Acct. #: _____

ASF Psychological and Therapeutic Services, LLC
331 W. State St., Media, PA 19063

Client: _____ DOB: __/___/___ Sex: M F

Spouse/Guardian/Parent (circle): _____DOB: __/___/___

Address: _____City/St/Zip: _____

Email (for email appointment confirmations): _____

Phone: Home: (___)_____ Cell: (____)_____Work: (___)_____

Please indicate preferred number with a *.

Employer /School_____

Emergency Contact: _____Emergency phone#:_____

If you are seeking treatment for your child you will need to agree to the following:

1) When a family is confronted by parental separation or divorce, it is very hard on everyone. It is particularly hard on children. When the parental relationship is unsafe, it is even more important that therapy presents a safe environment. That safety is particularly endangered where a child has to worry that what they say in therapy will be revealed in court and used against one of their parents.

Please initial: _____

2) All communications among the parent(s), their child(ren), and the Psychotherapist will be confidential and privileged from disclosure. Both parties stipulate that Dr. Fuhrman will not be required to testify at or to produce for any proceeding or in any court, opinions, records, documents, or recordings formed or created as part of the psychotherapy process. It is in the best interests of the child and the parties that no one feels influenced by any impending legal action when involved in psychotherapy. Without both parties entering into this type of stipulation, it is quite likely that the therapeutic alliance would be affected detrimentally. This stipulation does not preclude obeying the statutory requirements to report information about: child, adult dependent person or elder abuse, neglect or exploitation; an actual threat of violence against a reasonably identifiable victim(s); or mental illness that requires involuntary commitment because of danger to self or others or grave disability. **Please initial:** _____

Please note: If you are divorced or separated and are the parent of a child under the age of 14 seeking treatment for your child and you share legal custody with the other parent both parents must sign the consent form for the child to receive psychotherapy. I have read and understand the above.

_____ _____
Client Signature (over 14 years) Date

_____ _____
Parent Signature (if client under 18 years) Date

_____ _____
2nd Parent Signature Date

2nd Parent Phone Number: _____

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Insurance information and authorization:

_____ I don't have insurance/I am choosing not to use my insurance. I agreed to pay $_____ per session.

Party responsible for payment: _____

Health Insurance Company: _____Identification # _____

Name of Policy Holder: _____ Guarantor DOB ____/____ /___

2nd Insurance Company: _____Identification # _____

Name of Policy Holder: _____ Guarantor DOB ____/____ /___

Please initial each line.

_____ I hereby give permission to Amanda Fuhrman, PsyD/ASF Psychological and Therapeutic Services, LLC to release any and all pertinent information to my insurance company for the purposes of treatment authorization and for payment of services rendered to me or my dependent.

_____ I agree to pay all payments due when services are received.

_____ I agree to notify Amanda Fuhrman, PsyD of any changes in the status of my insurance as soon as possible.

_____ I have the right to revoke consent at any time via written communication to my therapist.

_____ If I choose to revoke consent I will be responsible for full fees.

_____ I understand that this consent will remain in effect for the duration of treatment with Amanda Fuhrman, PsyD.

_____ I authorize that a copy of this document can be used in place of the original.

_____ I understand that I am responsible for payment of services not covered by my insurance company.

I understand that this authorization is voluntary. I understand that I may have a copy of this form after I have signed it. I certify that this form has been fully explained to me and that I understand its contents.

_____ _____

Signature of client/representative/legal guardian Date

_____ _____

Printed name of client or representative Relationship to client

****

I have read and been given a copy of the Pennsylvania Notice Form concerning my privacy rights.

_____ _____

Client/Guardian Signature Date

ASF Psychological and Therapeutic Services, LLC
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Authorization to Obtain/Release Information to Primary Care Physician

***Please check one (must be completed): [ ] I DO authorize [ ] I DO NOT authorize [ ] No PCP

ASF Psychological and Therapeutic Services, LLC to release the reason for seeking treatment, treatment plan, diagnosis pertaining to my treatment during the period beginning ____/____ /_____ and ending 1 (one) year thereafter. This information is needed for the purpose of coordinating treatment. These records are to be released to my primary care physician. I have been informed that I have the right to revoke consent at any time by oral and written request, except to the extent that action has been taken in reliance on the authorization. I have been informed of my rights, subject to chapter 7100.111.3 of the Pennsylvania Mental Health Procedures Act and/or subject to Pennsylvania Drug and Alcohol Abuse Control Act, to inspect the material to be released. This form has been fully explained and I certify that I understand its contents and have been offered a copy. I may revoke this consent at any time through written communication with my therapist.

