

## Welcome to Networks Inc.

The information described below is offered to anticipate the most frequently asked questions about our professional services and business practice. Please read it carefully. If you have questions, it is important that you clarify them with your therapist prior to signing.

**Appointments & Fees:** Therapy sessions are 50 minutes. Time is set aside by the therapist specifically for the client session. **In the event that you must cancel an appointment, please call your therapist at least 24 hours in advance. Please do NOT E-mail as this is an inadequate means of notification. Failure to give adequate notice will result in your being billed our full appointment fee of \$115 for Master level therapists, \$125 for Ph.D. level therapists and \$135 for Substance Abuse Evaluations** (excluding Medicaid covered clients). Insurance companies (inc. Medicaid) can not be billed, nor will they reimburse for this cost.

**PLEASE NOTE THE FOLLOWING LIST OF OUR PROFESSIONAL FEES:**

Master level therapists - 1 <sup>st</sup> Session \$125, follow up sessions \$115;	Substance Abuse Evaluations per session - \$135;
Ph.D. level therapists - 1 <sup>st</sup> Session \$140, follow up sessions \$125;	Group Sessions - \$60.

**Miscellaneous Service Charges:** Please be advised that therapist time spent on client-related professional services outside of the therapy session is not billable to insurance. These services include but are not limited to: report writing, written assessments, court diversion/Dept. of Corrections written evaluations, phone consultations with clients or others (exceeding 15 minutes); face to face consultations with others such as attending school IEP meetings (exceeding 15 minutes), etc. Utilizing the above rates as a guide, this time is billed directly to the client and is pro-rated in quarter hour units (with the minimum of 15 minutes) charged at the quarter hour rate. *This excludes time spent writing customary outpatient treatment reports (OTR's) or other similarly related paperwork required by insurance.*

**Confidentiality:** Privacy and confidentiality are important to the relationship between client and therapist. There is legal and ethical protection for the information that you share with your therapist and it cannot be released without your express written consent. This also covers our written record. There are also exceptions to privacy/confidentiality which may include, but are not limited to when Networks Inc. clinicians provide collegial case coverage and case consultation. Additionally, in the event that your therapist is unavailable, a colleague will be covering. There are other exceptions to confidentiality that include but are not limited to: when there is reason to believe that you intend to harm yourself or another person; when a child, elder or disabled adult has been or might be abused or neglected; or if information has been requested by court order. If you have any questions about confidentiality, please raise them with your therapist.

**Confidentiality and Insurance Companies:** If you will be using benefits under a managed care plan including Medicaid, Networks may be required to provide information related to your case to the managed care reviewer and your primary physician, in writing and verbally. Networks Inc. will follow these procedures unless otherwise notified by you in writing.

If your insurance coverage changes, you are responsible for immediately notifying Networks of the change.

**You are ultimately responsible for fees not covered by your insurance.**

**Consent for Treatment:** I voluntarily consent to clinical evaluation/ treatment for myself or my minor child. I understand that there are both benefits and risks involved with engaging in psychotherapy and that there are no guarantees about the outcome.

*My signature below indicates that I have had an opportunity to ask and have my questions answered about the above information and I have read, understand and agree to abide by all of the above outlined terms.*

Signature \_\_\_\_\_  
Print Name of Client

\_\_\_\_\_  
Client Signature

Date \_\_\_\_\_

Signature \_\_\_\_\_  
Print Name of Parent or Legal Guardian

\_\_\_\_\_  
Signature of Parent or Legal Guardian

Date \_\_\_\_\_

Witness Signature \_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Witness Signature

Date \_\_\_\_\_



Date \_\_\_\_\_

Dear \_\_\_\_\_,

Enclosed please find an intake packet. Please fill it out and bring it with you to our appointment

on \_\_\_\_\_ at \_\_\_\_\_.

