Richard Katz Psychology

phone: 224-392-3258 address: 9150 Crawford Avenue, suite 204, Skokie, IL 60076

Welcome,

Please print all of the forms in this pdf. pack.

Please *take your time to read each page*.

This pack contains the following documents:

- New client Information, 2 pages
- Contract for services, 2 pages
- Choice to use insurance, 2 page
- New client history, 6 pages
- Notice of Privacy Practices form, (HIPAA Stuff) 2 pages

I hate to be demanding or authoritative, but really, ya gotta complete all of these forms in order for me to deliver services to you. My hunch is that it will take about a fifteen minutes to do.

Best Regards,

Richard Katz, Psy.D.

SECTION 1 – CLIENT INFORMATION

Name_____

Address_____

City_____State_____Zip_____

Primary Phone _____Accept texts? Yes ☐ No ☐
Accept Messages? Yes ☐ No ☐

Secondary Phone _____ Accept texts? Yes ☐ No ☐
Accept Messages? Yes ☐ No ☐

Email _____ Social Security # _____

Birth Date _____ Gender: ☐ Male ☐ Female

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ other ☐

SECTION 2 – POLICY HOLDER INFORMATION

CLIENT Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other

If the Client is the Policy Holder, check the ☐ Self, and go to SECTION 3

Policy Holder Name_____

Policy Holder Address_____

City_____State_____Zip_____

Primary Phone _____Accept texts? Yes ☐ No ☐
Accept Messages? Yes ☐ No ☐

Secondary Phone _____ Accept texts? Yes ☐ No ☐
Accept Messages? Yes ☐ No ☐

Date of Birth _____

Marital Status _____ Gender: ☐ Male ☐ Female

Policy Holder Employer or School _____

Policy Holder Employment Status _____

SECTION 3 – *PRIMARY* INSURANCE POLICY INFORMATION

Insurance Company Name (if Medicare, write "Medicare")_____

Address _____

City _____ State _____ Zip _____

Plan Name _____

Policy Number _____ Group Number _____

Member Services Phone_____ Provider Services Phone _____

IF YOU ARE USING *Medicare or have a secondary* INSURANCE PLAN GO TO NEXT PAGE

SECTION 4 – *secondary* INSURANCE POLICY INFORMATION

Secondary Insurance Company Name_____

Address _____

City _____ State _____ Zip _____

Plan Name _____

Policy Number _____ Group Number _____

Member Services Phone_____ Provider Services Phone _____

Contract for Services and Financial Agreement

Richard Katz Psychology
9150 Crawford Ave, ste 204, Skokie IL 60076
224-392-3258

Richard Katz Psychology provides psychotherapy and behavioral health services. Richard Katz, Psy.D. is licensed clinical psychologist in the State of Illinois. Your contract is with Richard Katz Psychology, LLC.

Client Rights and Risks: You have a right to inspect your records. Psychotherapy requires that you discuss what is troubling you and be willing to change your thoughts, beliefs, and behavior. Psychotherapy may cause you to remember unpleasant events, arouse intense emotions, and change close relationships. The purpose of psychotherapy is resolve your issues.

Confidentiality: Your information is held in confidence and will not be released without your consent.
Exceptions:

- I am required by law to report suspected child or elder abuse or neglect, inability to care for one's basic need for food, clothing and shelter, and threatening harm to oneself or others
- The courts may subpoena my records
- Information regarding diagnosis and treatment will be provided to insurance companies ONLY if you choose to use your insurance company to pay for services.

Appointments: All sessions are by appointment only. Standard appointment time is 53 minutes. Late arrivals will reduce the time available. **Cancellations less than 24 hours ahead of time and "no shows" will be billed to your credit card for the missed appointment amount.**

Fees:

Payment and copays for service are required at time of service.
Health insurance may help recover some of the costs. You must verify the amounts that insurance will pay. **If your policy requires preauthorization, YOU must obtain it before your first visit. Without preauthorization approval, your credit card will be charged the full amount.**
The actual fee your insurance company pays is a negotiated fee NOT my standard fee.
<u>If you have not yet met your deductible</u>, you will pay your insurance company's negotiated fee, not my standard fee.