_____ _____

Signature of Client (or Guardian of Client if under 18 years of age) Date

Primary Care physician name: _____

Address: _____City/St/Zip:_____

Telephone #:_____ Fax: _____

ASF Psychological and Therapeutic Services, LLC
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An Introduction to my Services

It is my goal to provide the highest level of competence, expertise, and service to my clients in the areas of individual psychotherapy and diagnostic evaluation. In the following page, I will describe some of my practice procedures, which may affect you. These procedures comprise a significant part of my treatment contract with you unless we mutually agree on specific exceptions.

Office Hours: Office hours are by appointment. If you need to contact me you will need to leave a voicemail and I will return your call as soon as I am able. I try to return all phone calls within a 24-48 hour period. Please indicate if your call is urgent and needs immediate attention.

Emergencies: In the event of an emergency, you should call 911 or go to your nearest emergency room. If you are in Delaware County, you can also call Delaware County's mobile crisis unit at **855-889-7827**.

Complaints: If you have any complaints, please address your grievance to: Amanda Fuhrman, Psy.D or Jane Iannuzzelli.

Cancellations: If the need arises for you to cancel an appointment, you must give 24 hours' notice. If you do not cancel within this time frame or you fail to show for your appointment, you will be charged a fee of $85 for the missed or late canceled session. . **Please initial:** _____

Payments: Payment is due at time of service. In cases where full payment presents an economic hardship, specific circumstances can be worked out. I ask that you read your insurance policy to be sure that you are fully aware of any limitations, co-pays or deductibles. If payment cannot be made I am willing to refer you to agencies that provide low or no cost services.

Any unaddressed balances that remain over 30 days are subject to a $5 administrative fee. This fee will continue to be incurred until your balance is addressed. Accounts more than 90 days past due may be referred to a collections agency. **Please initial:** _____

Health insurance: This is a partnership between you, your insurance company, and your therapist, depending on the reimbursement agreement. It is not a contract between the therapist and the insurance company. Your company may base its allowance on a fixed fee or HMO schedule, which may or may not coincide with my usual fees. In some cases, there are contractual agreements between me and your insurance company concerning fees. You are responsible for being aware of the coverage your insurance provides, as you are responsible for any fees not covered due to your failure to follow the procedures of your health plan.

Telephone Calls: Necessary, routine telephone calls to you or on your behalf are part of the practice and free of charge. Lengthy calls for scheduling or clinical matters will be billed at an hourly rate which is not covered by your insurance company.

Best wishes,

Amanda Fuhrman, Psy.D

****

Please sign below to indicate that you have read the information and agree to be in compliance with the above stated policies.

_____ _____

Client Signature over 14 years Date

_____ _____

Parent Signature (if client is under 18 years) Date

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Informed Consent for Treatment

I have chosen to receive treatment services under a benefit plan managed by my insurance company, or paid for by myself. My choice has been voluntary and I understand that I may terminate therapy at any time.

I know my treatment is provided by ASF Psychological and Therapeutic Services, LLC.

I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between me and my therapist, I will work with my therapist in a cooperative manner to resolve my difficulties.

I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information.

I understand that state and local laws require that my therapist reports all cases of abuse and neglect of minors or vulnerable adults.

I understand that state and local laws require that my therapist reports all cases in which there exists a danger to self or others.

I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand that I may be contacted by my insurance company, or its managed care component, (I) to ensure continuity and quality of my treatment and/or (II) after the completion of treatment, to assess the outcome of treatment.

I have read and had explained to me the basic rights of individuals, who seek such services. These rights include:

1. The right to be informed of the various steps and activities involved in receiving services.
2. The right to confidentiality under federal and state laws relating to the receipt of services.
3. The right to humane care and protection from harm, abuse, or neglect.
4. The right to make an informed decision whether to accept or refuse treatment.
5. The right to contact and consult with counsel at my expense.
6. The right to select practitioners of my choice at my expense.