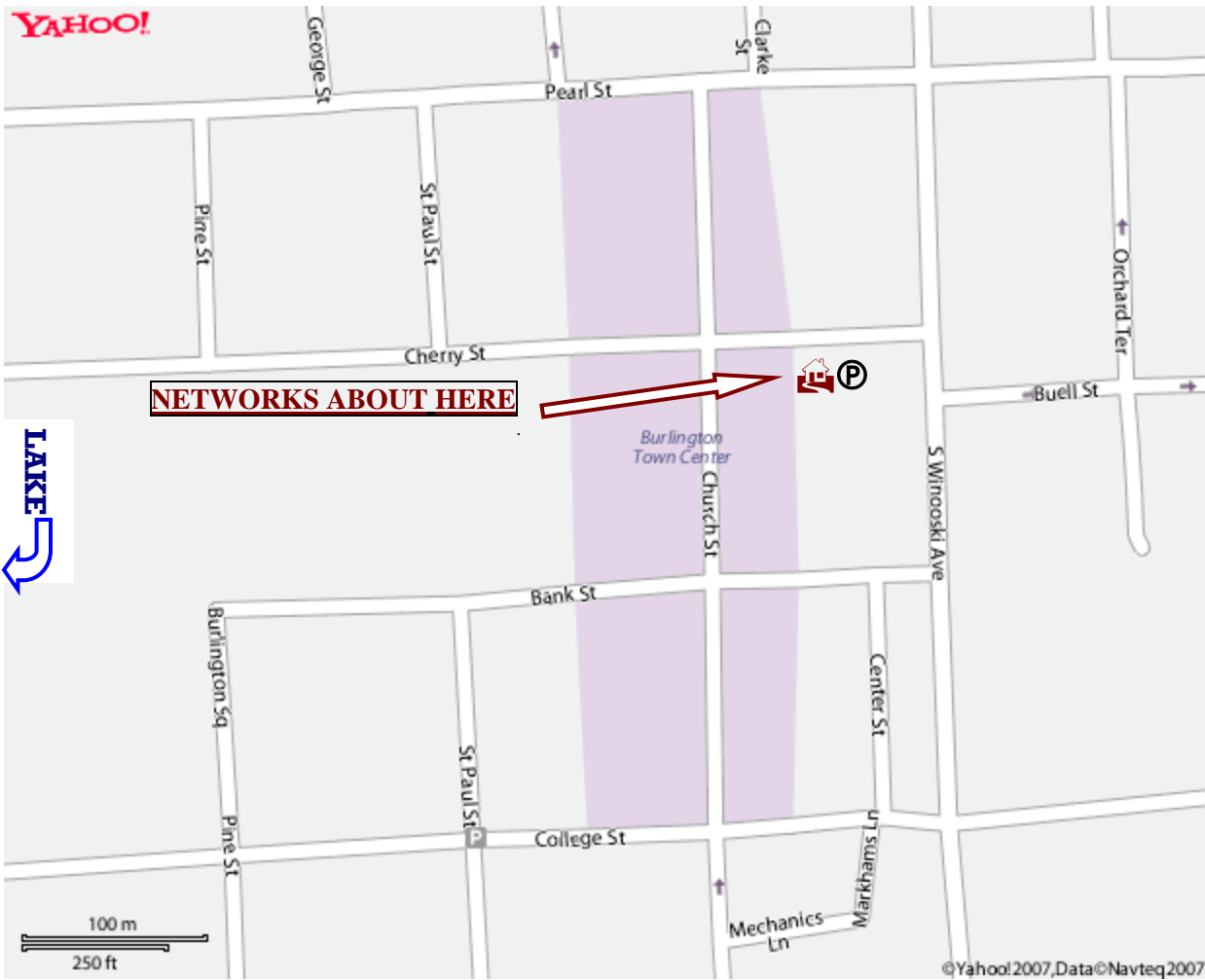
We are located at 149 Cherry Street (2nd floor), at the top of the street, on the block between Church Street and South Winooski Avenue. We are across the street from *Outdoor Gear Exchange* and upstairs from *American Apparel*. There is on-street metered parking and free parking (first 2 hrs) at the city parking lot next-door. Enter the glass door and continue up the stairs to our waiting area. Your therapist will meet you there.

Please call 802 863 2495, Ext. \_\_\_ with any questions or if you can not make this appointment.

Sincerely,

# MAP OF DOWNTOWN BURLINGTON

NETWORKS is located at **149 Cherry Street**, Burlington, VT



**NETWORKS ABOUT HERE**

**UVM**  
→

**LAKE**  
↪



Therapist: \_\_\_\_\_

DX Code: \_\_\_\_\_

Ref. By: \_\_\_\_\_

First DOS: \_\_\_\_ / \_\_\_\_ /20

Auth. #: \_\_\_\_\_

Where did you find out about us?  
(Flynn Ad? Front Porch? Web?)

Client Name \_\_\_\_\_

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Street Address \_\_\_\_\_ City / State \_\_\_\_\_, VT \_\_\_\_\_ Zip code \_\_\_\_\_ 054

(\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Home phone Work phone Cell / Other

**Primary Insurance Company & phone number:** \_\_\_\_\_

Certificate # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Name (if different from client) \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Street Address \_\_\_\_\_ City / State \_\_\_\_\_ Zip code \_\_\_\_\_

Place of employment: \_\_\_\_\_ Amount of Copay: \_\_\_\_\_

Relationship to client:  Self  Spouse  Child  Other \_\_\_\_\_

**Secondary Insurance Company & phone number:** \_\_\_\_\_

Certificate # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Name (if different from client) \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Street Address \_\_\_\_\_ City / State \_\_\_\_\_ Zip code \_\_\_\_\_

Place of employment: \_\_\_\_\_

Relationship to client:  Self  Spouse  Child  Other \_\_\_\_\_

**Responsible party for payments not covered by insurance:**

Name: \_\_\_\_\_

Street Address (if different from client) \_\_\_\_\_ City / State \_\_\_\_\_ Zip code \_\_\_\_\_



Signature of responsible party \_\_\_\_\_

**Client Information**

**Client Name:** \_\_\_\_\_

Relationship Status:  Single  Married  Civil Union  Divorced  Domestic Partner  Other

Occupation: \_\_\_\_\_ Education: \_\_\_\_\_ Religion: \_\_\_\_\_

Are you a veteran?  Yes  No

Are you retired?  Yes  No

Are you a full-time student?  Yes  No If Yes, Where? \_\_\_\_\_

Members in present house	Relationship to you	Age	Sex	Occupation

Other family members	Relationship to you	Age	Sex	Occupation	Location

Members in house you grew up in	Relationship to you	Age	Occupation	Location

Have you **or** someone significant in your life had any problems in the following areas?

