PERSONAL & BILLING INFORMATION

PATIENT INFORMATION

Name: ______________________ Birth Date: ______________ Age: ________

Street: ______________________ City: ______________ State: ________ Zip: ________

Phone - Landline: ______________________ May we leave messages for you there? ☐ yes ☐ no

Phone - Work: ______________________ May we leave messages for you there? ☐ yes ☐ no

Phone - Cell: ______________________ May we leave messages for you there? ☐ yes ☐ no

E-mail: ______________________ May we send messages about appointments to you? ☐ yes ☐ no

SS Number: ______________ Employer/School: ______________ Position/Grade: ______________

Marital Status: ☐ single ☐ married ☐ widowed ☐ domestic partner ☐ significant other ☐ divorced ☐ legally separated

Who referred you to our office? ______________________

Emergency Contact Name: ______________________ Relationship: ______________

Emergency Contact's Phone – Landline: ______________ Work: ______________ Cell: ______________

Family Doctor/PCP: ______________________ Phone: ______________

Doctor's Full Address, City & State: ______________________

FINANCIAL RESPONSIBLE PARTY INFORMATION

☐ Same as above or: Name: ______________________ Relationship to Patient: ______________

Resp. Party's Full Address: ☐ Same as above, or: ______________________

Responsible Party's Birth Date: ______________ Social Security Number: ______________

Phone - Landline: ______________ Work: ______________ Cell: ______________

Employer: ______________________ Position: ______________

INSURANCE INFORMATION *We will need to copy your insurance card(s).*

I. Insurance Company: ______________________

Subscriber/Policy Holder: ______________ Birth Date: ______________ SSN: ______________

Ins ID #: ______________ Group #: ______________ Subscriber Employer: ______________

Co-pay amount? ______________ Deductible amount? ______________ ***Don't be surprised - call to get this info if you do not know it.***

II. Insurance Company: ______________________

Subscriber/Policy Holder: ______________ Birth Date: ______________ SSN: ______________

Ins ID #: ______________ Group #: ______________ Subscriber Employer: ______________

Co-pay amount? ______________ Deductible amount? ______________ ***Don't be surprised - call to get this info if you do not know it.***

I certify that the insurance coverage or Employee Assistance Program coverage described above is valid for the above named patient and I assign all insurance & EAP benefits directly to my provider for services rendered. I accept financially responsible for all charges whether or not covered or paid by insurance.

I authorize the release information necessary to any party to secure payment for services provided and the use of this authorization & signature on claims for insurance or EAP payment. I certify that I am legally authorized to make this agreement on behalf of the patient named above and the responsible party named above.

☒ **I understand co-payments are due at the time of service; a rebilling charge is added to unpaid balances after 60 days; charges for collections efforts, if any, shall be paid by the responsible party above; and, there is a charge to me (not insurance) for appointments missed or cancelled with less than 24 hours notice.**

______________________ ______________
Signature of Adult Patient or Guardian Date Signed

CONTINUE...

CONSENT FOR TREATMENT AND OFFICE POLICY

Patient Name:____

CONSENT FOR PSYCHOLOGICAL SERVICES

Psychologists provide services relating to mental health and mental and emotional disorders, including evaluation, assessment, diagnosis, psychotherapy, and testing. Psychologists might also make referrals or consult with other service providers (with your permission). All services involve finding out about the patient's thoughts, feelings, and behaviors to help the patient resolve problems or concerns.

Evaluations help identify the nature of psychological or emotional problems or concerns. Psychotherapy is used to help the patient identify and work through past or present situations that cause concern. Many different techniques can be utilized to help the patient reach goals, including dialogue, interpretation, cognitive reframing and restructuring, journaling, self-exploration, behavioral modification, and catharsis.

Risks of psychological services may include experiencing uncomfortable feelings like guilt, anxiety, sadness, anger, and frustration. It may mean talking about painful events from your life. Potential benefits of psychological services and psychotherapy include improved self-satisfaction, improved mood, increased autonomy, empowerment, decreased stress and distress, improved relationships, improved day-to-day functioning and resolution of specific problems.

As part of treatment, the patient may be referred for other related services. For example, medication prescribed by a psychiatrist or primary care physician, a support group or inpatient care may be suggested.

