First Name Middle Initial Last Name Cell phone

Address City State Zip Code

Home Phone Place of Work Work Phone

Your Insurance Identification Number Date of Birth

Insured's Name and Date of Birth

Insured's Employer's Name and Address Phone Number

Insurance Identification Number Primary Insurance Carrier

Do You Have a Secondary Insurance? If yes, please list.

Name and Phone Number of Person I Should Contact in Case of Emergency.

Please list Your Physician. Please list any allergies you have.

Please list any medications you are taking and the illness they help you with.

Please list use of and frequency of use of the following; over-the-counter drugs, cigarettes, caffeinated beverages

Please circle any of the following you are currently experiencing. Please draw a line through any you have had a past history of.

Stroke	Seizures	Migraines	Liver damage	Thyroid problems	Anemia
Asthma	Anemia	Diabetes	Chronic pain	Chronic fatigue	Hepatitis
Cancer	Tuberculosis	Eating Disorder	Cardiac prob.	Urinary tract infection	Hypertension
Persistent flu-like symptoms			Communicable diseases		

How did you get my name?_____

Your Signature and Today's Date.

Thank you for completing this form.

INSURANCE AUTHORIZATION

I understand that by signing below I am authorizing:

- Contact of my insurance carrier and/or employer to determine my insurance benefits.
-All mental health/medical benefits to be paid directly to Betsy Zmuda-Swanson LCSW.
-Release of my medical records to the extent needed to obtain insurance payments.
-I can refuse to sign this authorization and opt to be 100% liable for all fees I incur.

I have called my insurance and know if I need a pre-authorization code for services.

Name:_____

Signature:_____

Date:_____ Relationship to patient:_____

FINANCIAL AGREEMENT

1. Charges are for services rendered. Results are not guaranteed.
2. Therapy sessions will last 50-55 minutes as allowed by insurance, unless we make a different agreement.
3. Fee for the first therapy session is $165. Sessions thereafter are $115.
4. Your insurance will be billed for charges, if you have so designated, but **you are responsible for the payment and any remainder. Insurance companies that require pre-authorization for services will not pay for the first session unless the authorization is in place for that date of service. Please call them before our first session to request authorization. They are unwilling to back date.**
5. **You are responsible for any co-pay at the time of service.**
6. It is your responsibility to be aware of and understand the coverage and limitations of your insurance carrier and/ or managed care company.
7. Any cancellations must be made **a full 24 hours in advance** in order to avoid a $70 fee. Your insurance will likely not pay this fee.
8. Charges for testifying in court, at your request are $200.00 per hour and a minimum of 4 hours must be paid in advance.
9. Checks returned for any reason (NFS, unsigned, undated, etc.) will result in a $60. fee charged to you.

I have read and understand the above Financial Agreement, and agree to its terms. I understand it is my responsibility to ask my insurance carrier if I have a co-pay and to pay the co-pay at the time services are rendered and to secure an authorization if needed.

Signed_____ Date _____

Witness_____ Date_____

Office Policy Statement

Welcome to the office of Betsy Zmuda-Swanson, MSW, LCSW, LISW. This statement is to acquaint you with the workings of this office. Please keep your copy in a place where you can readily refer to it. Engaging in counseling can be a true change of life experience. Therapy is a partnership. You provide the material and the direction in which you want to go. I provide tools and over 30 years of counseling experience. Together, you and I will identify treatment goals and work to accomplishing them. One of my goals will be to help you function and cope more effectively with problems. Your commitment to therapy, and honesty will play a major role in bringing about change. Sometimes the road to change is smooth. Frequently, it is bumpy. Please go to my website for more information

Office Hours

My office hours are generally from 9 a.m. through 6:30 p.m. Monday through Thursday. On Wednesdays, I am usually seeing clients at Marriage and Family Counseling Service, 309-786-4491. I am not in the office on Fridays.

Fee Schedule

Intake Rate:	Initial session and evaluation.	$165./hr
Standard Rate:	Includes office appointments, telephone consultations lasting more than ten minutes, insurance reports, third party consultations at your request, assessments, and report preparation.	$115./hr
Special Rates:	Forensic work: court testimony, preparation documentation, travel time, and consultation.	$200./hr
	Group psychotherapy.	$55./hr
	Failure to notify me 24 hours prior to canceling an appointment.	$70.
	Checks returned for any reason.	$60.

<u>Co-pays are to be paid at the time services are rendered</u>. Prior to your first session, it is your responsibility to have contacted your insurance, and be prepared at each session to pay your co-pay. Some insurances are easy for me to work with, others are not. I may need your help to work with your insurance company. If they refuse to pay for sessions you are responsibly for the session fees. Self-pay is always an option.

