# STEVEN KATKIN AND ASSOCIATES

All matters discussed is confidential except as required by law, as in cases of abuse or in cases of declared intention of harm to others or self.

## PATIENT INFORMATION

PATIENT'S NAME:____________________________SSN:____-__-____DATE OF BIRTH:________

ADDRESS:__________________________________ CITY:___________STATE:_____ZIP:________

HOME PHONE:_______________________ CELL: ___________________

EMPLOYER:______________________________________ WORK PHONE:_____________________

MARITAL STATUS: (CIRCLE ONE) MARRIED SINGLE SEPARATED DIVORCED WIDOWED

IF THIS PATIENT IS A CHILD, PLEASE INDICATE WITH WHOM THE CHILD RESIDES: MOTHER FATHER BOTH OTHER_________

**IF YOU ARE NOT THE PARENT OR GUARDIAN, WE WILL REQUIRE A "PERMISSION TO TREAT" FORM TO BE COMPLETED BY THE CUSTODIAL PARENT.**

WHO REFERRED YOU TO US?____________________________________________________

**I UNDERSTAND THAT I AM RESPONSIBLE FOR FULL PAYMENT.**

SIGNATURE________________________ DATE:______________________________

STEVEN KATKIN AND ASSOCIATES
5720 A Signal Hill Court Milford, Ohio 45150

# Authorization for Communication

Please contact using phone number(s): 1.___________________________ 2. __________________________

Please follow these directions when calling (if any): _______________________________________________

Emergency Contact: ____________________________ Relationship: __________ Phone: ________________

If this office should need to contact me via mail or email, I instruct them to use the following addresses:

Mail: _______________________________________

_______________________________________ Email: ___________________________________

_______________________________________

Please ***do not send*** correspondence to the address: _______________________________________________

- ☐ I understand that a copy of my Rights and Responsibilities is available to me both in the office and online at **www.katkintherapy.com**

- ☐ I understand that a brief version of the Privacy Practices of Katkin and Associates is also available to me both in the office and online at **www.katkintherapy.com**

_____________________________________ _________________

Signature of client or legal representative Date

STEVEN KATKIN AND ASSOCIATES, INC.

## Informed Consent for Treatment

I ________________________________________ (Or Parent/Guardian) agree and consent to participation in mental health services offered by Steven Katkin and Associates, Inc. As a client, I understand that I am consenting and agreeing only to those services that my provider is qualified to provide within: (1) the scope of the provider's license, certification and training; or (2) the scope of the license, certification and training of those mental health providers directly supervising the services received by the patient. If the patient is under the age of eighteen, I attest that I have legal custody of this child and am therefore able to give consent for and initiate treatment.

_____________________________________________ __________________

Signature of Patient or Legal Guardian Date

Relationship to Patient (Circle One) Self Mother Father Other:_____________________

## Patient Care Communication Form/Release of Information

I hereby authorize my provider(s) within **Steven Katkin and Associates, Inc.** to release the following information to: ___________________________ ________________ ________________

Doctor's Name Phone Number Fax Number

(Please check all that apply)

_____ Any applicable mental health information.
_____ Any applicable substance abuse information.
_____ Only medical information.

I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. If I do not revoke this authorization, it will expire one (1) year after I have terminated treatment.

____________________________________________ ______________

Signature Date

Notice to recipient of information: This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation 42 CFR Part 2 prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2.

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**HEALTH QUESTIONNAIRE**

Please List Any Allergies: ______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________

Medications you are currently taking: ______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________

Medical Conditions/Disorders: ______________________________________________
______________________________________________
______________________________________________
______________________________________________
______________________________________________

# FINANCIAL AGREEMENT/CONTRACT

**Between you and your therapist at Steven Katkin and Associates, Inc.**

Your appointment is reserved for you and/or your family. If you do not show up for this appointment or you do not cancel within 24 hours in advance, this appointment time often cannot be filled. Therefore, you will be responsible for payment of the Late Cancellation/No Show **charge of $75.00**.

**Payments for the services are due prior to the beginning of each session.**

All unpaid balances are due within 30 days. Balances past 90 days will be turned over to a third party collections agency. Steven Katkin and Associates reserves the right to deny services based upon unpaid account balances.

**Any paperwork requests aside from sending the report generated from this evaluation could be subject to additional fees at the counselor's hourly rate.**

***Please note:* *In the event that the patient is a minor, the parent who brings the child to the appointment is responsible for any payment due for the appointment, regardless of any legal understanding between the parental parties.***

I understand and agree with the statements and stipulations as listed above.

________________________________________________

Patient, Guardian of Patient or Legal Representative Date

ADHD evaluations are considered a self-pay service at this office.

**WE DO NOT BILL INSURANCE FOR ANY PART OF THE EVALUATION.**

Insurance companies do not reimburse for the time of crafting a written report that will be made available for you and any referral sources you would wish us or yourself to share this report. By signing this, you understand that you will be responsible for payment for the evaluation. Also, many of the insurance companies that do reimburse for evaluations require the Evaluator to manually call the insurance companies (wait on hold) to get an authorization for testing. We believe our time is better spent providing a quality assessment and not sitting on the phone.

____________________________________

Printed name

____________________________________

Signature