Patient Questionnaire - Siracusa Associates

77 Hospital Ave Suite 214 North Adams, MA 01247
Phone: (413) 398-5064
Fax: (413) 398-5496
Email: shrink681@gmail.com

Today's Date: ______________________

Client Name

Date of Birth

Sex: Male ◯ Female ◯

Relationship Status: Single ◯ Married/Partner ◯ Divorced ◯ Other ◯

Address

City, State, Zip

Telephone home work cell

EMAIL: ______________________

Education

Occupation

Current Employer or School

Referral Source: (name)

Emergency Contact (Name/Phone Number): (relationship)

Have you ever been here before? Yes ◯ No ◯ If so, when?

If under different name, please specify:

Have you received treatment anywhere else this year? Yes ◯ No ◯

If yes, with who? Do you allow contact? Yes ◯ No ◯

Name of Primary Care Physician: Do you allow contact? Yes ◯ No ◯

What brings you here?

Over➔

FAMILY INFORMATION:

Please list all people who live in your home:

Full Name	Relationship to Client	Date of Birth	Occupation/Grade

INSURANCE INFORMATION:

Insurance Plan: ______ Insurance ID # ______

Group # (if applicable) ______

Subscriber Name ______

Subscriber Date of Birth: ______

Subscriber's Social Security Number ______

Subscriber's Place of Employment ______

Please bring your insurance card for each visit so that we may verify eligibility.

CONSENT TO TREATMENT: I understand that the treatment offered will be best suited to the problem presented by myself or my family. The treatment will consist of an assessment of the nature of the problem and counseling or psychotherapy to help solve the personal aspects of the issue. I have read and received a copy of the Client Bill of Rights, Privacy Policy, and Financial Policy of Siracusa Associates. My records are confidential and will not be released to other individuals or agencies without my written consent. Appointments not cancelled 24 hours in advance will be charged.

I understand and agree to the above conditions.

______ Client Signature

______ Parent/Guardian Signature

______ Siracusa Associates

______ Date

Medical History -Siracusa Associates

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Patient's Name

Date of Birth:

Name of Primary Medical Doctor or Clinic:

Date of last completed physical examination:

Are you allergic to any medication? Yes ☐ No ☐

If yes, please list:

If patient is a child/adolescent, is your child's immunization status up to date Yes ☐ No ☐

Have you ever been treated for the following, currently or in the past:

	Currently	Past/When
Diabetes (sugar in the blood)	☐	☐
Heart Problems	☐	☐
High Blood Pressure	☐	☐
Epilepsy (seizures)	☐	☐
Cancer	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Lung or Respiratory Problems	☐	☐
Gynecological Problems	☐	☐
Sexual Abuse	☐	☐
Arthritis	☐	☐
Kidney Problems	☐	☐
Stomach Problems	☐	☐
Eye Problems	☐	☐

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Blood Problems ☐ ☐
Depression ☐ ☐
Thyroid Problems ☐ ☐
Skin Problems ☐ ☐
Frequent Headaches ☐ ☐
Bone Problems ☐ ☐
Physical Abuse ☐ ☐
Substance Abuse ☐ ☐
AIDS/HIV Positive ☐ ☐

Current Medications and Dosage:

Has anyone in your family been treated for any mentioned above? (Please specify)

Who?	What?	When?

Please list all past hypitalizations for medical, surgical, or psychiatric problems

Hospital	Date	Reasons

Do you smoke? Yes ○ No ○

How much per day? Age began

Have you ever felt like you ought to cut down on your drinking? Yes ○ No ○

Do you drink? Yes ○ No ○

Have people annoyed you by criticizing your drinking? Yes ○ No ○

Have you ever felt bad or guilty about your drinking? Yes ○ No ○

Is there any other medical information you feel we should know? Please specify.

Consent for Purposes of Treatment, Payment and Healthcare Operations

I, ______________________________ consent to the use or disclosure of my protected health information by **Siracusa Associates.** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Siracusa Associates.**

I have the right to revoke this consent, in writing, at any time, except to the extent that **Siracusa Associates** has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

____

Signature of Patient or Personal Representative

____

Name of Patient or Personal Representative

____

Date

____

Description of Personal Representative's Authority

Financial Policy- Siracusa Associates

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This is an agreement between Siracusa Associates, as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established I your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Siracusa Associates.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Payments: All payments are due at the time of service unless other arrangements are approved in writing. If you have a balance, it is due and payable when the statement is issued, and is past due if not paid within 30 days.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service. Any old balances would need to be paid before new service begins.