I understand my therapist and my insurance company and/or their managed care company may exchange any and all information pertaining to my therapy, to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance or utilization review purposes. I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

Psychotherapy is not easily described in general statements. It varies depending on the personality of the therapist and you, the client, and the particular problems which you, the client, bring. There are a number of different approaches which can be utilized to address the problems you hope to address. It is not like visiting a medical doctor in that psychotherapy or psychological counseling requires a very active effort

on your part. In order to be most successful, you will have to work on things talked about both during sessions and at home.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger and frustration, loneliness and helplessness. Psychotherapy often requires discussing unpleasant aspects of your life. Psychotherapy has also been shown to have benefits for people who undertake it. Therapy often leads to better relationships, resolutions of specific problems, a significant reduction in feelings of distress, but there are no guarantees about what will happen.

The first few sessions will involve an evaluation of your needs. At the end of the evaluation you will be offered some initial impressions of what the work will include and the initial treatment plan to follow, if you decide to continue. You should evaluate this information along with your own assessment about whether you feel comfortable working with my practice. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, they should be discussed whenever they arise. If your doubts persist, I would be happy to help you secure an appropriate consultation with another mental health provider.

_____ _____

Client Signature (over 14 years) Date

_____ _____

Parent Signature (if client under 18 years) Date

Mandated reporting requirement:

If you tell me you are going to hurt someone else or you plan to harm yourself I am required by law to report that to someone else. If I have reason to suspect, on the basis of my professional judgment, that a child is or has been abused, I am required to report my suspicions to the authority or government agency vested to conduct child abuse investigations. I am required to make such reports even if I do not see the child in my professional capacity.

I am mandated to report suspected child abuse if anyone aged 14 or older tells me that he or she committed child abuse, even if the victim is no longer in danger.

I am also mandated to report suspected child abuse if anyone tells me that he or she knows of any child who is currently being abused.

Your signature indicates that you have read and understand the above. Should you have any questions about this change please do not hesitate to ask.

_____ _____

Client signature Date

_____ _____

Parent name Parent signature

_____ _____

Parent name Parent signature

ASF Psychological and Therapeutic Services, LLC
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Statement of Members' Rights

> Members have the right to be treated with dignity and respect.
> Members have the right to fair treatment. This is regardless of their race, religion, gender, ethnicity, age, disability or source of payment.
> Members have the right to have their treatment and other member information kept private. Only by law, may records be released without member permission.
> Members have the right to easily access care in a timely fashion.
> Members have the right to know all about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
> Members have the right to share in developing their plan of care.
> Members have the right to information in a language they can understand.
> Members have the right to have a clear explanation of their treatment options and condition.
> Members have the right to information about Magellan, it's practitioners, services and role in treatment process.
> Members have the right to get information about clinical guidelines used in providing and managing their care.
> Members have the right to information about the providers work history and training.
> Members have the right to know about advocacy and community groups and prevention services.
> Members have the right to provide input on insurance policies and services.
> Members have the right to freely file a complaint, grievance or appeal and to learn how to do so.
> Members have the right to know about the laws that relate to their rights and responsibilities.
> Members have the right to know of their rights and responsibilities in the treatment process.

Statement of Members' Responsibilities

> Members have the responsibility to treat those giving them care with dignity and respect.
> Members have the responsibility to give provider information they need. This is so they can deliver the best possible care.
> Members have the responsibility to ask their providers questions about their care. This is so they can understand their care and their role in that care.
> Members have the responsibility to follow their treatment plans for their care. The plan of care is to be agreed upon by the member and provider.
> Members have the responsibility to follow the agreed upon medication plan.
> Members have the responsibility to tell their provider about medication changes, including medications given to them by others.
> Members have the responsibility to keep their appointments. Members should call their providers as soon as possible if they need to cancel visits.
> Members have the responsibility to let their provider know when the treatment plan no longer works for them.
> Members have the responsibility to let their provider know about problems with paying fees.
> Members have the responsibility to not take actions that could harm others.
> Members have the responsibility to report abuse.
> Members have the responsibility to report fraud.
> Members have the responsibility to openly report concerns about the quality of care.

_____ _____

Client Signature (if 14 or above) Date

_____ _____

Parent(s) Signature (if under 18) Therapist initials

ASF Psychological and Therapeutic Services, LLC
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Consent to Use and Disclose Your Health Information

This form is an agreement between you, and me/us, When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here: .

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use and share your information, and so we may change our notice of privacy practices. If we do change it, you can get a copy by calling us at 610-574-1262, or from Amanda S. Fuhrman, our privacy officer.

If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as you asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

_____ _____

Signature of client or his or her personal representative Date

_____ _____

Printed name of client or personal representative Relationship to the client