Michael Burke, Psy.D. & Associates, P.C.

CLIENT INFORMATION FORM

Date: _____ **Home Phone:** _____

Client Name: _____ **Cell Phone:** _____

Address: _____ **Work Phone:** _____

_____

Age: _____ **Birth Date:** _____ **Sex:** _____ **Race:** _____

Employment Status: Full-Time:___ Part-Time:___ Unemployed:___ Homemaker:___ Student:___

Employer: _____

Marital Status: Single:___ Married:___ Separated:___ Divorced:___ Widowed:___

Name of Spouse: _____

Guardian (If Applicable): _____

Address: _____ Phone: _____

Past Counseling:

Are you currently receiving other counseling? Yes_____ No_____

Other counselor: _____

Referred by: _____

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

****If at any time, you do not understand this information, or any information provided to you, please ask your therapist.****

Consent to treatment:
The undersigned grants authority to Michael Burke, Psy.D. & Associates, P.C., to perform those procedures and treatments necessary for this client are generally used in the care of clients in this and similar facilities.

X_____ _____ _____

Signature of client (If over 19) Date Witness

X_____ _____ _____

Signature of Guardian Date Relationship to client

(Must have legal custody in order for signature to be valid)

Tele-reminder Release:

I, _____, give my consent for Michael Burke, Psy.D. & Associates, P.C., to confirm my scheduled appointment through their automated tele-reminder system. **These calls will come from Utah, an (801) area code.** You are able to receive a phone call **OR** text message in addition to an email. I understand this system may call or text the number I provide or email the address provided, and leave an automated message reminding me of my appointment.

Please specify your desired form of receiving reminders (may select only **ONE** choice between voice and text).

_____ Voice Call or _____Text Message or _____Email

Preferred phone number: _____ and/or Email Address: _____

X_____ _____

Patient (**If over the age of 19**) or legal guardian signature Date

No thank you, I would rather **NOT** receive tele-reminder calls to remind me of my appointment. _____

Advance Health Care Directive:

You have the right to give instructions about your own health care.

You also have the right to name someone else to make health care decision for you in the event that you are unable to do so.

The Advance Health Care Directive form lets you do one or both of these things. It also enables you to write down your wishes about organ donation and primary physician selections.

I would like more information regarding Advance Health Care Directive. Yes_____ No_____

Coordination of Care:

We believe you should be treated as a whole person. We collaborate with others when it is indicated and authorized. This includes managed behavioral health care, primary care physician (PCP), hospitals and schools. Communication between behavioral health providers and your primary care physician (PCP) is important to ensure that you receive comprehensive and quality health care. This PHI (Protected health information) may include diagnosis, treatment plan, and medication if necessary. **This information will not be released without your signed consent.**

_____ Yes please notify my PCP. I am aware that I will need to sign a release for this.
_____ Yes please notify my Medication Management Provider. I am aware that I will need to sign a release for this.
_____ I waive notification of my PCP that I am seeking or receiving mental health services, and I direct you **NOT** to notify him/her.
_____ I do not have a PCP and do not wish to see or confer with one.

X_____ _____

Patient (**IF over the age of 19**) or legal guardian signature Date

Michael Burke, Psy.D. & Associates, P.C.

Member Rights and Responsibilities

Statement of Members Rights

- Members have the right to be treated with dignity and respect.
- Members have the right to fair treatment regardless of race, religion, gender, age, ethnicity, disability or source of payment.
- Members have the right to have their treatment and other information kept private. Only when permitted by law may records be released without member permission.
- Members have the right to easily access timely care in a timely fashion.
- Members have the right to know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
- Members have the right to share in developing their plan of care.
- Members have the right to information in a language they can understand.
- Members have the right to information in a language they can understand.
- Members have the right to information about Magellan, its practitioners, services, and roles in the treatment process.
- Members have the right to ask their provider about their work history training.
- Members have the right to give input on the Members Rights and Responsibilities policy.
- Members have the right to freely file a complaint if necessary.
- Members have the right to know of their rights and responsibilities in the treatment process.

Statement of Member Responsibilities

- Members have the responsibility to treat those giving them care with dignity and respect.
- Members have the responsibility to give providers information they need so that providers can deliver the best possible care.
- Members have the responsibility to ask questions about their care in order to help them understand their care.
- Members have the responsibility to follow the treatment plan. The plan of care is agreed up on by the provider and the member.
- Members have the responsibility to follow the agreed upon medication plan.
- Members have the responsibility to tell their provider and primary care physician about medication changes, including medications given to them by others.
- Members have the responsibility to keep their appointments. Members should call their provider immediately if they know they will need to cancel an appointment.
- Members have the responsibility to let their provider know whether the treatment plan is working for them.
- Members have the responsibility to let their provider know how problems with paying fees.
- Members have the responsibility to report abuse and fraud.
- Members have the responsibility to openly report concerns about the quality of care they received.