Emergency Situations

I am in a solo private practice and provide outpatient services. I cannot guarantee around the clock availability. I make the assumption that my clients are not in need of day-to-day supervision. If you feel that you may need after hours care, please bring this up in our first session. If necessary, I can make a referral to a place where your needs could be better met. Sometimes in the course of therapy, especially when people are working on the character

structures of Existence or Need, more support is desired. I can be available by text, 309 235-3040.

If you have a dire emergency that you feel absolutely requires contacting me outside of business hours, my phone number is 309 762-5061. Please be aware, I live with other people. If you call my home and or leave an answering machine message, my household members may see or hear the information you leave. If you are in an emergency and cannot reach me, please call one of the 24-hour emergency lines. Robert Young Center is located at Trinity West Hospital, 309-779-2031. Genesis West Medical Center's 24-hour emergency line is 563-421-2975. Both of these facilities also evaluate crisis mental health situations in their emergency rooms, and can arrange for inpatient care if necessary.

Confidentiality

The work psychotherapists do necessitates a very high level of confidentiality, and we are bound by a strict code of professional and legal ethics to maintain your privacy. As a rule, **NO** information about you leaves my office without your written consent. There are some uncommon exceptions to this rule, which relate to your safety and that of others. These are suicide or homicide threats, threats to seriously physically harm another person, a blatant loss of contact with reality and inability to care for one's basic needs, reports of abuse or neglect of children by one who is in the role of a caregiver. It is unlikely, but on rare occasions psychotherapy records are court ordered. If you think this is a possibility in your case, please inform me and we will discuss the issue in greater detail. If you are a minor, your parents or legal guardians have some legal rights to information about your treatment. I make every effort, in that situation to honor your confidentiality and discuss with you the possibility, and your consent to share information that is acceptable to all.

If you opt to have therapy paid for through your insurance benefits, I am obliged to share your diagnostic code, session code, and dates of service. Some insurance companies also require brief treatment plans and summaries in order to authorize more sessions. If your insurance company requests more information than described in the preceding two sentences, I will discuss this further with you. My office is set up to maximize your privacy and confidentiality.

In addition to the information listed above, there are other extremely rare circumstances that may require clinicians to make certain disclosures without consent, i.e. for national security purposes, Worker's Compensation Laws, and or other situations required by law.

Client Agreement

I have read and I understand this document, and agree to abide by all the professional and financial policies herein. I also acknowledge I have read and have received a copy of my patient rights and responsibilities.

_____ _____ _____

PRINTED NAME SIGNATURE DATE

_____

WITNESS

Patient Rights and Responsibilities

-Patients have the right to be treated with personal dignity and respect.
-Patients have the right to care that is considerate, respects their personal values and belief system.
-Patients have the right to personal privacy and confidentiality of information.
-Patients have the right to request restrictions on the use and disclosure of (PHI) Protected Health Information for treatment, payment, and health care operations purposes. (The Clinician is not legally required to agree to your request. However, she must agree to "reasonable requests".
-Patients have the right to receive information about managed care company's services, practitioners, clinical guidelines, and patient rights and responsibilities.
-Patients have the right to reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.
-Patients have the right to participate in an informed way in the decision making process regarding their treatment planning.
-Patients have the right to discuss with their providers the medically necessary treatment options for their condition regardless of cost of benefit coverage.
-Patients have the right to individualized treatment, including:
    -adequate and humane services regardless of the sources of financial support
    -provision of services within the least restrictive environment possible
    -an individualized treatment or program plan
    -periodic review of the treatment or program plan
    -an adequate number of competent, qualified, and experienced clinical staff to supervise and carry out the treatment or program plan.
-Patients have the right to participate in the consideration of ethical issues that arise in the provision of care and services, including; resolving conflict, withholding resuscitative services, forgoing or withdrawing life-sustaining treatment, and participating in investigational studies or clinical trials.
-Patients have the right to designate a surrogate decision-maker if the member is incapable of understanding a proposed treatment or procedure or is unable to communicate their wishes regarding care.
-Patients and their families have the right to be informed of their rights in a language they understand.
-Patients have the right to voice complaints or appeals about managed care company or the care provider.
-Patients have the right to be informed of rules and regulations concerning patients conduct.
-Patients have the responsibility to give their provider and managed care company needed in order to receive care.
-Patients have the responsibility to follow their agreed upon treatment plan and instructions for care.
-Patients have the responsibility to participate, to the degree possible, in understanding their behavioral health problems and developing with their provider mutually agreed upon treatment goals.