SOI *The Structure of Intellect*

ADD & SOI COUNSELING AND TESTING CENTER
MANHATTAN BEACH, CA 90266 • **(310) 546-6500** • FAX (310) 546-9068 • www.addsoi.com

Welcome to SOI Counseling. We look forward to working with you. This form requests information about you and/or your family that will help us plan your care. If you have any questions, please feel free to discuss them with your provider.

Patient Name _____ Today's Date _____

Address _____ Birthdate _____

City,State,Zip _____ Age _____

Phone # (_____)_____ (_____)_____ (_____)_____

Home OK to leave messages? Y N **Work** OK to leave messages? Y N **Cell** OK to leave messages? Y N

SSN_____ Occupation_____ E-mail_____

Emergency Contact _____
Name Relationship to patient phone number

Name & phone of primary care physician_____

Name & phone of psychiatrist (if any)_____

Who referred you?_____

Primary Insurance Information:

Insured Name: _____ Authorization No:_____

Insured SSN: _____ Copay Amount:_____

Insured DOB: _____ Maximum Visits:_____

Employer: _____

Mental Health Carrier: _____

Relationship to Insured:_____

Member No:_____

Policy/Group No:_____

Areas of Concern:

Please describe your reason(s) for seeking treatment at this time (include date the problem started):_____

_____

_____

Was there an event that made these issues or problems surface? ___Y ___N If yes, please describe: _____

_____

Do you have any specific goals for treatment? What result(s) do you expect from treatment?_____

_____

_____

Other Information:

Please describe your interests/hobbies_____

Are you now or have you ever been involved in a lawsuit? ___Y ___ N Please describe_____

_____

Has anyone in your family had a psychiatric (nervous or mental) illness? _____Yes _____No If yes, please explain what/when:

_____

Any medication? ___Y ___N What? _____ Hospitalization? ___Y ___N When?_____

Please circle the following issues or problems you would like to work on in treatment and rate the severity (1-4):

NO PROBLEM 1	MILD PROBLEM 2	MODERATE PROBLEM 3	SEVERE PROBLEM 4
____Anger/temper	____Diet	____Motivation	____Headaches
____Depression	____Anxiety	____Controlling stress	____Loss of loved one
____Problems at school	____Problems at work	____Lack of friends	____Loneliness
____Problems coping	____Abuse/victimization	____Financial problems	____Legal matters
____Panic	____Concentration	____Sleep	____Fears
____Body Image	____Nightmares	____Energy	____Divorce/Separation
____Marriage/Relationship issues	____Sexuality/Sexual issues	____Family conflict	____Behavioral problems
____Drug/alcohol habit	____Relaxation	____ADD/ADHD	____Shyness
____Self-control	____My thoughts	____Eating Disorder	____Being a parent

Are there any compulsive/repetitive behaviors or thoughts that are of concern to you and/or the people close to you? (i.e., overeating, hoarding, checking, counting, washing, illness-related, thoughts of harming someone, sexual behavior, etc.)? _____Yes _____No
If yes, please describe:_____
_____

MEDICAL

When were you last examined by a physician?_____ Outcome?_____

Medications

Type	Dosage	Start Date	Prescribing M.D.	Phone No.

Side Effects_____

_____

Alternative treatments_____

Allergies

Type_____ Severity_____ Treatment_____

Type_____ Severity_____ Treatment_____

Please list any over-the-counter medications you currently use such as vitamins, sleeping/diet pills, aspirin/pain relievers, etc.

_____

_____

IMMEDIATE FAMILY

LIST MEMBERS OF YOUR FAMILY OR OTHERS WITH WHOM YOU LIVE:

Name(s)	**Age**	**Relationship**	**Occupation**

Marital Status

___single, never married
___engaged ____ mos.
___married _____ yrs.
___divorced ____ yrs.
___separated ___ yrs.
___divorce in process ___ mos.
___live-in for ____ yrs.
___prior marriages (self)
___prior marriages (partner)

Intimate Relationship

___never been in serious relationship
___not currently in relationship
___currently in serious relationship

Relationship satisfaction

___very satisfied w/relationship
___satisfied with relationship
___somewhat satisfied w/relationship
___dissatisfied w/relationship
___very dissatisfied w/relationship

List minor children NOT living in same household

Name Age Sex Relationship

_____
_____
_____
_____

Frequency of visitation of above:_____
_____
_____

Describe any part or current significant issues in **intimate** relationships:_____
_____

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all
Mother	_____	_____	_____
Father	_____	_____	_____
Stepmother	_____	_____	_____
Stepfather	_____	_____	_____
Brother(s)	_____	_____	_____
Sister(s)	_____	_____	_____

