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New Patient Registration

Patient Name: _____
Last First MI

Patient's Date of Birth (MM/DD/YY): ____/____/____ Gender: M F Other

Patient's Address: _____

City, State, Zip Code: _____

Phone: _____ _____ _____
Home Work Cell

Email Address(s): _____

Patient's Insurance ID: _____ Group Number: _____

Patient Status: Single Married Other

Employed Full Time Student Part Time Student

Is your condition related to (circle if applicable): Employment? Y/N Auto Accident? Y/N Other Accident? Y/N

Primary Cardholder's Name: _____
Last First MI

Primary Card Holder's Date of Birth: ____/____/____ Phone #: _____ Gender: M F
MM DD YYYY

Primary Card Holder's Social Security Number: _____

Primary Card Holder's Address: _____

City, State, Zip Code: _____

Patient's Relationship to Primary Card Holder: Self Spouse Child Other

Referred By: _____

I authorize the release of information necessary to process my claim for services and pay my benefits. A photocopy of this authorization is considered valid as an original. I understand that I am responsible of fees for service.

_____ _____
Signature of Responsible Party Date

CONSENT FOR OUTPATIENT SERVICES

CONTRACT FOR PROFESSIONAL SERVICES
Welcome to my office. I look forward to working with you. This document contains important information about my professional services and business policies. Please read it carefully. Note any questions you have so we can discuss them. Once you sign this document it will constitute a binding agreement between us.

CONTACTING ME BY TELEPHONE
Typically, I am not immediately available by telephone. Though I am usually in my office between 8 AM and 5 PM, I do not answer the phone when I am with a patient. When I am unavailable, your call will be answered by my private and confidential answering machine. You may leave confidential messages on my answering machine. I am the only person who retrieves messages. I make every effort to return your call the same day you call, with the exception of weekends and holidays. If you are difficult to reach, please email me at drtansy@michaeltansy.com. If you are unable to reach me and feel that you can't wait for me to return your call, contact your pediatrician, family physician or psychiatrist. If you cannot reach me and you are experiencing an urgent or life-threatening situation, dial 911, the 24-hour EMPACT Crisis Line at (480) 784-1500, or go to the nearest emergency room. I respect your ability and self-responsibility to seek and obtain assistance in a crisis. If you feel this arrangement will not meet your needs, I will be happy to assist you with referrals to other mental health professionals.

CONTACTING BY EMAIL
Often patients contact me by email. Please be aware that email is not a secure form of communication. If you contact me by email, please, do not provide any sensitive about yourself or your family member as I cannot guarantee it will remain private. Please limit email correspondence to requesting a reply from me without further disclosure. When doing so, please leave your best telephone contact information.

PSYCHOTHERAPY SERVICES; RIGHTS AND RESPONSIBILITIES
Psychotherapy outcome depends on the personality of both the client and the therapist. It will require a very active effort on both our parts. You will have to work both during our sessions and between sessions to achieve the most successful outcome.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable, unsettling, or painful thoughts and feelings. However, often psychotherapy leads to significant reduction of distress, increased satisfaction with life, and the resolution of specific problems. There are many ways to approach complex problems and there is no guarantee about what will happen in our work together.

Initially, we will focus on assessment, including the identification of goals and consideration of related history, circumstances and resources. This may occur over several sessions and be periodically reviewed. Some therapy is quite brief, requiring only a few sessions to resolve a problem and obtain relief. However, since therapy may involve a large commitment of time, money and energy, it is important that you feel comfortable continuing our work together. You have the right to stop our therapeutic relationship at any time, and, again, I would be happy to assist with referrals.

I will be professional, attentive to your issues and respectful of your time and financial resources. I will inform you promptly and reasonably in advance of any necessary change in scheduling, anticipated absences, or the need for treatment to end.

Many insurers now limit mental health benefits to a short-term treatment approach. While much can be accomplished in short-term therapy, many clients feel that more services are necessary after insurance benefits expire. Once we have all of the information about your insurance coverage, we can discuss, as needed what we can expect to accomplish with the benefits that are available, and what will happen if your benefits are exhausted before you feel ready to end therapy.

Due to the difficult emotions that may arise in the course of treatment, it has been helpful to clarify that I reserve the right to terminate treatment immediately should there be any threat to myself, my family or acquaintances, or to my property. To date I have not needed to follow through on this.

In psychotherapy, individuals frequently deal with memories about the past. The current scientific knowledge about memories indicates that memory is imperfect and that there is no guarantee that all information retrieved in the course of therapy is accurate. Information revealed, no matter how clearly it is recalled, may or may not reflect events as they actually occurred. This is important to consider in deciding which actions to take in one's life.