Self Pay Clients: All fees must be paid in full at the time of service. You will be provided with a receipt upon request. <u>Speak with me about reduced fees.</u>
Clients Using Insurance: Copay must be paid in full at time of service. Your insurance will be billed for the full service cost. I do not negotiate settlements or disputed costs.
All Clients: Clients and parents/guardians of minor clients are responsible for payment and insurance claims. Accounts become delinquent after thirty (30) days. **Delinquent accounts may be sent to a collection agency. You are responsible for collection agency fees.**

Phone Calls: Phone calls over five (5) minutes are billed in 15 minute units at $40 per 15 minutes. This will be charged to your credit card.

Client/Responsible Party Acknowledgementa nd Acceptance of Terms: I have read and understand both pages of this Contract and Financial Agreement, and I have been given a copy of the Contract and Financial Agreement. I hereby authorize Richard Katz Psychology, LLC to abide by my completed **Insurance Declaration Form** which I submitted with this contract. I understand that my insurance coverage is between me and my insurance company. I agree to accept financial responsiblity for payment of all charges. I agree to pay for collection and/or court costs and reasonable legal fees if I do not pay the bill. I understand that co-pays and deductibles are not negotiable.

Consent to Treatment and Fee: I agree to full responsibility for all expenses incurred by me and/or on account of this client and assign Richard Katz Psychology and all insurance benefits due me to the full extent of my financial obligation to Richard Katz Psychology. I have received a copy of Richard Katz Psychology Privacy Policy. I have submitted a completed the Insurance Declaration Form to Richard Katz Psychology.

Fee Schedule

I understand that the STANDARD FEES detailed in the table below may be submitted to my insurance company for payment ONLY if I authorize Richard Katz Psychology to submit a bill to my insurance company. I understand that I am ONLY responsible for co-pays and deductible amounts.

I understand that ADDITIONAL FEES detailed in the table below are totally my responsibility. These fees will not be submitted to my insurance company.

FOR SELF PAY CLIENTS: SPEAK WITH ME ABOUT REDUCED (SLIDING SCALE) FEES.

STANDARD FEES	0-30 minutes	31-52 minutes	53-60 minutes	Flat Fees	
Intake Interview				$210	
Individual Psychotherapy Session	$100	$165	$200		
Multiple Family Members/Clients Fee	$35	$35	$35		
Consultation w/Family-client not present				$165	
ADDITIONAL FEES – paid by you	5-60 minutes				Additional 30 minutes
Psychotherapy After the First 60 minutes	---				$75
Consultation with outside agencies/schools	$165				$75
Cancelled within 24 hours or missed	--			$125	
Depositions, subpoenas, legal or court proceedings	$300				$150

Client(s) Signature(s)_____Date_____
mm-dd-yyyy

Client(s) Signature(s)_____Date_____
mm-dd-yyyy

If I fail to attend a scheduled appointment or cancel a scheduled appointment within 24 hours, I authorize Richard Katz to charge my credit card with a fee of $125.

Credit Card Type: Visa ☐ MC ☐ AMEX ☐ DISC ☐ Security Code_____ Exp. Date: ____/_____

☐☐☐☐ -- ☐☐☐☐ -- ☐☐☐☐ -- ☐☐☐☐

Billing Address of Credit Card

_____

Street City/State Zip Code

_____

Name as it appears on card Signature Date

YOU MUST COMPLETE THIS FORM BEFORE SERVICES WILL BE DELIVERED

1. KNOW YOUR "OUT OF POCKET" EXPENSES BEFORE RECEIVING SERVICES

2. WILL YOU OR WILL YOU not **USE INSURANCE TO PAY FOR SERVICES???**

By choosing to pay for services yourself, I (Richard Katz Psy.D) will not be authorized to share your records with your insurance company.