Family alcohol/ Drug Abuse History:

___ Father ___Stepparent/Live-In
___ Mother ___Uncle(s)/Aunt(s)
___ Grandparent ___Spouse/Partner
___ Sibling(s) ___Children
___ Other_____
_____

Parents' current marital status:

____married to each other
____separated for _____ years
____divorced for ____ years
____mother remarried _____ times
____father remarried _____ times
____mother involved with someone
____father involved with someone
____mother deceased for ___ years
age of patient at mother's death __
____father deceased for ____ years
age of patient at father's death ___

SUBSTANCE USE HISTORY (check all that apply for patient):

Self-Perception of substance use:
Amount

____ **None**
____ Occasional/social
____ Problem use
____ Dependent
____ Don't want to stop
____ Addicted/Cannot stop
____ Motivated to stop

Previous treatment:

____ 12-Step
____ Out Patient
____ In Patient

Substances used:	**First use age**	**Last use age**	**Current?**	**Frequency**
___**alcohol**	_____	_____	_____	_____	_____
___amphetamines/speed	_____	_____	_____	_____	_____
___barbiturates/downers	_____	_____	_____	_____	_____
___cocaine/crack	_____	_____	_____	_____	_____
___hallucinogens (LSD,etc)	_____	_____	_____	_____	_____
___inhalants (glue,etc)	_____	_____	_____	_____	_____
___marijuana or hashish	_____	_____	_____	_____	_____
___PCP/Ecstasy	_____	_____	_____	_____	_____
___prescription drugs	_____	_____	_____	_____	_____
___nicotine/cigarettes	_____	_____	_____	_____	_____
___caffeine	_____	_____	_____	_____	_____
___other _____	_____	_____	_____	_____	_____

Physical/mental consequences of substance use (check all that apply):

____ outpatient (age(s)_____)
____ inpatient (age(s)_____)
____12-step program (age(s)_____)
____stopped on own (age(s)_____)
____other (age(s)_____
Describe:_____

___hangovers ___binges
___seizures ___overdose
___withdrawal symptoms
___medical conditions
___relationship conflicts
___loss of control of amt used

___blackouts ___job loss
___arrests/DUI ___assaults
___sleep disturbances
___tolerance changes
___suicidal impulse
___other _____

The following information is provided to you so you have a better understanding of how your care will be coordinated. Please read each item carefully and sign in the appropriate spaces.

TREATMENT PHILOSOPHY

During the initial evaluation period, you and your provider will clarify together the nature of the problems for which you are seeking treatment, define some reasonable treatment goals, and develop a treatment plan that will help you achieve those goals. ***If your insurance is a managed healthcare plan, the number of sessions available to you may be severely limited.*** You are expected to be compliant with the agreed upon treatment plan between sessions and keep your appointments. Research has shown that, often times, brief, time limited therapy focusing on specific goals results in more rapid reduction of symptoms and improvement in patient functioning. The treatment plan may include attending support groups, reading selected materials, and/or completing specific written or verbal assignments.

CONFIDENTIALITY:

All information between provider and patient is held strictly confidential unless:

1. patient authorizes release of information with his/her signature.
2. patient presents a physical danger to self.
3. patient presents a danger to others.
4. child/elder abuse is suspected.
5. patient fails to pay for services rendered and formal collection becomes necessary.

We are required by law to inform potential victims and legal authorities so protective measures can be taken.

FINANCIAL TERMS

Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for your treatment and your provider will be paid directly by the carrier. You will be responsible for any applicable **deductibles** and **copayments**. Copayments must be paid at the time services are rendered. If you are not eligible for benefits at the time services are rendered, you are responsible for full payment of provider's hourly rate, which is $_____. Your copayment for services is $_____. **Patient initials** _____

CANCELED/MISSED APPOINTMENTS

A scheduled appointment means that time is reserved only for you. ***If an appointment is missed or canceled with less than 24 hours notice, you will be billed directly according to the scheduled fee or according to the rules of your health plan***. Most health plans do not cover payment for missed appointment; therefore, you are responsible for payment in full. **Patient initials** _____

APPEALS AND GRIEVANCES

I acknowledge my right to request an appeal in case that outpatient care is not certified. I understand that I would request an Appeal directly through my insurance carrier. I also understand that I may submit a grievance to my provider at any time to register a complaint about my care. I also understand the California Department of Managed Care (DMC) regulates health services. Their telephone number is 800-400-0815, and I may contact them to register a complaint against my health care plan.