(Check all that apply)	Who? (i.e.: Self)	When? (i.e.: Fall 2003)
Marital		
Relationship		
Family		
Children		
Employment		
School		
Financial		
Legal		
Death		
Pregnancy / miscarriage		
Abortion		
Physical / sexual abuse		
Changes in living situation		
Experiences you cannot explain		
Feelings difficult to handle		
Alcohol / drugs		

What are your reasons for seeking therapy now? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If you or someone significant in your life uses drugs or alcohol, please specify who, type of drugs, and frequency of use: \_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

How many alcoholic drinks / beers do you or someone significant in your life drink at a sitting?  
 Please circle and state who: \_\_\_\_\_

None                      1 – 3                      4 – 6                      7 or more

Previous Therapy: Include outpatient treatment, psychiatric hospitalization, dates, therapist names, and reasons  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Significant Medical Information List any major medical problems, including hospitalizations and dates of treatment  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List all medications, prescriptions and non-prescription you have taken during the last 6 months  
 \_\_\_\_\_  
 \_\_\_\_\_

List any allergies, current & past? (e.g.: nuts, hay fever, etc) \_\_\_\_\_

When was your last physical? \_\_\_\_\_ Where? \_\_\_\_\_

List any *drug* allergies?(e.g.: sulfa) \_\_\_\_\_

Has any member of your family had a serious medical or emotional problem? (Please fill-in below)

<b>Family Member</b>	<b>Problem</b>

**Emergency Contact Information:**

Name	
Relationship	
Address	
City / State / Zip	
Home Phone	(    )                      -
Work Phone	(    )                      -

**PRIMARY CARE PHYSICIAN CONSENT FORM**

Communication with your primary care provider (PCP) can be important to make sure all care is complete, comprehensive and well coordinated. This form allows for that exchange of information. We do not release information without your signed authorization.

CLIENT & PCP INFORMATION

Name \_\_\_\_\_ SS # or ID# \_\_\_\_\_ D.O.B. \_\_\_\_\_ / / \_\_\_\_\_ ID # \_\_\_\_\_

Insurance \_\_\_\_\_ First Date of Service \_\_\_\_\_ / / \_\_\_\_\_

Referred By: Self \_\_\_\_\_ Other: \_\_\_\_\_

Name of Physician \_\_\_\_\_ Facility / Practice Address \_\_\_\_\_

( ) - \_\_\_\_\_ ( ) - \_\_\_\_\_

Phone number \_\_\_\_\_ Fax number \_\_\_\_\_

**CLIENT Consent to Communicate with Primary Care Physician**

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR Part 2, 45 C.F.R. parts 160 & 164 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and prohibits any further disclosure by the designated recipient of this information unless expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. I have not been coerced to sign this authorization. I understand that I might be denied services if I refuse to consent to a disclosure for the purposes of treatment, payment, or health care operations, if permitted by state law. I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits nor will I be denied services if I refuse to consent to a disclosure for other purposes. I understand that prepayment for copies of my records as well as payment for services rendered may be required for copies of my record when released to anyone other than a medical provider, facility or institution. I understand that by signing this form I am confirming my authorization for use and/or disclosure of the protected health information described above with the people and/or organizations named above. I have read this release and understand its contents. I have also been provided a copy of this form. I also understand that I may revoke this consent at any time by notifying the provider in writing (except to the extent that action has already been taken in reliance on it). This release will automatically expire twelve months from the date signed below or upon the date specified here

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_ to:  
 (PRINT name of patient/client) (Name of Provider)

**CLIENT PLEASE CHECK ONE:**  **NOT** release any applicable information to my physician.  
 release applicable information to my physician.

\_\_\_\_\_ / / \_\_\_\_\_  
 Print Name of Client Signature of Client Date signed

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_ to:  
 (PRINT name of parent/legal guardian) (Name of Provider)

**PARENT/LEGAL GUARDIAN PLEASE CHECK ONE:**  **NOT** release applicable information to the child's physician.  
 release applicable information to the child's physician.

\_\_\_\_\_ / / \_\_\_\_\_  
 Print Name of Parent or Legal Guardian Signature of Parent or Legal Guardian Date signed

TO BE FILLED OUT BY PROVIDER

**Reason for Report:** (to be completed by Provider)  
 Initial Report  Treatment Update  Discharge  Other  \_\_\_\_\_

**Treatment Information:** (to be completed by Provider) Diagnosis: \_\_\_\_\_

Presenting Problem: \_\_\_\_\_

Type / Dosage of Psychotropic Medication: \_\_\_\_\_ MD \_\_\_\_\_

Type / Frequency of treatment: Weekly  Bi Weekly  Monthly  Other : \_\_\_\_\_

**Mental Health Care Provider Information:**

\_\_\_\_\_ / / \_\_\_\_\_  
 Print Name Signature Date