Therapy Solutions
TAKE YOUR LIFE BACK.

CLIENT INTAKE FORM

PLEASE FILL OUT FORM COMPLETELY, ACCURATELY AND PRINT

Office Use Only
Client ID #_____
Staff Initials_____

Date_____

CLIENT INFORMATION

Client's Legal Name_____ **Preferred Name**_____ **SSN** _____- _____-_____

Date of Birth_____ **Age** _____ **Birth Sex:** ☐ Male ☐ Female **Marital Status:** ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Unknown

Home Address_____ **City**_____ **State**_____ **Zip**_____

Billing Address *(if different than above)*_____ **City**_____ **State**_____ **Zip**_____

Person Responsible for Account *(if different than client)*_____ **Relationship**_____

CONTACT INFORMATION

***Cell Phone**_____ **Home Phone**_____ **Work Phone**_____

***Email Address**_____

Appointment Reminder: *(Pick one)* ☐ Voice Call ☐ Text Message ☐ Email

Emergency Contact Name_____ **Relationship**_____ **Phone**_____

Parent or Legal Guardian Name *(if minor)* _____ **Phone**_____

REFERRAL INFORMATION

Reason for Referral_____ **Referring Physician**_____ **PCP**_____

1. **Is this appointment related to a work accident?** ☐ Yes ☐ No
2. **Is this appointment related to an auto accident?** ☐ Yes ☐ No
3. **Are you receiving home health services?** ☐ Yes ☐ No
4. **Have you been seen for this issue in the past year?** ☐ Yes ☐ No If yes, when were you seen?_____
5. **How did you hear about Therapy Solutions?** ☐ Doctor ☐ Family/Friend ☐ Phone Book ☐ Newspaper ☐ TV ☐ Radio ☐ Website ☐ Social Media ☐ Other: _____

EMPLOYER INFORMATION

Employer Name_____ **Employer Phone**_____

Work Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Student ☐ Volunteer ☐ Unemployed ☐ N/A

MENTAL HEALTH COUNSELING ONLY

Are there any custodial rights in place?

☐ Yes ☐ No ☐ N/A

If yes, please provide a copy of custodial/guardianship papers.
Papers on File_____

Are there any court orders in place, including a divorce decree?

☐ Yes ☐ No ☐ N/A

If yes, please provide a copy of court order.
Papers on File_____

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CLIENT INSURANCE FORM

PLEASE FILL OUT FORM COMPLETELY, ACCURATELY AND PRINT

****ALL ITEMS MUST BE COMPLETE FOR CLAIM SUBMISSION****

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Client ID #_____
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A. PRIMARY INSURANCE INFORMATION / POLICY HOLDER INFORMATION

Primary Insurance_____ **ID/Member #**_____ **Group #**_____

Policy Holder *(if other than self)*_____ **Policy Holder DOB**_____ ☐ Spouse ☐ Parent ☐ Other

Policy Holder Address *(only if different)* _____ **City**_____ **State**_____ **Zip**_____

Policy Holder Phone_____ **Policy Holder Employer**_____

B. SECONDARY INSURANCE INFORMATION / POLICY HOLDER INFORMATION

Secondary Insurance_____ **ID/Member #**_____ **Group #**_____

Policy Holder *(if other than self)*_____ **Policy Holder DOB**_____ ☐ Spouse ☐ Parent ☐ Other

Policy Holder Address *(only if different)* _____ **City**_____ **State**_____ **Zip**_____

Policy Holder Phone_____ **Policy Holder Employer**_____

C. NORTH DAKOTA WSI *MUST ALSO PROVIDE HEALTH INSURANCE INFORMATION

Have you ever been seen or received *any* treatment under this claim prior to this appointment? ☐ Yes ☐ No