EMERGENCY PROCEDURES

If you need to contact your provider, leave a message according to the instructions on the office telephone message and your call will be returned. If you experience a true life threatening emergency and need immediate attention, you should leave a message for your provider and then call 911 or go to the nearest hospital emergency room.

RELEASE OF INFORMATION TO HEALTH PLAN

I authorize release of information regarding my care to my health plan for the payment of claims, certification/case management decisions and other purposes related to the administration of benefits for my Health Plan. **Patient initials** _____

RELEASE OF INFORMATION TO PRIMARY CARE PHYSICIAN

I authorize the release of information to my Primary Care Physician (name)_____ at (telephone number)_____ for purposes related to my health care. **Patient initials** _____

CONSENT FOR TREATMENT

I further authorize and request that my treating provider carry out psychological examinations, treatments, and/or diagnostic procedures that now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that, while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

I understand and agree to all of the above information.

_____

Patient (or Parent/Guardian) Name – *Printed* Date

_____

Patient (or Parent/Guardian) Name – *Signature* Date

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to the provider for services described on Form HCFA-1500.

SIGNED _____ Date_____

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COUNSELING AND TESTING CENTER

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CONSENT FOR RELEASE OF INFORMATION OR RECORDS

I hereby authorize _____ to mutually disclose records and/or information to _____, regarding _____, date of birth _____/_____/_____, obtained in the course of his/her diagnosis and treatment. This release will remain in effect for one year from the date below unless revoked.

These records are protected by the California Welfare and Institution Code Section 5328. Disclosure shall be limited to the information specified below (please circle):

Clinical Evaluation
Diagnosis
Discharge Summary
Diagnostic Exam
Results of Psychological/Vocational Tests
Educational Assessment & Behavioral Reports

_____ _____
Signature of client/parent/guardian/conservator Date

Date consent revoked _____

_____
Signature of client/parent/guardian/conservator

I UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION IF I SO REQUEST

Scott Wilson, MFCC
Counseling & Hellerwork

Valerie Maxwell, Ph.D.
Director, Counseling & Testing
Psychologist Psy 9844

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES ☐ NO ☐

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ ***If yes***, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

Manhattan Beach, CA 90266

The Learning Gym
SOI & ADD Counseling & Testing Center
Dr. Valerie Maxwell, Director

Phone 310-546-6500
Fax 310-546-8929

Insurance Questionnaire / Payment Agreement

In order to determine what insurance benefits you have available, we ***require*** you to contact your insurance company at the phone number listed on your insurance card, and ask (and enter below) the following information. **Failure to fill this form out *COMPLETELY* will disable us from billing your insurance provider for services rendered. It is your responsibility to pay for any outstanding balance.** Psychological Services and Therapy are *confidential* processes to which we are legally and ethically bound. However, if you file for insurance benefits or reimbursement, please be aware that your confidentially may be compromised.
Once you have completed this form, please fax it with a copy of the front and back of your insurance card to 310-546-8929.

Our office must receive this information BEFORE you will be scheduled for a testing appointment.

***Be sure you call or are transferred to the Mental Health department, *not* medical. When you reach a representative please state:**

"I AM CALLING TO CHECK MY OUTPATIENT MENTAL HEALTH BENEFITS."

1. **Is Dr. Valerie Maxwell a provider under my plan? Yes / No**
2. **Is my mental health insurance carved out to a different insurance provider? Yes / No**
   a. **(If #2 is Yes) What insurance covers mental health? _____**
3. **Is there a deductible for MENTAL HEALTH? (if none, enter "0"): $ _____**
   a. **(If #3 is *not* 0) Has the Deductible been met? Yes / No**
4. **Do I need an authorization for mental health? Yes / No**
   a. **(If #3 is Yes) What is the authorization number? _____**
   b. **(If you have an authorization #) How many sessions are authorized to start? _____**
   c. **What is the start and end dates of the authorized sessions? Start_____ End_____**
5. **What is the MAXIMUM number of sessions I can use? _____**
6. **What is my co-payment? _____**
7. **Address to send Mental Health Claims:**
   (Often times **different** than address on card, please ask)

   Insurance provider:_____

   Address:_____

   _____

   7. Ph# Called:_____

   Date of Call:_____

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PAY FOR SERVICES NOT COVERED BY MY INSURANCE, WHETHER BECAUSE I FAILED TO OBTAIN AUTHORIZATION, DENIAL, OR LIMITATION OF BENEFITS, CO-PAY, ETC. I HEREBY UNDERSTAND THAT IF I HAVE AN OUTSTANDING BALANCE, I WILL MAKE ARRANGEMENTS TO PAY THE AMOUNT DUE.

_____ Signature

_____ Date

_____ Print Name

_____ Client Name (Print)