My signature shows that I have been informed of my rights and responsibilities and that I understand this information.

X_____

Patient **(If over the age of 19)** or legal guardian signature

Date: _____

My signature shows that I have explained this statement to the client.

X_____ _____

Signature of witness Date

Michael Burke, Psy.D. & Associates, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Notice of Privacy Practices: You have the right to read our Privacy Policies before you decide whether or not to sign this consent. A copy of our Notice and/or this consent is available upon your request. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the users and disclosures we make of your protected health information.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

I have been shown a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my personal health information to carry out treatment, payment activities, and healthcare operations.

Patient Name: _____

Parent/Legal Guardian Name: _____

Signature: _____ Date: _____

Relationship to Patient: _____

For office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ Other (please specify) _____

Primary Insurance Plan		
Patient Name:	Date of Birth	
Insurance Plan:	Policy #	Group #
Insurance Company Address:	Phone #	
Subscriber Name:	Relationship to patient:	
Subscriber Soc Sec #: (last 4)	Subscriber Date of Birth:	
Subscriber Employer:	Employer Phone #:	
Employer Address:		

For Medicare Patients Only	
Medicare ID Number:	Part B Effective Date:

Other Insurance Coverage (Secondary Insurance)		
Patient Name:	Date of Birth:	
Insurance Plan:	Policy #	Group #
Insurance Company Address:	Phone #	
Subscriber Name:	Relationship to Patient:	
Subscriber Soc Sec #: (last 4)	Subscriber Date of Birth:	
Subscriber Employer:	Employer Phone #	
Employer Address:		

- ☐ We will expect payment for services rendered (minus insurance reimbursement) after each appointment, or monthly after a bill is mailed to you.
  - ○ _____ (Initial)
- ☐ I agree to assume financial responsibility for the regular fee charged for a missed appointment or an appointment cancelled within less than 24 hours notice
  - ○ _____ (Initial)
- ☐ I hereby authorize Michael Burke, Psy.D. & Associates, P.C. to release necessary medical information to my insurance company(s) and third party payer(s) in order to process insurance claims. I authorize payments of medical benefits to the provider of services.
- ☐ I have read and I do understand the above information.

X_____ _____

Patient (**If over the age of 19**) or legal guardian signature Date

Financial Policy

Thank you for choosing Michael Burke, Psy.D. & Associates. Please carefully review our financial policy. Our business office is available to answer any questions you may have regarding our financial policy or your payment responsibilities. They can be reached at (308) 234-5644.

Insurance Services

Michael Burke, Psy.D. & Associates, P.C., hereafter referred to as the clinic, participates with many health plans. AS A COURTESY TO OUR CLIENTS, we will file claims with these companies; however, it is ultimately your responsibility for the full and timely payment of your account.

Please be prepared to submit your current insurance card at each visit. A scanned copy of this card may be kept as a part of your permanent record. Please also provide the clinic with up to date contact information, including your home address, telephone number, and emergency contact information.

The clinic will attempt to verify coverage and benefits prior to your visit with the therapist. If we are unable to obtain a verification of coverage, you will be asked to pay in full, or reschedule your visit at a time the verification can be obtained. This verification will be used to estimate your financial responsibility; however, this verification is not a guarantee by your health plan of coverage or payment.

Please be aware that certain diagnoses may not be covered or may be considered "not medically necessary" by your health plan. You are responsible for payment of these services. Please also be aware that many health plans limit annual coverage. In the even your care exceeds a plan limitation, you will be responsible for the balance. It is your responsibility to know the benefits and limitations of your current health care coverage. The clinic will provide care base on the client's needs, not a client's insurance coverage. Your therapist is not responsible for knowing your plan's specific benefit and coverage limitations.

Failure to Cancel Appointments/No Shows

The clinic has the right to charge the regular appointment fee for a missed appointment or an appointment cancelled with less than 24 hour's notice. In order to cancel an appointment, you must call 24 hours in advance to allow time for our office to fill that appointment time. Also, after 2 times of a missed appointment or an appointment cancelled with less than 24 hours notice, the therapist has the right to remove you from the recurring calendar appointment time.

Past Due Accounts

If your account becomes past due, we will take necessary steps to collect this debt. Please take time to speak with our business office to make arrangements to pay your bill.

NSF Checks

If a check is returned for insufficient funds, account closed, or payment is stopped, your account will be charged a $35.00 fee. In the event this happens, you will be asked to use debit/credit or cash for future visits.

Copays

All copays are due at the time services are rendered. If unable to pay your copay, please contact the business office BEFORE your appointment to make arrangements.

_____ _____

Signature of client **(If over the age of 19)** Date

_____ _____

Signature Parent/Legal Representative Relationship to client