If yes, when and where? _____

Area of Injury *(Body Part)* _____ **Date of Injury** _____

Claim #_____ **Employer at the time of injury**_____ **SSN**_____

Employer Address _____ **City/State/Zip** _____ **Employer Phone #**_____

D. OUT OF STATE WORKER'S COMP *MUST ALSO PROVIDE HEALTH INSURANCE INFORMATION

Have you ever been seen or received *any* treatment under this claim prior to this appointment? ☐ Yes ☐ No

If yes, when and where? _____

Area of Injury *(Body Part)* _____ **Date of Injury** _____

Claim #_____ **Employer at the time of injury**_____ **SSN**_____

Employer Address _____ **City/State/Zip** _____ **Employer Phone #**_____

Employer's Worker's Comp_____ **Contact Person for Claim**_____ **Contact Phone #**_____

Claim Submission Mailing Address _____ **City/State/Zip** _____

E. AUTOMOBILE INSURANCE INFORMATION *MUST ALSO PROVIDE HEALTH INSURANCE INFORMATION

Claim #_____ **SSN**_____ ☐ At Fault ☐ No Fault

Insurance Company Name_____ **Name of Insured** *(if other than client)*_____

Insurance Company Address (City/State/Zip)_____ **State Accident Occurred**_____

Adjustor_____ **Phone**_____ **Fax**_____

F. EMPLOYEE ASSISTANCE PROGRAM (EAP) – COUNSELING *MUST ALSO PROVIDE HEALTH INSURANCE INFORMATION

Will you be utilizing your EAP program for this and future appointments? ☐ Yes ☐ No

Name of EAP _____ **Employer EAP is sponsored by**_____

G. SELF-PAY *MY CIRCUMSTANCES QUALIFY FOR SELF-PAY

☐ **Check box if self-pay** *(Note: Self-pay payments must be paid in full and are due at the beginning of each session)*

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CLIENT CONSENTS

Office Use Only
Client ID #_____
Staff Initials_____

Thank you for choosing Therapy Solutions as a provider. We are honored by your choice and are committed to providing you with the highest quality care. We ask that you thoroughly read through and sign this form to acknowledge your understanding of our client consents.

PLEASE INITIAL BELOW:

_____ **Consent for Care & Policy Disclosure:** I do hereby give my consent for Therapy Solutions to perform any therapeutic procedure or treatment considered in the evaluation and treatment as described to me or as my physician or therapist determines are necessary and consistent with my diagnosis. I understand I have an opportunity to ask questions regarding my treatment and that my therapist will be available to answer any questions. I understand I may terminate any treatment at any time.

_____ **Acknowledgement to Treat – Minor:** I give Therapy Solutions authorization to evaluate and treat my child.
Guardianship: If guardianship of a minor is transferred over the course of treatment it is necessary to inform us immediately. At that time, new forms will be filled out and signed. If Therapy Solutions is not informed, the signor of the forms on file will be responsible for any additional charges that may incur.
Separated & Divorced Parents: Our policy is that the parent who brings the child to our office for treatment is responsible for payment.

_____ **Assignment of Benefits & Release of Information:** I hereby assign all medical benefits to which I am entitled, to include any major medical, private insurance and third party payers to Therapy Solutions. A photocopy of this assignment is to be considered as valid as the original. I am responsible for understanding my insurance coverage. I hereby authorize Therapy Solutions to release all information necessary, including medical records to secure payment. I understand that I am financially responsible for all charges not covered by my insurance or other third party payers and that the balance after insurance or third party payment has been made is due within thirty (30) days. I agree to contact my insurance carrier to find out if my treatment is covered and to take such steps as required to qualify my treatment for coverage. I agree to inform Therapy Solutions of any changes in my insurance. I authorize payment directly to Therapy Solutions for services rendered.

