Beach Counseling Services
Joel G. Prather, Psy.D., P.A.
12133 Panama City Beach Pkwy | Panama City Beach, FL 32407
Office: (850) 249-9636 | Fax: (850) 249-9635 | E-mail: reception@beachcounseling.net

Client Registration Information - Child

Client's Full Name: _____
Date of Birth: _____/_____/_____ **Sex:** Male/Female Client Social Security Number _____
Mailing Address: _____City: _____State: _____Zip: _____
Marital/Legal Status: S DP M W D Employer / School: _____ E-mail address: _____
Phones: Home: _____ Work: _____ Cell: _____

As a courtesy to you and in order to serve you better, our staff will contact you to remind you of your appointment date and time. Please only provide phone numbers you permit us to leave voicemail on.

Guardian's Name: _____ Relationship:_____
Phone Number:_____
Address (City, State, and Zip):_____

Emergency Contact Name: _____ Phone(s): _____
Relationship: _____ Emergency Contact Address: _____

X _____ _____
Signature of Client or Personal Representative Responsible for Payment **Date**
I certify that the information on this sheet is correct and hereby authorize Joel G. Prather, Psy.D., P.A. to provide therapy or other services deemed necessary for the client above.

Please tell us about your child.

How did you find us: Doctor / School / Other: _____

What symptoms are currently concerning you/your child? (please circle):

Sadness Depression Self-Harm Sleeping Problems Changes in Appetite

Difficulty with Concentration Anxiety Aggression Social Isolation Bed Wetting

Intense Fears Stomach Aches Headaches Academic Difficulty Defiance to Authority

Hyperactivity Impulsivity Changes in Weight

History of Concerns

Please describe what concerns you have regarding your child/adolescent*:_____

_____

_____

Is your child currently taking medications or previously been on prescription medication? List them here:

_____

How long has the problem(s) existed? **New Problem / Returning Problem** _____

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Have there been any significant stressors in your family: losses, births, moves, trauma, divorce, or hospitalizations in the last several years? _____

_____

Does your child have siblings?: **Yes / No**
If yes, please provide their names and ages: _____

Please describe custody arrangements: _____
_____

Primary Care Doctor*: _____
Psychiatrist / Other*: _____
If you wish us to communicate with your provider, please complete our Release of Information page at the end of this packet.

_____

IS CHILD ON DISABILITY? PLEASE NOTE THAT WE ARE NOT MEDICARE PROVIDERS, NOR ARE WE BILLABLE TO MEDICARE SUPPLEMENTAL POLICIES. IF YOU ARE ON DISABILITY, WE REQUIRE A MEDICARE OPT-OUT FORM. PLEASE NOTIFY THIS OFFICE. IN THIS CASE YOU MUST PAY FOR SERVICES IN ADVANCE.

Developmental History:

Was your child born full term? **Yes / No** Details: _____

Was your child healthy at birth? **Yes / No** Details: _____

Was your child able to reach their developmental milestones at a normal rate (speaking, walking, potty training? **Yes / No** Details: _____

Academic History: Grade? _____ School?_____ Primary Teacher: _____

Has your child/adolescent ever had to repeat a grade level?_____

Accommodations at school:
IEP / 504 / Education Plan (gifted) / MTSS / Other: _____

Has your child ever been suspended from school? **Yes / No** Details: _____

Mental Health History:

Has your child/adolescent ever received any type of mental health treatment? **Yes / No**
If yes, who was the provider and what services were rendered? _____
Is there any family history of mental health distress? **Yes / No** _____

_____

Please use the back of this form to tell us anything else you would like for us to know before we meet your child.

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Financial Information

_____ **(If applicable, initial here)** ***I do not have insurance and agree to pay at the beginning of each visit.***
Self-pay rates for counseling are $140 for your initial visit and start at $115 for follow up sessions. These rates are subject to change without notice.

Insurance

If you would like our office to review your insurance coverage, please complete the following:
****FRONT & BACK COPY OF INSURANCE CARD AND ID ARE REQUIRED FOR SCHEDULING****
Primary Medical Ins. Co: _____
Does your insurance require pre-authorization for your visit today? **Yes / No**
Ins. I.D. Number _____ Group Number _____

Insurance Primary Member Name: _____ Employer: _____

Subscriber D.O.B. (required): _____ Subscriber Social Security (required): _____

Address on File w/ Ins. Co: _____Ins. Phone No. (back of card): _____

Please note the patient is responsible for filing claims with anything other than their primary insurance. As a courtesy we may verify whether your secondary insurance requires authorization, and make an attempt to obtain this. If you have secondary insurance, please discuss this with our staff upon scheduling.

