefits, I will bring full payment for services provided at the time of visit, and take full responsibility for completing necessary forms and submitting my own claims for reimbursement.

I agree to offer checks only when I have funds available, and agree that if a check is returned for non-sufficient funds, to pay Epiphany! $30 for each time a check is returned. I agree that if checks are returned for non-sufficient funds more than once, to make all future payments in cash or valid credit cards. I agree that if my credit card declines, or if a mailed bill is necessary, to pay a $5 administration fee for each mailed bill or credit card decline. I agree to pay Epiphany! $5 every three weeks for the length of time an unpaid balance remains unpaid, and understand that if my account is unpaid for 60-90 days, my account will go to collections, and that I am responsible for all reasonable costs associated with collection agency and legal efforts. I understand that if my account goes to collections, it cannot be removed, and that I cannot be an active client with unpaid balances. I understand that any of the above fees are subject to change without notice. I also agree to notify Epiphany! of any changes in my billing information; this will help me avoid additional fees associated with declined cards and non-payment due to an address change. It is my responsibility to update my information consistently.

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Attendance and Keeping Appointments

I realize that in order to optimize my progress, regular sessions are recommended. I agree to cancel any appointments at least **48 HOURS IN ADVANCE** of my scheduled appointment. I agree that if I cancel inside this timeframe, I will compensate my therapist for having reserved his/her time, in the amount of $90. I understand that if another client schedules a new appointment during my scheduled appointment time, I may not be charged for my late-canceled appointment. I understand that as a courtesy and if available, I may be offered a 'make-up' appointment that does not extend my therapist's workday, and that is within 48 hours of my scheduled and canceled appointment. Attending a make-up appointment will reduce the cancellation fee to $25. I understand make-up appointments are a courtesy, and may not always be available, or convenient to me. If there are no make-up appointments available or accepted, I agree to compensate my therapist for his/her time reserved, as indicated above. I understand that if I over-use or abuse this make-up appointment courtesy, this courtesy may no longer be made available to me. I agree to provide credit card information and authorization for such forfeited appointment payments at the time of admission for such purposes. I agree to be on time for sessions, and be ready to start the appointment on time. I agree to allot 5 extra minutes to check in with reception before my appointment starts. I realize that if I am late for an appointment or delayed by checking in, my appointment will still end at its designated time. I understand that the therapist will make every effort to be on time for my session, and that on occasion, he/she may be dedicating a few extra minutes to a client in need. In this case, the therapist will offer to extend the session to the full-allotted time from start time.

FOR LATE CANCELLATION PURPOSES ONLY (REQUIRED):

Card Type (circle one) VISA MASTERCARD DISCOVER AMEX

Name on Card: _____

Number: _____

Expiration Date: _____/_____ 3-Digit Code (4-Digit for AMEX): _____

Credit Card Billing Zip Code: _____

Please note: Health Spending Account debit/credit cards are not accepted for late cancellation purposes.

Confidentiality

Out of respect for clients, I agree to keep private the names and circumstances of people seen or treated in the office. I understand that the current HIPAA law prohibits therapists from divulging information to non-authorized parties, and that out of concern for my own or another's welfare, my written consent will be necessary to share information with anyone. I understand that if I present as a clear danger to myself or others, my/the therapist has a legal and ethical responsibility to protect me or targeted victims by contacting police, family members, targeted victims, The Department of Child Welfare (in the case of questionable physical or sexual contact with minors), and anyone that may help prevent such harm. I give Epiphany! permission to share the necessary information with my insurance company in order to receive payment for services rendered. I understand that in the event of a court subpoena, the therapist will do all he/she can to protect my information, and that he/she will only reveal such information if absolutely mandated by law. I realize that I do have a right to request my records, and that there may be a fee required for such. I understand that if my therapist believes that having me access my records would be detrimental to my well-being, he/she has the right to interpret the records with me, or refuse me access to my records.

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Availability

I understand that the therapist's time is valuable, and agree to use session time to address clinical issues. I agree to call the therapist between sessions only in the event of a true clinical crisis. In that case, I agree to have attempted to manage this crisis independently, and to communicate to the therapist the attempts I have made, and specifically with what I need help. I agree that if the situation warrants more than 10 minutes of phone time, to schedule an appointment with the therapist or his/her delegate within the period suggested by my therapist, and if crisis phone calls are made frequently, to increase the frequency of my scheduled in-person sessions with the therapist. I understand that if my call is received after office hours, or if my therapist is not available, it will be received and returned by another therapist. I agree that if my crisis cannot wait until a therapist returns my call, to call the crisis hotline, or go to my nearest emergency room. I understand that I may access all of these numbers by calling the main Epiphany! phone number. I agree to call the Epiphany main number for all scheduling and non-urgent matters.

Client Litigation

The Therapist will not voluntarily participate in any litigation or custody dispute in which the Client and another individual, or entity, are parties. The Therapist has a policy of not communicating with the Client's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in the Client's legal matter. The Therapist will generally not provide records or testimony unless compelled to do so. Should the Therapist be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving the Client, the Client agrees to reimburse the Therapist for any time spent for preparation, travel, or the time which the Therapist has made him/herself available for such an appearance at the Therapist's usual and customary hourly rate of: $120.00.

Termination

I recognize the importance of planning treatment, and discussing ending treatment with my therapist. I agree to discuss in session any challenges I am experiencing during the time I am engaged in therapy, including displeasure or confusion about therapy techniques, direction, and/or observations. I agree to accept and/or return inquiry calls from my therapist should I have an unexpected absence from treatment. I understand that I will be discharged if I do not return inquiry calls from my therapist, and/or if I have not attended treatment for 60 or more days. I understand that I may re-initiate treatment at Epiphany! any time after my discharge, although entering treatment with the same clinician is not guaranteed.

Emergency Contact

I give permission for Epiphany! to contact the person below in the event of a medical emergency:

Name, phone number, relationship to client:

_____

I consent to treatment at Epiphany!, understand and agree to all the terms in this Client-Therapist Agreement, & understand it applies to any and all services provided at Epiphany!:

Signature:_____ Date: _____

Clients aged 14-17 years old may consent to his/her own treatment; however, a parent's agreement to the above outlined policies must be acknowledged below in addition to the client's signature:

Guardian Signature: _____ Date: _____ *(For clients under 18 only)*
Guardian Date of Birth:_____ Guardian SSN: _____