_____ **Notice of Privacy Practices / HIPAA:** I acknowledge that I have read through the ***Notice of Privacy Practices*** from Therapy Solutions. I understand that my protected health information may be used as described in the notice. I have been notified I have the right to request a copy of the *Notice of Privacy Practices.*

BY SIGNING, I ACKNOWLEDGE THAT ALL THE INFORMATION PROVIDED ABOVE IS ACCURATE. IF AT ANY TIME ANY OF THIS INFORMATION CHANGES, I AM AWARE THAT I MUST INFORM THERAPY SOLUTIONS IMMEDIATELY. THERAPY SOLUTIONS WILL ONLY SUBMIT CLAIMS TO THE INSURANCE CARRIER THAT IS PROVIDED TO THEM AT THE TIME OF THE APPOINTMENTS. IF THERE IS A LAPSE IN COVERAGE OR YOUR INSURANCE TERMS YOU WILL BE RESPONSIBLE FOR THE REMAINING BALANCE.

Client Signature / Parent or Legal Guardian **Date**

Print

CLIENT FINANCIAL RESPONSIBILITY & AGREEMENT OF BILLING PROCEDURES

Office Use Only
Client ID #_____
Staff Initials_____

Insurance: Therapy Solutions participates in most insurance plans including Medicare & Medicaid. If you do not wish to use your insurance or are insured by a plan we are not contracted with, payment in full is expected at the time of service. If you are insured by a plan we are contracted with, a copy of your current insurance card is required. If you are covered under more than one insurance plan, you must provide all insurance information at the time of service. It is your responsibility to know and understand your insurance benefits. Please contact your insurance company regarding any questions you may have.

Commercial Insurance: We will submit your claims to your insurance and will do everything to maximize your benefits. You are responsible for any copayment, coinsurance and deductible, which includes, any amount not paid by insurance, outside of contractual adjustments made by your insurance.

Referrals: If your insurance plan has a designated primary care physician and you are required to obtain a written referral from that doctor, you must provide the referral at the time of check-in or have it faxed prior to your appointment. If at the first visit you do not have a current, valid referral, you may be asked to either reschedule or be considered ***self-pay*** until the referral is on file.

EAP (Employee Assistance Programs): We accept certain EAPs. It is the client's responsibility to contact their EAP regarding any necessary referrals and paperwork to ensure the specific therapist is a contracted provider. We will submit to the EAP however; if they refuse payment for services rendered then we will bill your insurance or it becomes ***self-pay***. It is your responsibility to be aware of your authorized dates and number of sessions. *We will not retroactively bill for services that have already been submitted to your insurance. Primary insurance must also be provided.*

Workers Compensation: It is your responsibility to have all necessary paperwork and pre-authorization necessary for treatment. You will become responsible for any claims that are denied by workers comp. *Primary insurance must be provided.*

MVA (Motor Vehicle Accident): It is your responsibility to have all necessary information needed for us to submit claims to your insurance. Your *primary insurance information must be provided*, in case you exhaust your PIP benefits. At that point, we will bill your primary insurance.

Self-Pay: Therapy Solutions designates accounts, Self-Pay, under the following circumstances: (1) client is covered by an insurance plan that our providers do not participate in, (2) client does not have a current, valid insurance on file and has failed to provide one that day, (3) client does not have a valid insurance referral on file, (4) client is participating in services not covered by their insurance plan, or (5) client does not have health insurance coverage. Payments are due at the time of service; counseling appointments are due at check-in & all other services are due at check-out.

Responsible Financial Party: If you inform Therapy Solutions that an organization will be covering your services the following must be provided at the first date of service; the name of the organization, contact person name, address, phone number and a release of information must be signed. If this information is not provided at the time of service, and / or the statement balance is not paid in full prior to the next billing cycle, the balance due will become client responsibility.

Claim Submission: The billing department will submit your claims and work to maximize your benefits to ensure payment. Your insurance company may need you to contact them directly for certain information. You are responsible to provide all necessary information to your insurance, please be aware these requests may impact whether your services are covered. If they request information directly from us, we provide it immediately. Your insurance benefit is a contract between you and the insurance company.