EAP

Will your sessions be covered under an Employee Assistance Program (EAP)? Yes / No
If **yes**, the following information is required:
EAP Name:_____ Authorization Number:_____
Company Sponsor:_____ Begin Date: _____ Expiration Date:_____
Number of sessions:_____ EAP Phone Number:_____

Medicare

Medicare Beneficiaries: Are you on Medicare or a Medicare Supplement? We are not providers for Medicare and do not take Medicare supplements. If your claim is denied because of your affiliation with Medicare, you will be personally responsible for the charges. The **patient with the Medicare policy will be responsible for cost in full** and **should notify this office of that policy, as they should request of this office a Medicare Opt-Out Form**.

Assignment & Release: I, the undersigned, certify that I, or my dependent, have insurance coverage with _____ and assign directly to the psychotherapist Joel G. Prather, Psy.D, PA all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the psychotherapist to release all information necessary to secure the payment of benefits, and I authorize the use of this signature on all insurance submissions.

X _____ _____
Signature of Client or Personal Representative Responsible for Payment **Date**
I certify that the information on this sheet is correct and hereby authorize Joel G. Prather, Psy.D., P.A. to provide therapy or other services deemed necessary for the client above.

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Credit Card on File
REQUIRED FOR SERVICES

There are situations in which **your insurance company may bill us back your visit**. If that is the case, YOU ARE RESPONSIBLE FOR THAT PAYMENT. In order for us to provide adequate and uninterrupted service to you, **you MUST have a credit card on file**. If the insurance company charges back your claim for any reason, YOUR CARD MAY BE CHARGED the remainder of the fee for your visit if you do not respond to our contact efforts. Please understand that the insurance may take 90 days or more to bill back your claim. **If we are charged back, WE MAY CHARGE YOUR CARD without prior notice.**

If balances delinquent more than 60 days are not paid, the balance will be charged in full to this credit card. This is an alternative to sending delinquent accounts to collections. All returned checks will be immediately charged to the credit card, plus a $25.00 returned check fee. Missed and late cancellation charges will be charged immediately. Please provide your credit card information below for our record:

Please Circle Credit Card Type: MasterCard / Visa
Credit Card Number: _____-_____-_____-_____ Exp. Date: _____

Name on Card: _____
Billing Address (include zip): _____ Sec. Code (3 digits): _____
***Cardholder acknowledges contact with vendor and agrees to authorize payments for any unpaid balances as explained above. ***

X _____ _____

Signature of Client or Personal Representative Responsible for Payment **Date**

Additional Fees

There will be **additional fees for services not reimbursed by your insurance**. Such services may be included, but not limited to: **letters to third parties, forms, reports**, and other special requests.

These **services will be billed at the rate of $100 per hour, prorated, $25 minimum per service**. These rates are subject to change without notice.

***IF TESTING IS REQUESTED, PLEASE DISCUSS TESTING FEES AND INSURANCE LIMITATIONS WITH OUR OFFICE.**

X _____ _____

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Policies & Procedures
Client-Therapist Agreement

Initials, Review, and Signature are Required, Please.

☐ **Sessions**: All sessions are by appointment only. Due to the nature of a full week's schedule, it is best to secure your appointments two to four weeks ahead to ensure a suitable time. We recommend recurring appointments. As part of your therapy program, please plan to return weekly for six to eight weeks of services or comply with the agreed recommendation of your clinician. The office will make all attempts to secure last-minute appointments, but when non-emergent these may not be available. Some insurance may not pay for these crisis appointments. Appointments are secured on a first-come, first-serve basis. According to insurance reimbursement, each individual, couple or family session is billed at 45-52 or 53-60 minutes, followed by session documentation and other procedures. These times are at the discretion of your clinician. Due to ethical standards and equality for each patient in regards to schedule appointment times it is important to make every effort to adhere to your appointment time and recognize that concerns brought up at the end of your appointment may need to be explored at your next session.

☐ **Cancellation/Missed Appointments**: If you are unable to keep an appointment, we require at least a 24 hours' notice. Without adequate notification, $75 will be charged for all broken appointments. Credit cards kept on file will be billed for no show/no call and less than 24 hour appointment cancellations. We care about our patients, and thus sudden emergency will be taken into consideration. Please discuss this with our receptionist. Continuous late cancellations or missed appointments will result in termination of services and/or referral to other mental health professionals in the community. **Broken appointments** will be billed to the client, as insurance does not cover missed appointments. There is a **$75 broken appointment fee, which is also applicable to cancellation made with less than 24 business hours' notice** to our office, at our discretion. Please understand that we hold this time specifically for you. **TEXT MESSAGE REMINDERS ARE A COURTESY AND NOT A GUARANTEE!**

☐ **Fees & Alternative Billing**: Self-pay rates for counseling are $140 for your initial visit and start at $115 for follow up sessions. Please refer to the testing fee agreement form for these specific service details.

☐ **Payments**: All fees and co-pays must be paid at the time of services via cash or credit card. Checks are acceptable if no other form of payment is available. If checks are returned there is a fee.