By choosing to submit your bills to your insurance company, I (Richard Katz Psy.D) will share your records with your insurance company.

☐ OPTION ONE. I want to pay for services myself. I will pay for sessions "out-of-pocket" by cash, credit card, or check. I do not authorize Richard Katz Psychology to share my private information with my insurance company

☐ OPTION TWO. I want my insurance company to pay for services. If Richard Katz Psy.D is and "in network" provider my rates may be discounted according to the contract Richard Katz Psy.D. has with my insurance company. I might still have to pay a co-pay. Unless my deductible has been met, I will have to pay full fee until my deductible is met.

By choosing OPTION TWO, you MUST complete page 2 of this document

If Richard Katz Psychology is NOT "in network" I will be responsible for copay, coinsurance amounts, deductible payments, and any fees not covered by my plan. I will pay full fee to Richard Katz Psychology and will submit receipt for services to my insurance company for my reimbursement.

_____ _____

Client or Client's Representative's Signature Date mm—dd—yyyy

_____ _____

Richard Katz, Psy.D. Date mm—dd—yyyy

VERIFYING COVERAGE BENEFITS DOES NOT GUARANTEE THAT THE INSURANCE WILL PAY

- HOW TO DETERMINE YOUR INSURANCE COVERAGE,
- HOW TO DETERMINE WHAT YOUR COPAY WILL BE
- HOW TO DETERMINE IF YOU WILL NEED TO PAY MORE THAN YOUR COPAY.

YOU MUST CALL YOUR INSURANCE COMPANY.
HAVE THE FOLLOWING INFORMATION BEFORE YOU CALL

Insured's Name_____ Birth Date____/____/____

Policy ID #_____Group #_____

Client's Name_____ Birth Date____/_____/_____

Insurance Company Name	Phone:	Mail Claims To:

Date and Time of Call_____ Name of Person You Spoke To_____

What to Say...

"I'm calling to clarify my benefits and coverage for out-patient mental health."

"Is Richard Katz, Psy.D. on your participating provider list? ☐ YES (In Network)
His NPI is 134 621 6504" ☐ NO (Out of Network)

If Richard Katz is IN NETWORK, ask for network benefits.
If Richard Katz is NOT IN NETWORK, ask for OUT of NETWORK benefits.

"What is my deductible amount? $_____. How much has been met to date? $_____"

"Is that for my family or for the individual?_____ Is it per Calendar Year? ☐ Yes ☐ No"

"When does the calendar year begin_____"

"What is my copay? $_____ "Is that a fixed amount or a percentage?_____"

"What is the Effective Date of my policy?_____

"How many visits am I allowed per calendar year?_____

"What is the lifetime maximum?_____ Is Pre-authorization required? ☐ Yes ☐ No
"What phone number must my therapist call to get pre-authorization? _____

Adult History ©, Richard Katz, Psy.D. 2017

Please note, while this information is confidential, your medical insurance company can have access to it.

Please complete ALL the questions. This is a 6 page form.

Sources of Stress
Please list the reasons that bring you here today. This may include certain problems, issues, significant losses or changes that are causing you stress.

1._____

2._____

3._____

4._____

Adult Strength Scale

Please circle the areas below that apply to you. N/A means the question doesn't apply to you

Home

1. I feel part of the family	Seldom	Just a little	Pretty Much	Very Much	N/A
2. I get along with my spouse	Seldom	Just a little	Pretty Much	Very Much	N/A
3. I am physically healthy	Seldom	Just a little	Pretty Much	Very Much	N/A
4. I have an enjoyable social life	Seldom	Just a little	Pretty Much	Very Much	N/A
5. I feel accepted by others	Seldom	Just a little	Pretty Much	Very Much	N/A
6. I am a good father/mother	Seldom	Just a little	Pretty Much	Very Much	N/A
7. I participate in decision making	Seldom	Just a little	Pretty Much	Very Much	N/A