Copayments, Coinsurance & Deductibles: All copays are due at the time of service this arrangement is part of the contract with your insurance company & we are obligated to collect at each visit. Coinsurance and deductibles are billed out on a monthly statement unless other payment arrangements have been made.

Non-Covered Services: At times, some or all of the services you receive may be non-covered or not considered reasonable or medically necessary by your insurance. You will be responsible for these services in full.

Coverage Changes: If your insurance coverage changes, or you no longer have insurance, we must be notified prior to your next visit or at the time of service. This allows us to make the appropriate changes to your account to ensure your claims are being submitted correctly. If we are not informed and your claims are denied / not paid and we are past timely filing for your updated insurance, you will be responsible for the balance.

Statements: If you have a balance on your account, we will send a monthly statement. All balances under $100 must be paid in full within **30 days** of billing. Statements will be available by mail or patient portal. We are only able to send a statement to one address.

Non-Payment: If your account is over 90 days past due, your monthly statement will be sent with a final notice sticker. You have until the first of the next month to pay the account in full, unless other payment arrangements are made. Please be aware that if your account remains unpaid, it will be sent to a collection agency. You will be responsible for any incurred fees in relation to returned checks.

Late Cancel / No Show: For all appointments we ask that you provide an 8 hour advance notice for cancellations. There will be a $50.00 fee assessed for missed appointments without an 8 hour advance notice or for if you do not show up for your session. You must pay the $50.00 fee prior to scheduling another appointment or your next appointment.

Litigation: If your treatment is related to an injury or accident that involves legal proceedings, Therapy Solutions policy is to not wait for settlement or payment. Therefore you are responsible for payment at the time of service.

I have read & understand the payment and billing policy and agree to abide by its guidelines.

Signature of Client or Responsible Party **Date**

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The Missed Visit Policy

At Therapy Solutions, we strive to bring hope and healing to our clients, but we need your participation to enable that to happen. To prevent others from having to wait for their care, we need your compliance with our attendance policy.

Please read our policy and sign at the bottom indicating you understand our expectations and our policy.

1. **If you're running late**, we need you to call as soon as you know you're running late. We will check with your provider to make sure there's enough time to provide the care you need and deserve.
    - If you are more than 15 minutes late, your session may need to be rescheduled and our missed visit policy will apply at that time. Chronically late patients will be asked to change their appointment times.
2. **If you are sick at any time during care, we need you to call us as soon as you have symptoms**. Please don't wait for the day of your appointment. At that time we will provide a plan for what happens next.
    - Example: If you're sick on Monday but your appt is Wednesday, let us know Monday.
3. **If you need to cancel or change a scheduled appointment, for any reason, we need an 8 hour notice.**
    - This allows enough time to get you rescheduled AND help another patient get in for the care they need and deserve.
    - When you call to cancel an appointment, have your schedule ready as we will reschedule you right away.
4. **We reserve the right to charge a missed visit fee of $50 if you do not provide at least an 8 hour notice of your appointment change or cancellation, and we will comply with payer policy in carrying it out.**
    - This fee is your responsibility and is due at the time of your next service due to the inconvenience and disruption it creates for other patients seeking care.
    - For worker's comp patients, we're required to notify your claims adjuster for cancellations and no-shows.
    - No-shows create problems and confusion and are not accepted. Call for any change or update.
5. **Patients who have multiple same-day cancellations or no-shows** will be removed from the active schedule and placed on our day-to-day list to avoid future last-minute cancellations that keep other patients from care.

One patient's late (or lack of) notice for appointment changes or cancellations, keeps other patients from getting the care they need and deserve. You can avoid any problems with this policy by calling our office **at least 8 hours** in advance for any illness, appointment changes, or cancellations.

This policy has been verbally reviewed with me and by signing below I am indicating that I understand this policy.

Patient Signature	Patient Name	Date