Karen Johnston Gieseke, Ph.D. and Associates
42 Valley Rd. #3C
Middletown, RI 02842
401-842-0009

Date_____

Home phone_____

Child Form

PATIENT INFORMATION

Name of minor child_____
(last) (first) (Middle)
Sex_____M_____F Age_____ Birthdate_____
Home Address_____
City, State, Zip Code_____
Person Financially Responsible_____Cell phone_____
Work phone_____
Whom may we thank for referring you?_____

INSURANCE COVERAGE

Father's/Guardian's name_____

Address (if different from patient's)_____
_____
Home phone (if different)_____work phone_____
Email address:_____
Employer_____
Social Security Number_____ Birthdate_____
Insurance Plan Name_____ phone number_____
Insurance Plan Address_____
_____
Group#_____Policy #_____

Mother's/Guardian's name_____

Address (if different from patient's)_____
Home phone (if different)_____work phone_____
Employer_____
Social Security Number_____Birthdate_____
Insurance Plan Name_____phone number_____
Insurance Plan Address_____
_____
Group # Policy #
In case of emergency contact person and number:

FAMILY HISTORY

Has any member of the family or close relative had:

Yes	No	Yes	No	Yes	No
___	___ Arthritis	___	___Diabetes	___	___Mental Disorders
___	___Asthma	___	___Heart Disease	___	___Migraines
___	___Cancer	___	___High BP	___	___Tuberculosis
___	___Chemical Dependency	___	___kidney disease	___	___Other
___	___Convulsion/epilepsy	___	___hemophilia		

BIRTH HISTORY

Hospital_____Obstetrician_____
Type of Delivery_____Complications_____
Birth Weight_____Length_____Discharge Weight_____
Any problems immediately after birth?_____
Any problems with developmental milestones?_____

HEALTH HISTORY

Minor Child's physician_____
Date of last physical_____Results_____
Does minor child currently take any medications?_____
Has your child been hospitalized?_____
Has your child had any history of or difficulty with any of the following:

Yes	No	Yes	No	Yes	No
___	___AIDS	___	___Chicken Pox	___	___Heart problems
___	___Anemia	___	___Constipation/diarrhea	___	___Hepatitis
___	___Asthma	___	___Convulsions	___	___Kidney disease
___	___Bed wetting	___	___Diabetes	___	___Lead poisoning
___	___Birth defects	___	___Drug/alcohol abuse	___	___Liver disease
___	___Bladder problems	___	___Ear infections	___	___Measles
___	___Cancer	___	___Epilepsy	___	___Mononucleosis
___	___Hearing problems	___	___Pneumonia	___	___Speech problems
___	___Vision problems	___	___Thyroid disease	___	___Sinus problems
___	___Learning disabilities	___	___ADHD	___	___Depression
___	___Anxiety	___	___Suicidal behavior	___	___Other

RELEASE AND ASSIGNMENT

This information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my minor child's insurance status.

I certify _____is covered by insurance with _____ and assign directly to Dr. Gieseke all insurance benefits for services provided. ***I understand that I am financially responsible for all charges whether or not paid by insurance.*** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signed_____Date_____
(Please circle one)I **allow/do not allow** Dr Gieseke and Associates to contact my child's Primary care physician_____
Signed_____Date_____

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Dear New Client,

Welcome to my practice! Please carefully read the following information and sign below. It is important that the financial issues be clarified before we work together, so you do not have to be concerned with these at a later date.

Payment Information
Individual and family therapy are provided at a rate of $160.00-$180.00 per 45 minute interval, unless you are using insurance coverage with which I have a contract. In that case, a discounted amount will be charged to your insurance and your co-payment will be accepted at the time of the visit. For all other insurance, the amount must be paid in full until reimbursement rates are established and all deductibles have been met. If you are unsure what portion of these charges your insurance policy will cover, please contact your insurance company or consult the literature provided by your employer or insurance company. Please check your coverage as soon as possible to avoid being surprised by receiving less reimbursement than you expected. ***Any balance not paid by your insurance company is your responsibility.***

Please have your payment ready at the start of the appointment, which allows us to focus on treatment, not payments. Checks should be made out to Karen J. Gieseke, Ph.D. As a courtesy to you, I will file insurance claims as quickly as possible so that you may be promptly reimbursed for any overpayments you have made at this office. Insurance will be billed based on the information provided at the first visit. Any changes in coverage, address changes, or other changes should be reported as soon as possible. The Office Manager handles all billing.