☐ **Confidentiality**: I am legally, ethically, and morally required to keep all information strictly confidential. As confidentiality is necessary to facilitate the therapeutic process, it is important that you understand the following legal exceptions to confidentiality: (1) If you disclose that you intend to harm yourself, someone else, or damage property, I must take steps to prevent you from harming yourself and/or inform the intended victim of the possible danger. (2) Reporting any reasonable suspicion of child abuse is required by Florida State Law, FS 415.504, to the Florida Abuse Hotline at 1-800-96-ABUSE. (3) If you utilize third party payments, information you have authorized to be available can be released by the use of a Release of Information form. (4) Clients must sign a Release of Information Form for the therapist to release or receive information, records, or other information from others regarding your case.

☐ **Urgent Appointments, Emergencies, and After Hours**: If there is an urgent but non-emergent issue during hours of operation, the patient will either be scheduled to attend session that same day with a provider or scheduled a phone appointment with them IF an available appointment does exist. In case of emergency if patient is unable to reach the office, regardless of time of day, the patient should dial "911" on their telephone or call Emerald Coast Behavioral Hospital at: (850) 763-0017 and/or visit the facility at: **1940 Harrison Avenue, Panama City, FL 32405**. If the patient does admit themselves to Emerald Coast Behavioral Hospital, we ask you to complete a Release of Information with your clinician's name at that facility in order to allow proper managed care and communications.

I certify that I have reviewed and agreed to the above:

X _____ _____

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Testing Fee Agreement Form

____/_____/2020

Please note that some insurance companies do not cover testing administration fees. Any assessments not covered by insurance are the responsibility of the patient or the patient's charge. **Payments are due at the time that services are rendered.**

Blue Cross & Blue Shield DOES NOT cover testing services with our office.

Patient Information

Patient Name: _____

Date of Birth: _____

Parent / Guardian Name: _____

Relationship to Patient: _____

Fees (Please initial by ordered testing):

____ $275.00 - Includes: Assessment administration, & follow up (Initial visit cost: $115.00).

____ $350.00 - Includes: Assessment administration, follow up, and detailed written report (Initial visit cost: $115.00).

I understand that the indicated testing administration fee is not or may not be billable to my insurance company, if applicable, and I understand that I am responsible in full for the indicated fee.

_____
Printed Name of Patient or Patient's Representative

_____ _____
Signature **Date**

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Release of Information

(REQUIRED for Communication with ANY Physician, Attorney, School, or Family Member for Patients Over the Age of 18.)(If under 18 it is recommended to add your child's pediatrician)

I wish to: SEND / REQUEST RECORDS (Please Circle One)

Client's Name _____Date of Birth: _____

Between: Beach Counseling & Psychological Services and

_____
(Agency, physician, other (list)

Phone, Fax, and Mailing Address of this Agency: _____

Nature of information to be released (Please mark or initial):

_____ YES _____ NO Verbal IN ORDER TO DISCUSS DIAGNOSTICS, TREATMENT MODALITIES, ETC WITH ANY PARTY YOU PERMIT ABOVE-PHYSICIAN, ATTORNEY, FAMILY MEMBER

_____ YES _____ NO To obtain reports from releasing agency so the therapist can use this information for diagnosis and treatment.

_____ YES _____ NO To allow therapists to send reports to the above named agency. REQUIRED IN ORDER TO RELEASE RECORDS TO YOUR PHYSICIAN.

_____ YES _____ NO Other:_____ IF ADDITIONAL DETAILS/LIMITATIONS OF PERMISSION ARE REQUESTED, PLEASE DESCRIBE HERE

I hereby consent to the use or disclosure of my protected health information as specified above. I understand that this consent is voluntary and I may refuse to sign it. I understand that I may revoke this consent at any time by giving written communication to my provider or any member of the office staff. A revocation will not affect any action taken in reliance on the consent prior to the revocation. Other limitations on my right to revoke this consent may be found in my provider's Notice of Privacy Practices. I understand that if the recipient is not a health care provider or a health plan, the information disclosed under this consent may no longer be protected by federal privacy regulations and may be re-disclosed by the recipient. I understand that I should receive a copy of this consent, even if I do not ask for it.

I understand that treatment may not be denied if I refuse to sign this consent, except: (1) if the consent is the very reason for seeking health care (e.g., a pre-employment physical), that the health care may be denied, or (2) if the consent is for disclosure to a research study, I may be denied the treatment that is part of the study. In addition, the following consequences might occur: (1) if the consent is to demonstrate to a health plan that a service should be paid for, the health plan may refuse to pay for it, and (2) if the consent is sought by an insurer because I am seeking enrollment or eligibility, the insurer may deny me the coverage that I am seeking. I understand that a health plan may not refuse payment or benefits if I refuse to consent to disclosure of certain psychotherapy notes.

Unless sooner revoked by me, this authorization expires:

_____ YES _____ NO ONE (1) YEAR AFTER MY FINAL THERAPY SESSION WITH THE ABOVE NAMED THERAPIST.

_____ Other Time Limitation (Please specify) _____

_____ _____

Client Signature & Date **Witness Signature & Date**