All findings and recommendations made because of an evaluation will be based on the evaluation alone. The outcome of an evaluation cannot be determined in advance and is not guaranteed. In no case will the psychologist agree to render specific findings or make specific recommendations as a condition of the patient's participation or for any other reason. The results of psychological treatment cannot be guaranteed either, but the likelihood of a positive outcome is enhanced by the patient's active participation.

All services provided by Karen Robie, Ph.D. are voluntary. The patient may end treatment at any time. However, planned transitions (such as discontinuing therapy) are thought to be in the patient's best interest. The patient has the right to refuse any suggestion made by the psychologist at any time without being penalized in any way.

⌧ **Initial to verify you understand & agree to the above: _______**

OFFICE POLICY

<u>I. Confidentiality:</u> Information revealed by a patient to a psychologist during a professional relationship is confidential and privileged. The privilege is intended to protect the interests of the patient by encouraging free disclosure to the psychologist and by preventing disclosure (by the psychologist) to others. The patient, rather than the psychologist, holds and may assert the privilege. Psychologists have a primary responsibility to protect the patient's right to confidentiality in accordance with law and professional standards of practice.

With few exceptions, confidential information may be disclosed only with informed written consent of the patient, or another person legally authorized to give consent on behalf of the patient. Confidential information may be disclosed without written consent: 1) to protect against clear, substantial risk of imminent serious harm being inflicted by the patient on him or herself or another person; 2) to comply with a court order; 3) to comply with regulatory mandates to report actual or suspected abuse/neglect of a child/vulnerable adult; and 4) to get medical care in a medical emergency while at the psychologist's office.

When it is necessary to disclose confidential information to respond to a specific situation, the disclosure will be only to appropriate authorities, a potential victim, professional/healthcare workers, and/or your family.

To protect privacy & confidentiality, Dr. Robie will not engage in or respond to any social media with patients past or present.

<u>II. Fees, Billing and Payments:</u> Standard service charges are: evaluation: \$210; therapy < 38 min: \$145; therapy 38–52 min: \$160, therapy ≥ 53 min: \$175; family/marital therapy per hour: \$180; testing, per hour: \$210; and \$175 per hour for other services such as filling out disability forms, record review, report writing and consultation. Telephone calls and other communication between appointments (other than for scheduling) are charged at \$175 per hour and cannot be billed to insurance. Extended evaluations, extended therapy and crisis sessions are subject to additional charge. Copies of records are charged in accordance with Ohio law.

The patient/responsible party is responsible for deductibles and co-payments, and ALL charges not covered by insurance or EAP, unless prohibited. The co-pay is due at the time of service. Any balance unpaid after 60 days is subject to \$10 per month rebilling charge. If financial problems make it difficult for you to keep current with your bill, please discuss them to work out alternative arrangements for billing. If you do not pay your bill, services may be put on hold so you can catch up.

Collections and/or legal action will be used if your account is more than 60 days in arrears unless suitable arrangements for payment are made and honored. If such action is necessary, the costs of collection by the agency/attorney, filing the claim, or bringing the proceeding will be added to the balance due. Collection charges are based on a percentage of the balance and may equal 50% of the unpaid balance or more.

If you use insurance to cover the costs of psychological services that means you give permission for the insurance company, or their designee, to access clinical information about you. Insurance is billed monthly. Statements are mailed monthly and include all outstanding charges, including those billed to but not yet paid by insurance. Please inform us immediately of any change in insurance coverage or eligibility. You must provide all documentation necessary to ensure payment by insurance and if you do not, you will be responsible for all fees.

⌧ **Initial to verify you understand & agree to the above: _______**

<u>III. Cancellations and Timeliness:</u> When you schedule an appointment, time is specifically reserved for you. Twenty-four hours' notice is required for all appointment cancellations. ***You (not the insurance company) will be charged \$85 for missed or skipped appointments and for appointments cancelled with less than 24 hours notice.***

If you need to reschedule an appointment, you may do so by telephone (419-537-0900) or email to billing@robiepsych.com or psych@robiepsych.com. Please do not rely on email for confidential information. <u>Do not send email if you do not want an email reply.</u>

You may leave a voice mail 24 hours per day, 7 days a week. All messages are date and time stamped to keep track of cancellations. Under rare circumstances, such as extreme weather conditions or an emergency hospitalization, the no show/late cancellation fee may be waived at the discretion of the psychologist.