Work

1. I get to work on time	Seldom	Just a little	Pretty Much	Very Much	N/A
2. I get along with my co-workers	Seldom	Just a little	Pretty Much	Very Much	N/A
3. I am respected by my co-workers	Seldom	Just a little	Pretty Much	Very Much	N/A
4. I am respected by my supervisor(s)	Seldom	Just a little	Pretty Much	Very Much	N/A
5. I enjoy working	Seldom	Just a little	Pretty Much	Very Much	N/A
6. I have realistic career goals	Seldom	Just a little	Pretty Much	Very Much	N/A
7. I am a hard worker	Seldom	Just a little	Pretty Much	Very Much	N/A
8. I balance home and work	Seldom	Just a little	Pretty Much	Very Much	N/A

Emotional

1. I cope well with frustration	Seldom	Just a little	Pretty Much	Very Much	N/A
2. I cope well with disappointment	Seldom	Just a little	Pretty Much	Very Much	N/A
3. I use anger constructively	Seldom	Just a little	Pretty Much	Very Much	N/A
4. I am satisfied with life	Seldom	Just a little	Pretty Much	Very Much	N/A
5. I accept responsibilities for my mistakes	Seldom	Just a little	Pretty Much	Very Much	N/A

6. I drink (alcohol) responsibly	Seldom	Just a little	Pretty Much	Very Much	N/A
7. I can take constructive criticism	Seldom	Just a little	Pretty Much	Very Much	N/A
8. I think before I act	Seldom	Just a little	Pretty Much	Very Much	N/A
9. I have good self-esteem	Seldom	Just a little	Pretty Much	Very Much	N/A

Social

1. I make and keep friends	Seldom	Just a little	Pretty Much	Very Much	N/A
2. I'm open to new ideas	Seldom	Just a little	Pretty Much	Very Much	N/A
3. I am considerate of others	Seldom	Just a little	Pretty Much	Very Much	N/A
4. I stand up for myself	Seldom	Just a little	Pretty Much	Very Much	N/A
5. I show leadership	Seldom	Just a little	Pretty Much	Very Much	N/A
6. I am able to compromise	Seldom	Just a little	Pretty Much	Very Much	N/A
7. I'm comfortable around others	Seldom	Just a little	Pretty Much	Very Much	N/A
8. I get along with others	Seldom	Just a little	Pretty Much	Very Much	N/A

Attention

1. I cope with external distraction	Seldom	Just a little	Pretty Much	Very Much	N/A
2. I maintain attention to tasks	Seldom	Just a little	Pretty Much	Very Much	N/A
3. I follow through on tasks	Seldom	Just a little	Pretty Much	Very Much	N/A
4. I am able to compromise	Seldom	Just a little	Pretty Much	Very Much	N/A

Problems That You Are Struggling With

Please check ( ) those that apply to you.

( ) Depression
( ) Anxiety or panic attacks
( ) Suicidal thoughts
( ) Suicidal actions
( ) Brother/sister problem
( ) Violence in family-actual or threatened
( ) Sexual problem
( ) Unemployed
( ) Legal problems
( ) Compulsive gambling
( ) Death of a loved one
( ) Parent-child conflict (you)
( ) Parent-child conflict (your spouse)
( ) Marital/relationship problems
( ) Remarried family problems
( ) Anger/temper problems
( ) Job/school problem
( ) Sexual Abuse - Adult/Child
( ) Low self - esteem
( ) Eating problems
( ) Major losses/difficult changes
( ) Communication problems
( ) Alcohol/Drugs: Please include history, current use, as well as type, amount, and frequency

_____
_____
_____
_____

Problems With Coping

Please check ( ) those that apply to you

( ) Sleep problems
( ) Difficulty falling asleep
( ) Waking in the middle of the night
( ) Waking too early
( ) Sleeping to much
( ) Nightmares
( ) Moody or crying more than usual
( ) Change in appetite
( ) Gaining weight (specify _____)
( ) Losing weight (specify _____)
( ) Not hungry or not eating
( ) Throwing up after eating
( ) Feeling sick to my stomach
( ) Constipation or diarrhea