Canceling Appointments
Please make note of all your appointments. **Appointments not canceled at least 24 hours prior to the scheduled visit will be billed to you at a cost of $50.00**. Please be aware that your insurance will not pay for missed appointments. This is necessary to keep our business running. As you may be aware, we have set aside a considerable amount of time just for you, and when an appointment is cancelled without notice we are unable to give that time to anyone else who may need it. With prior warning, we are often able to fill the vacant time with another client who wishes to be seen.

Emergencies
This office is not readily equipped for emergency services. However, in the event of an emergency, you may try to reach us by pager or cellular phone, and we make every attempt to be available to our clients. However, in the unlikely event that my colleagues or I cannot be reached, please go to the nearest emergency room. If we are out of the area or on vacation, another provider will be arranged to accept all emergency calls.

Authorization to bill insurance
I authorize the release of any medical information necessary to process this claim and request the payment of any commercial insurance carrier benefits either to myself or to the provider or service. My signature below indicates that I have read and understood the above policies.

_____ _____Signature Date

Collection of Deductible/Coinsurance/Copayment Form

Client's Name:_____ Client's DOB___/___/____

Client's Health Plan: _____

Client's ID Number: _____

Client's Mailing Address: _____

City:_____ State:_____ Zip Code: _____

Dear Client,

We have verified with your insurance carrier that your insurance coverage indicates a deductible balance of $_____ and/or a co-payment of $_____.
Since you are responsible for paying for services that fall under your deductible/coinsurance/co-payment, please check the appropriate box to identify your selected payment method.

- o I will pay the deductible/coinsurance/co-payment for services I receive today in full prior to leaving the office today.
- o As a participating provider, my therapist will submit the claim on my behalf for services rendered directly to my insurance carrier. Upon receipt of my Explanation of Benefits from my insurance carrier, I understand that I am responsible for any applicable deductible/coinsurance/copayment **and I must provide payment directly to my provider within 30 days**. My provider and I have agreed to a financial arrangement/payment plan to pay for any applicable deductible/coinsurance/co-payment. If I do not pay in accordance within the agreed upon arrangement, I understand my provider may seek alternative methods to collect these monies.

I understand that I am responsible for paying my provider directly for any applicable deductible/coinsurance/co-payment. This is a mandatory requirement when receiving healthcare services. I understand that if I do not fulfill this requirement, my provider may notify my insurance carrier, and seek alternative methods of collection. Failure to meet my obligations is a violation of my agreement with my insurance carrier and the carrier may take additional action. I also understand that if I have longstanding unpaid deductibles/coinsurance/co-payments owed to my provider, my provider may terminate the therapist/patient relationship as a result, subject to the requirements of state and/or federal law.

I further understand that if my provider collects any applicable deductible/coinsurance/co-payment from me and is also reimbursed directly from my insurance carrier, that I will be reimbursed from my provider any overpayment owed to me, no later than 45 days after the provider's receipt of insurance carrier notification.

Patient/Guardian Signature:_____ Date:_____

I have received my HIPPA privacy notice

Signature_____Date_____

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Additional patient Information regarding office charges

Some services that therapists may provide are not covered by health insurance. The following is a list of **uncovered** charges:

Writing letters/Reports
Testing Supplies
Phone calls lasting more than 10 minutes
Consultation with teachers/school/other professionals
Attending meetings outside the office
Testifying in court
Consultation with attorney
Review of records/school testing/IEP etc.
Educational Testing

These services are billed at a 45 minute interval rate of $85.00 for master's level therapists and $100 for psychologists, with the exception court related expenditures, which are not covered by *any* health insurance carrier; this is billed at a flat hourly rate of $225.00 for all therapists. Your insurance cannot be billed for the above services. Only therapy sessions are covered by health insurance. If the service lasts only a fraction of an hour, then your charges are prorated to reflect the exact amount of time spent on the service.

If you have no insurance coverage or wish to pay cash for services the following is a list of charges, which reflects a discount for cash payments. Your payment is due at the time of the visit.

	Master's Level Therapist	Doctoral Level Psychologist
90791 Initial Intake	$100.00	$110.00
90847 Family Therapy	$95.00	$105.00
90834 Individual Therapy	$85.00	$95.00
Educational Testing		$600.00

If you have any questions, please see the office manager.

Thank You.

I agree to these terms.

_____ _____

Signature Date