Please address any questions you may have about consent for treatment & office policy <u>before</u> you sign. Your signature signifies that you 1) consent to psychological treatment, 2) agree to the office policies as outlined above, and 3) understand that the "Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information" is available online at nwopsych.com and is posted in the office.

_______________________________________ ____________________
Patient's Signature Today's Date

_______________________________________ ____________________
Guardian/Authorized Representative's Signature Today's Date

CONTINUE…

PERSONAL HISTORY

Patient Name:______________________________ Age:__________

Highest educational level **finished**: ☐ 1, 2 or 3 ☐ 4, 5 or 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ HS Grad ☐ GED ☐ College:__________

PROBLEM List - Check any that are a problem for you **NOW**

	Abuse of a child		Grief, loss or bereavement		Low energy, tired or fatigue		Mania or hypomania
	Abuse of an adult		Panic attacks		Sexual behavior or problem		Suicidal thoughts
	Anger or temper control		Depression		Gender identity concern		Intentional self-injury
	Criminal behavior or legal		Hopeless or helpless feelings		Eating problem		Sexual abuse/assault/rape
	Poor impulse control		Loneliness		Intentional vomiting		Domestic violence
	Negative or irritability		Social isolation		Weight gain or loss		Violence or violent behavior
	Lying, sneaking, or cheating		Self esteem problems		Excessive exercise		Alcohol and/or drug abuse
	Anxiety and worry		ADD/ADHD		Sleep		School problem
	Extreme fears		Concentration problem		Family problem		Job or employment problem
	Stress		Memory problem		Marital/partner problem		Suspiciousness/paranoia
	Compulsive behaviors		Mood swings or moodiness		Divorce or separation		Hallucinations
	Obsessive thoughts		Too much energy or hyper		Social/relationship problem		Concerns about health

PERSONAL Medical History -check all that applies to you – now or in the past. **N=NOW P=PAST**

	Epilepsy or seizure		Kidney problem		Joint or bone problem		Vision or hearing problem
	Head or brain injury		Thyroid problem		Arthritis or gout		Hormonal concern or PMS
	Neurological problem		Liver problem		Fibromyalgia		Reproductive problem
	Headache or migraine		Diabetes		Myalgic encephalomyelitis/CFS		STD or HIV/AIDS
	Stroke or TIA		Pancreatitis		Auto-immune disorder		Mental illness
	Lung or pulmonary disease		Stomach or bowel problem		Chronic pain		Intentional self-injury
	Asthma		Urinary problem		Cancer		Suicide attempt
	High or low blood pressure		Blood-related problem		Sleep apnea		Learning disability
	Heart trouble		Skin problem		Dental problem		Developmental disability

Serious accidents, hospital stays, operations & other health or medical problems or disabilities:

____

____

Medications (include prescription, over-the-counter, “borrowed” and herbal preparations):

Medication Name	Dose & Frequency	What do you take this medication for?

Medication changes over the **past six months**? ☐ None, or: ______________________________

Current doctors or clinics OTHER than PCP, and the city of his or her office: ☐ None, or:

____

Date of last PCP visit:__________________ # of physician visits in last 18 months:__________________

CONTINUE…

Drug Allergies: ☐ No known drug allergies, or: ______

Cigarette/tobacco use (over last year): ☐ None, or: ______

Caffeine use (present): ☐ None, or ______

Alcohol, cannabis, or other drug use (over last two years): ☐ None, or:

______

Military service: ☐ None, or: ______ Type of Discharge: ______

Legal history (pending and past, include bankruptcy): ☐ None, or:

______

History of traumas (as you define "trauma"), abuse or domestic violence: ☐ None, or:

______

______

Mental Health, Counseling, Psychological or Psychiatric Treatment History - list ALL prior treatment & support groups: ☐ None

Treatment Provider	Start & End Dates	Reason for Treatment	Treatment Outcome

Alcohol or Drug Abuse Treatment History - list ALL prior treatment & support group (AA, NA, etc.) involvement: ☐ None

Treatment Provider	Start & End Dates	Reason for Treatment	Treatment Outcome

FAMILY History - check all that apply

	Neurological/brain problems			Cancer			Dementia/Alzheimer			Mood swings
	Heart disease			Diabetes			Learning disability			Depression
	Thyroid disease			Fibromyalgia/ME/CFS			Developmental disability			Suicide gestures/attempts
	Liver disease			Chronic pain			Anxiety			Alcoholism/drug abuse
	Pancreatitis			Disability			Anger control problems			Mental illness
	Other:						Other:			

Anything else you would like to add:

______

______

______ Signature of Patient or Guardian

______ Date

CONTINUE...