( ) Difficulties concentrating
( ) Problems remembering things
( ) Withdrawing from others
( ) Repeated actions I can't stop
( ) Can't stop washing hands/body, counting or checking things
( ) People picking on me
( ) Self-harm
( ) I cut myself
( ) I burn myself
( ) I hit myself
( ) Feeling guilty, worthless, or hopeless
( ) Fatigue/low energy
( ) Hyper/too much energy
( ) Loss of interest in things
( ) Disturbing thoughts I can't stop
( ) Low self esteem
( ) Hallucinations
( ) I hear things that are not real
( ) I see things that are not real
( ) I smell things that are not real
( ) I feel things that are not real

Any thing else you'd like to tell me about?

_____

_____

Have you ever seriously thought of committing suicide? YES NO

Have you ever attempted suicide? YES NO

If you have attempted suicide please tell me WHEN and what method you used.

When Method

_____

_____

_____

List Previous Inpatient Psychiatric and/or Drug-alcohol Rehab. Hospitalizations (if none, write "None")

Dates (from-to) Reason

_____

_____

_____

_____

Have you ever had any counseling or psychotherapy? YES NO

Tell me WHY and WHEN for each time you were in therapy.

Think back to those experiences and tell me WHAT WORKED and WHAT did not WORK.

Please tell me what medications you are taking now. Include over-the-counter drugs, supplements, herbal and other substances used.

Medication	How Much	How Often	What does it do?

Are You Allergic to Any Drugs? YES NO
If you are allergic to any drugs, please list them here

Are you currently on probation? YES NO
Have you ever been on probation? YES NO
Have you ever been in jail or prison? YES NO

If you answered "yes" to any of these questions, please explain your answer below. Include the dates of the probation and the term in jail.

Family Information
Please list the people that you currently live with

Name	Relationship	Age

Do you have other children not living with you? YES NO
If yes, please give names and ages

Name	Age

Does your family have any psychiatric or substance abuse history? YES NO

If you answered "yes", please explain

Does your family have a history of major health problems? YES NO

If you answered "yes", please explain

Please describe your relationship with your parents. What are the good parts? What are the bad parts? You can use the back side of this sheet if you need to further explain

Name	**Good Parts**	**Bad Parts**
Birth Mom		
Birth Dad		
Step Mom		
Step Dad		
Other Mom		
Other Dad		

Please list family, friends, support groups and community groups that are helpful to you. You can use the back side of this sheet if you need to further explain

Person or Group	**How are they helpful?**

Have you ever been in the military? YES NO

Did you receive an honorable discharge? YES NO

Please describe the experience.

What is your highest level of your schooling? _____

Do you own any guns or weapons? YES NO

Where are they located?

Current Functioning

Please place an "X" on the following scale to indicate how well you are coping at the present time. 100% means that you are coping the best that you can do considering your situation.

0%-----10%-----20%-----30%-----40%-----50%-----60%-----70%-----80%-----90%-----100%

Your Goals in Counseling

Goals are very important in counseling. They provide us with a focus and direction that will help us to help you. Please list the goal(s) that you hope to address and achieve in counseling. Please be as specific as possible.

1._____

2._____

3._____

4._____

How Many Sessions Do You Think You Will Need To Get Back On Track?

Please place a checkmark ( ) in the answer which best describes your expectations.

( ) 1-3 sessions ( ) 4-6 sessions ( ) 7-9 sessions ( ) 10-12 sessions
( ) 13-15 sessions
( ) Other (please specify): _____

Signature: _____Date: _____

NOTICE OF PRIVACY PRACTICES FOR RICHARD KATZ, Psy.D.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU

- *MAY BE USED AND DISCLOSED*
- *HOW YOU CAN GET ACCESS TO THIS INFORMATION*

1. USE AND DISCLOSURE OF PROTECTED HEALTH CARE INFORMATION—WITH YOUR CONSENT

I may need to give insurance companies or other agencies (such as Medicare) the minimum necessary information in order for them to pay me for the services I have provided to you.
This is explained in "The Choice to Use Insurance" Form and "Contract for Service and Financial Agreement" Form.