Required Payments: Any co-payments required by an insurance company must be paid at the time of service. * A billing fee of $15 per month will be imposed for co-payments not made at the time that services are rendered.

Payment Options if you have no insurance: You choose to pay by cash, check, or credit/debit card on the day that treatment is rendered. Special written arrangements can be approved by your individual therapist.

Insurance: We will bill your primary insurance company as a courtesy to you. * **We do NOT accept Medicaid (MassHealth) as a secondary insurance for co pays. THE ONLY EXCEPTION TO THIS IS WHEN MEDICARE IS PRIMARY**. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the allowed charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or NO payment from the insurance company. To avoid unexpected medical bills, know what your plan benefits are. **This knowledge is your responsibility**.

Divorce: In the case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

* **Missed Appointment Fees:** Each time that a patient does not show up for an appointment, or cancels with less than **24 hours notice**, if we are unable to fill the scheduled time, **a $100 fee will be charged**. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their care to another clinician.

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Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one and a half percent (1.5%) per month or an **ANNUAL PERCENTAGE RATE** of eighteen percent (18%). The finance charge on your account is computed by applying the periodic rate (1.5%0 to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

* **Past Due Accounts:** If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Returned Checks: There is a **$25 fee** for any **checks returned** by the bank.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transferring of Records: You will need to request in writing, and pay a reasonable coping fee ($25) if you want to have copies of your records sent to another clinician, doctor, or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Worker's Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as a part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for the charges incurred due to a personal injury case.

Additional Family Members: You _____ **DO** _____**DO NOT** give up permission to leave messages with other family members (spouse, significant other, children, household members) if we need to contact you regarding an appointment time or overdue balance. **NO** information regarding your treatment will be released to any family member or any other person without your written consent.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effective.

* **Patient's Name:** ____

Responsible party (if different): ______________________________________

* **Signature of Responsible Party:** ______________________________________

Signature by Siracusa Associates: ____________________________________

Date: _____________________________

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CLIENTS BILL OF RIGHTS

YOU HAVE THE RIGHT:

1. To receive professional treatment regardless of race, religion, sex, sexual preference, or income.

2. To be assured confidential treatment and counseling. Access to your records will not be given to any individual or institution without a Release of Information signed by you or your legal guardian. PLEASE NOTE: Insurance companies may request your records without a signed authorization if you are using your insurance to pay for your services.

3. To be treated with consideration, respect, and dignity.

4. To view your records upon request.

YOU ALSO HAVE SOME RESPONSIBILITIES:

1. To attend scheduled sessions or give 24-hour notice if cancellation is necessary.

2. To be as open and honest as possible with us concerning your treatment and health.

3. To inform your clinician of any changes in your:
   -health and/or medications
   -address, telephone number, workplace, etc.
   -insurance.

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SIRACUSA ASSOCIATES

IMPORTANT INSURANCE INFORMATION

For your information:

Some patients have incurred unexpected costs due to not fully understanding their mental health insurance benefits. This "check list" is intended to help you understand what your insurance does not cover.

Most insurance companies have put their toll free number on the back of the insurance card. We encourage you to call your insurance company and tell them that you are seeking outpatient psychotherapy. The following are questions you should ask:

- Is the patient (you, your spouse, your child) covered by the policy for outpatient psychotherapy?
- Is there a deductible that you are responsible for?
- Is there a co-payment that you are responsible for? Will this change dependent on the number of visits you have?
- What are the limits of your coverage for these services? (Do they have a limit for the number of appointments or money they will pay?)

Please note:

If you are using your insurance to cover your services at Siracusa Associates, your insurance company may request your records at any given time. If this presents a concern to you, please discuss this with your therapist.

We hope this information is helpful and we are willing to help you with any questions you may have regarding insurance coverage or any aspect of your treatment at Siracusa Associates.