ALCOHOL & DRUG USE SCREENING

Name:____

Please CHECK YES or NO for each of the following questions about your drinking or drug use ***OVER THE PAST THREE YEARS.***

	YES	NO
Can you stop drinking alcohol (beer, wine, liquor, etc.) without a struggle after 1 or 2 drinks every time?		
Have you been unable to remember what happened while you were drinking or had a blackout?		
Has your drinking or drug use caused a problem between you and any family member or friends?		
Have you been in trouble at home, school, or work because of your drinking or any other drug use?		
Have you been told you have pancreatitis, liver trouble or cirrhosis?		
Have you gotten sick, had shakes or DTs (delirium tremens) when you stopped drinking or after drinking a lot?		
Have you had medical problems *(such as memory loss, hepatitis, seizures, bleeding)* because of drug use?		

	YES	NO
Have you had withdrawal symptoms or felt sick when you stopped taking drugs or when a drug was wearing off?		
Have you used drugs or medications that were prescribed for someone else (except those you can buy in a drug store)?		
Have you used your medicine in a way that differs from how your doctor told you to take it?		
Have you gone to anyone for help (including treatment, AA, NA and CA) about your drinking or drug use?		
Have you done things you would not normally do or done illegal things while you are drinking or using any drug?		
Have you failed a urinary drug screen or refused to take a urinary drug screen for any reason?		
Have you had an addiction to gambling, sex, spending or anything else?		

____ ______________________________

Signature of Patient Date

CONTINUE…

KAREN ROBIE, PH.D.

Psychologist, licensed in Ohio and Michigan

4930 N HOLLAND SYLVANIA ROAD, SUITE B
SYLVANIA, OHIO 43560

PHONE: 419-537-0900 • FAX: 419-537-1300
E-MAIL: karenrobie@robiepsych.com

Complete this form to allow Karen Robie, Ph.D. to exchange basic information about your visit here with your primary care physician and to obtain records from your physician. If you refuse this permission, please write REFUSED & sign.

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: ______________________________

Birth Date: ______________________ SSN (Last 4): ______________________

The above named individual, or legal representative, gives permission to **Karen Robie, Ph.D., 4930 N Holland Sylvania Road, Suite B, Sylvania, OH 43560** to release and receive confidential information contained in psychological, psychotherapy, clinical, medical, hospital, school or related records which may include information about a) medical and health status, b) protected alcohol and drug abuse treatment, c) mental health treatment, d) communicable diseases and infections such as AIDS, HIV, or ARC diagnosis and treatment, and e) physical or sexual abuse, if any, of the patient named above to/with:

Primary Care Physician: ______________________________

Address: ______________________________

City: ______________ State: __________ Zip: ______________

Approximate date(s) of treatment/services: **All, unless specified here**:______________________

Specific information authorized:

1. **Diagnostic Summary/Evaluation Results**
2. **Treatment Plan, Course & Progress**
3. **Medical History/Physical Exam**
4. **Medications Prescribed & Med History**

Specific information to be EXCLUDED: **None, unless specified here**: ______________________

Purpose and need for information release/exchange: **To Further Care and Treatment and Coordination of Care**

This authorization will be continuous for the course of treatment with Karen Robie, Ph.D. unless revoked in writing to Dr. Robie or the releasing entity. Revocation may occur at any time except to the extent that action has already been taken in reliance on it. Information provided under the terms of this authorization may be discussed with the patient named above and will otherwise be held as confidential. Information disclosed to Dr. Robie will not be re-released without written authorization; we ask the same courtesy of any receiving entity but cannot assure it and released information may no longer be protected by HIPAA privacy rules. Signing this authorization may not be used as a condition for treatment, payment, enrollment, or eligibility for benefits.

______________________________ ______________
Patient's Signature Date

______________________________ ______________
Parent/Guardian/Legally Authorized Representative's Signature Date

____
Basis of Representative's Authorization to Sign

______________________________ ______________
Witness Signature, if needed Date

THIS IS YOUR COPY. PLEASE REMOVE IT AND KEEP IT FOR YOUR RECORDS.

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