Psychological Consultation & Assessment, Inc.
INDIVIDUAL CLIENT INFORMATION

Today's Date

Your cooperation in completing this questionnaire will be helpful in planning our services for you. Please answer each item carefully or ask your clinician for clarification if you do not understand an item.

Last Name	First Name and MI	
Street Address:		
City:	State:	Zip Code:
Is it appropriate to send correspondence to this address? ☐Yes ☐No		
Home Phone:	Cell Phone:	Work Phone/Ext:
EMAIL:		Social Security#:
Age: DOB:	Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed	
School:		Grade:
Occupation:	Education:	
Gender Identity (optional):	Sexual Orientation (optional):	
Ethnicity (optional):	Preferred Pronouns (optional):	

Briefly describe your reason for seeking treatment today:

List any major health diagnosis, for which you currently receive treatment. Please include any medication you are taking.

Please list any previous mental health treatment, including names of clinicians and approximate dates of treatment.

Treatment	Clinician

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Please list the members of your family and all others in your home.

NAME	AGE/BIRTHDATE	RELATIONSHIP	OCCUPATION

Please check any of your concerns:

☐Nervousness	☐Depression	☐Fears
☐Shyness	☐Sexual Problems	☐Suicidal Thoughts
☐Separation	☐Divorce	☐Finances
☐Drug Usage	☐Alcohol Usage	☐Friends
☐Anger	☐Self-Control	☐Unhappiness
☐Sleep	☐Stress	☐Work
☐Relaxation	☐Headaches	☐Tiredness
☐Legal Matters	☐Memory	☐Ambition
☐Energy	☐Insomnia	☐Making Decisions
☐Loneliness	☐Concentration	☐Inferiority Feelings
☐Education	☐Career Choices	☐Health Problem
☐Temper	☐Nightmares	☐Marriage
☐Children	☐Appetite	☐Stomach Trouble
☐Bowel Troubles	☐Being a Parent	☐My Thoughts

Please add any additional information which you feel may be useful to us.

_____

_____

_____

Substance use:

I consume alcohol: ☐ Never ☐ Occasionally ☐ Frequently ☐Excessively ☐To Intoxication

I have used opioids: ☐ Never ☐ Occasionally ☐ Frequently ☐ Excessively

I ☐ have/ ☐ had an addiction: ☐ yes ☐ no If yes, identify the addiction:

I have had treatment for an addiction: ☐ n/a ☐ yes ☐ no If yes, identify type of treatment:

_____

_____

Veterans:

☐	I am a U.S. Military Veteran
☐	I am a family member of a veteran
☐	I have attempted suicide or considered suicide
☐	I have been diagnosed with PTSD, anxiety or a related disorder
☐	I may require family and/or marital counseling

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Please indicate any mental health diagnoses:

_____

_____

_____

_____

Please initial the space below to indicate receipt and understanding of the following documents:

_____ Fee Agreement and Financial Policy

_____ Notice of Privacy Practices

_____ Informed Consent for Treatment

Please initial the space below to indicate receipt and understanding of billing practices:

_____ I have been advised by my insurance company/PC&A of my outpatient mental health benefits. I understand that I am responsible for my copay, coinsurance, deductibles and any other applicable fees at time of service. Please note that PC&A does not participate with all insurance companies.

I agree to the information contained in the above referenced documents. I grant permission to the staff of PC&A to provide psychological and/or counseling services to the above named individual and I understand I may revoke this permission in writing at any time.

_____ _____
Client Signature Date

_____ _____
Signature of parent or legal guardian Date

_____ _____
Witness Signature Date

FEE AGREEMENT AND FINANCIAL POLICY

Thank you for choosing Psychological Consultation & Assessment, Inc. Please review this Fee Agreement and Financial Policy, which describes our schedule of fees for services, charges not covered by insurance, and additional fees. Please be sure that you understand the policies regarding cancelations and missed appointments, methods of payment, insurance reimbursement, and past due accounts. If you have any questions, please ask a staff member prior to signing this agreement.

Service Charges

The following are PC&A service charges and corresponding insurance billing codes:

Initial Intake:	90791	$200
Session Fee(s):		
1-Hour Session (53-60 minutes)	90837	$160
1-Hour Family Session Patient not Present (53-60 minutes)	90846	$160
1-Hour Family Session Patient Present (53-60 minutes)	90847	$160
45-Minute Session (38-52 minutes)	90834	$120
30-Minute Session (16-37 minutes)	90832	$90

Evaluation/Testing: Based on Referral/Test Instruments (Payment is due up front and then insurance is billed for the charges).

Private Pay:	
Initial Intake	$160
1-Hour Session	$120
45-Minute Session	$90

Charges Not Covered by Insurance:		
Court Appearances (including preparation, travel & court time)	Per Hour	$200
Phone Consultation	Per Hour	$100
Case Management- includes but not limited to letters, requested consultation with outside or government agencies, treatment summaries	Per Hour	$100
Additional Fees:		
Late cancelations/missed appointment (less than 24-hour notice)	Per Occurrence	$55
Returned check		$50

Payment

You are expected to pay your responsibility, after insurance, in full each visit.
Private Pay Patients will be responsible for paying in full on the date of service.
Accepted methods of payment are cash, check, & credit.
PC&A will submit claims to your insurance for reimbursement, both in and out of network.

FEE AGREEMENT AND FINANCIAL POLICY

I agree to allow (1) PC&A to bill my insurance directly for services provided; (2) appoint PC&A as my authorized representative to act for me in obtaining payment; (3) assign all of my rights to claims and payment by my insurance to PC&A ; (4) agree to assist with the claims process as required by PC&A or my insurance provider; (5) agree for charges **not to exceed $100** in the case of remaining patient responsibility after insurance to be charged to the card on file. Any balance remaining above $100 will be charged on the 15th of the following month. Patient responsibility is reflected on your EOB sent to you by your insurance company.

I understand that if my insurance plan requires that I meet a deductible amount prior to coverage by insurance, I will be responsible for the full session fee until the required deductible amount has been met.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO BE BOUND BY THE TERMS CONTAINED IN THIS AGREEMENT.

Patient Signature Date

Parent/Guardian Signature Date

Witness (PC&A Staff Member) Date

Credit Card Authorization

(this is required to be on file)

I authorize regularly scheduled charges to the credit card on file. I will be charged the amount indicated below each billing period. A receipt for each payment will be provided to me, via email/text, and the charge will appear on my credit card statement. I agree that no prior notification will be provided unless requested.

I _____ authorize Psychological Consultation & Assessment to charge my credit/debit card indicated below for $_____ on the date of service. I also agree to pay $_____ on the 15th day of each month for any charges not covered by insurance. (deductible, co-insurance, non-covered charges)

Patient Information

Name: _____ DOB: _____

Billing Information

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

Card Details

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name _____
CC Number _____
Expiration Date ____ /____
CVV ____
Zip Code _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify PC&A, Inc. in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____ DATE _____
(Cardholder's Signature)