MEETINGS
All appointments are 45 minutes. Usually, I schedule one 45-minute session each week to two weeks at a time we agree on, although some sessions may be more frequent. Once an appointment is scheduled, you are obligated to pay for it unless you provide 24 hours advance notice of cancellation and we agree that you were unable to attend due to circumstances beyond your control.

PROFESSIONAL FEES
My hourly fee is $125.00. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 5 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $200.00 per hour for preparation and attendance at any legal proceeding.

BILLING AND PAYMENTS
You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using other professional means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such action is necessary, the cost of these services will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

INSURANCE REIMBURSEMENT
In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide mental health coverage. Before our initial visit you are expected to provide your insurance information to me and I will contact your insurance company about your mental health benefits, including deductibles, co-pays, and treatment authorization. I will complete and bill your insurance for all of our appointments. You are expected to pay any deductible or co-pays at the time of the appointment. However, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your insurance company. Your insurance company's number is on the back of your insurance card. Of course I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

Insurance benefits often are limited to short-term treatment approaches designed to work out specific problems that interfere with a person's immediate functioning. Some insurance plans require approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients need more services after insurance benefits end. Some insurance plans do allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

All insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the process described above.

PROFESSIONAL RECORDS
The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

MINORS
To participate in psychological treatment I require the signed permission of *both* parents unless the court has severed the relationship between a parent and the child, for which I require supporting documentation from the custodial parent, or parent has abandoned the patient, or the parent is deceased.

For patients who are less than eighteen years old, the law provides parents the right to examine their child's treatment records. However, in order for children to trust that I hold their disclosure in confidence, I request that parents agree to give up access to minor children's records. If needed, I provide parents only with general information about our work together, unless I feel there is a high risk that the child will seriously harm his or her self, or someone else. In this case, I will notify them of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to discuss any objections they may have with what I am prepared to discuss.

GENERAL v. SPECIALTY PRACTICE
Psychologists are licensed to practice at a general level. By license they are not prohibited to from providing any sort of psychological service. However, as psychology is too broad for any single psychologist to practice competently in all areas, effective and responsible psychological practice is specialized and psychologists should limit their services to areas of practice for which they are competent. While I am competent to serve children and adults for a variety of general issues there are many specialty psychological services I do not offer. Services I do not provide service include psychological evaluations, psycho-educational evaluations, readiness to work evaluations, court-referred or court-related assessments or treatment, emergency psychological assessment or services, or services to children, adults, or families in matters of high conflict divorce, marriage and family therapy, and group psychotherapy. In these matters I make every effort to assist individuals to providers who may hold competence in these areas. Often I refer individuals to their insurance plan panel of providers, to the Arizona Psychological Association (480-675-9477), to the Arizona Board of Psychologist Examiners (https://psychboard.az.gov) or to the Arizona Board of Behavioral Health Examiners (www.azbbhe.us).

CONFIDENTIALITY

I follow the standards of my profession in preserving your confidentiality. While these standards strictly limit the communication of psychologists, you should know that there are a number of exceptions. Please be aware that in issues related to concern over potential harm to self or others, the abuse of children or the elderly or disabled, and in response to court orders, there are some limits and overrides to the general status of confidentiality. For example, it may be necessary to contact family members or others who can help provide protection in the event that there is a grave threat of harm. As part of my professional growth, for purposes of peer review, and in problematic situations, it is my practice to periodically consult professional colleagues regarding my therapeutic approach. Your signature below constitutes understanding of this practice and a release for me to discuss case issues with my professional colleagues on an as-needed basis. The professionals with whom I may consult are also bound to keep the information confidential.

Regarding child and adolescent counseling, what you tell me is confidential except suicidal tendencies, homicidal tendencies, abuse or other dangerous behavior. If your insurance company requires treatment reports, I must send them those.

Increasingly, insurance companies have been requiring more extensive clinical information before approving payment for services. They may require advanced authorization and ongoing detailed reports of specific progress on therapeutic goals. All insurance companies claim to keep this information confidential, but once it leaves my office, I have no control over what happens to it. Utilization of insurance benefits typically constitutes permission to release any information, which they request to make payment determinations. In all situations, I will strive to use my best clinical judgment regarding issues of your confidentiality.

PRACTICE CLOSING

In the event I close my practice, or upon my death, you may contact the Arizona Psychological Association or the Arizona Board of Psychologist Examiners to get information on how to access your records.

CONSENT FOR TREATMENT

I have read the information above, understand and agree with the terms, and voluntarily consent to participate as a client, or have my child participate as a client, in psychological services, and agree to the above fee. *Please continue to feel free to talk with me throughout our work together about any clinical or business policy issues as they may arise. I truly appreciate the opportunity to be of professional service to you and look forward to our work together.*

Client Signature: _____ Date: _____

Father's signature (for minors): _____ Date: _____

Mother's signature (for minors): _____ Date: _____