2. INFORMATION DISCLOSED—WITHOUT YOUR CONSENT

a. EMERGENCIES: Information may be shared in the event of an immediate emergency you are facing—for example if you suffer a medical emergency in my office and paramedics are called.
b. JUDICIAL PROCEEDINGS: Information may be shared if I am presented with a valid court order or other lawful process.
c. PUBLIC HEALTH ACTIVITY: If I judge that you are in immediate danger to yourself or others, I may disclose health information about you to legal authorities, as well as alerting any other person who may be in danger.
d. CHILD / ELDER ABUSE: I am a mandated reporter which may require me to disclose health information about you if there is the suspicion of child and/or elder abuse or neglect
e. CRIMINAL ACTIVITY OR DANGER TO OTHERS: I may disclose health information if a crime is committed on my premises or against me or others or if I believe there is someone in immediate danger.
f. NATIONAL SECURITY, INTELLIGENCE ACTIVITIES, PROTECTIVE SERVICE TO THE PRESIDENT and OTHERS. I may release health information about you to federal officials authorized by law in order to protect national or international persons or in case of national security
g. HEALTH OVERSIGHT ACTIVITIES: I may disclose health information to a health oversight agency for activities authorized by law, such as audits or inspections of records by the government to assure compliance with civil rights laws. This type of inquiry is typically anonymous.
h. MARKETING: I may send you announcements or newsletters about services I provide that I think might be of interest to you. You may request that your name be removed from this notification list. At no time will I share your name with any other third party.
i. SCHEDULING APPOINTMENTS: I may use your phone number to call or text you or leave messages regarding your appointments.

3. YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

a. RIGHT TO INSPECT AND COPY: You have the right to look at and get copies of your health information, with limited exceptions. Your request must be in writing. <u>A reasonable charge may be made for this service operation.</u>
b. RIGHT TO AMEND: You have the right to request that I amend your health information. Your request must be in writing. You must explain why the information should be amended. I have the right to deny that request under certain circumstances.

c. RIGHT TO AN ACCOUNTING OF DISCLOSURES: You have a right to receive a list of instances where I disclosed your health information for a purpose other than treatment or payment or health care operations. You must submit your request in writing. This accounting will be available for 7 years after the last date of service with Richard Katz, Psy.D.
d. RIGHT TO REQUEST RESTRICTIONS: You have the right to request a limitation or restriction of the health information I use or disclose about you. For example, you could ask me to not share information with your insurance company, in which case you would be totally responsible for service fees. To request a restriction, you must make your request in writing. This request does not apply to section 2, INFORMATION DISCLOSED WITHOUT YOUR CONSENT.
e. RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS. You have the right to request that I communicate with you in a certain manner or location. For example, you may request that I communicate with you only via a specified phone number. You must make this request in writing.
f. RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE: You have the right to receive a paper copy of this notice. Copies are available at my office.
g. REVOCATION OF WRITTEN AUTHORIZATION FOR RELEASE OF INFORMATION. You may revoke a written authorization for release of information at any time. The revocation must be in writing, and dated. The revocation will become effective when it is recieved in my office. The revocation will only be for disclosures not already completed.

I may change these privacy practices at any time provided they are permitted by applicable laws.

QUESTIONS AND COMPLAINTS

You may file a complaint with me if you believe your privacy rights have been violated. You may also file a complaint with the U.S. Department of Health and Human Services. There is no penalty for filing a complaint.

For more information about HIPAA (Health Insurance Portability and Accounting Act of 1996)

Write to: U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue S.W.
Washington, D.C. 20201
Telephone: 212-619-1257

_____ ____/_____/_____
Client / Responsible Party Signature Printed Name Date

_____ ____/_____/_____
Richard Katz, Psy.D. Date