Crossroads Counseling

Dr. Sharon von Lentz, Psy.D
11811 N Tatum Blvd., suite 3031
Phoenix, AZ 85028
(602) 334-3776

INTAKE FORM

Please type or print legibly

Patient Name: ____ Date____________
(First) (Last) (Middle Initial)

Birth Date: _______ /_______ /_________ Age: _______ SS# ______________________ ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Never Married ☐ Domestic Partnership ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Name of parent/guardian (if under 18 years):____
(First) (Last) (Middle Initial)

Address: ____
(City) (State) (Zip)

Home Phone: (_________)____________________ May we leave a message? ☐ Yes ☐ No

Cell: (_________)____________________________ May we leave a message? ☐ Yes ☐ No

Work: (__________)______________________________ May we leave a message? ☐ Yes ☐ No

E-mail (Required): ____
Required for Billing Purposes

Employer____ ☐ Part Time ☐ Full Time

Employer's Address____

Referred by ____

Child in Therapy: **(Both parents must sign forms for any child or adolescent in therapy)**

Grade Level: __________________ Name of School: ______________________________________

Religious Background ___________________________________ Has your child had any counseling before? ☐ Yes ☐ No

Child's custodian/guardian(s) is/are: ____

EMERGENCY CONTACT INFORMATION

Name ______________________________________ Relationship ___________________________________

Phone (H)__________________________ Phone (W)__________________(C)_______________________

In Case of Emergency, may we contact this person? ☐ Yes ☐ No

RELIGIOUS PREFERENCE ____

(updated 7-31-19 AB)

Who is responsible for this account? YOU and… ☐ Cash ☐ Personal Health Insurance ☐ Parent ☐Other

INSURANCE INFORMATION (only needed if I don't have a copy of insurance card)

Policy Holder____

Policy Holder's date of birth ______________________________________

Address (if different)____

____

Insurance Company____

Address____

____

Phone____

Policy Holder's Member #____

Group # ____

Employer____

____

MEDICAL INFORMATION

What brings you to counseling now?____

How long have your current problems existed?____

Describe your present concerns: (Circle one) Mild Moderate Moderately Severe Severe A Crisis

What psychiatric medications do you take? ____

What serious mental illnesses have you had? ____

Have you made a suicide attempt? ☐ Yes ☐ No

Have you ever been hospitalized for psychiatric treatment? ☐ Yes ☐ No When?____

Where were you hospitalized? ____For how long?______________________________

Have you had prior counseling or therapy? ☐ Yes ☐ No When?____

Is your visit Court Appointed? ☐ Yes ☐ No

Do you have any legal issues? ☐ Yes ☐ No If yes, Explain: ____

Is CPS Involved? ☐ Yes ☐ No If yes, Explain: ____

Are the Police Involved? ☐ Yes ☐ No If yes, Explain: ____

If you are involved in a lawsuit or currently in custody dispute, please note that I do not specialize in these matters, and it may be best for you to find another therapist.

Financial Policy

Your Financial and Insurance Verification Responsibilities

Every attempt is made to comply with insurance company's requirements. Since policies and benefits differ among employers and individuals participating with each insurance company, we are unable to know the specifics of your policy. Your insurance company informs all participants that it is ultimately YOUR responsibility to verify benefits and coverage information prior to having any services rendered. Crossroads Counseling and Dr. Sharon von Lentz cannot guarantee the cost of services performed will be covered by your insurance. To limit the charges that you may be responsible for, please ensure that we always have up-to-date information regarding your insurance company. In order to bill your insurance a diagnosis must be given to them. The advantage of CASH PAY is that your insurance company does NOT get a diagnosis.

You will be responsible for payment of all services if any of the following circumstances apply:
- If you do not have insurance.
- If you do not have a referral when required.
- If you are with an insurance company I am not contracted with; or
- If a claim denial from the insurance company is not able to be resolved within 3 months..

Credit/Debit Card on File – This is a requirement for my practice. Visa or Mastercard ONLY

As a result of the above, a credit/debit card needs to be on file for unpaid sessions after 2- 3 months, no show appointments and late cancelled appointments (**cancelled less than 48 hours**). Monday appointments need to be cancelled by the previous Friday.

Signature of card owner ____ Date ________________________
(May be electronically signed)
Print name____

Billing Address: ____State__________ Zip Code__________________

CC#____________ _____________ _____________ ______________ _____Expiration Date ______________ CCV Code______

Email for receipt____
Or texts for my convenience If I want a receipt each week or at the end of the year. Initial

Other Policies

I welcome you to counseling and look forward to working with you. The following information will be helpful in establishing a good therapy relationship between us. Please read this information carefully, initial, and ask any questions that you have.

Informed Consent I understand that there may be both risks and benefits associated with participation in counseling. Counseling may improve my ability to relate to others, provide a clearer understanding of myself, my values, and my goals, and an ability to deal with everyday stress. Although counseling can be beneficial to many people, it may not be helpful for everyone. Therefore, it is essential that you discuss any questions or discomfort you might have with your counselor. Weekly appointments are expected in the beginning of therapy. As you improve, biweekly and then monthly appointments are appropriate. It is not appropriate to end therapy abruptly. If you want to end therapy, please schedule a termination session to discuss the reason for termination.

___________ *(Please Initial)*

Initial Appointment Your initial appointment is considered a diagnostic interview. From the information you share on this first visit, we will decide together what the goals of therapy are. We will also discuss the type of therapy needed, the frequency of therapy sessions (weekly, bi-weekly, etc.), and schedule your next appointments.

___________ *(Please Initial)*

Appointments I /we agree to receiving unencrypted texts or emails for our convenience. Each therapy session lasts 45-60 minutes. All appointments are scheduled directly with me, in person or by phone. **(TEXTING IS PREFERRED)**

___________ *(Please Initial)*

Insurance Once we have all 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 your sessions. It is important to remember that you always have the right to pay cash for my services.

___________ *(Please Initial)*

I understand that if I change my insurance policy and I fail to inform you of the change, for every session that is billed to the incorrect plan I will be charged $50. This is just like a bounced check. This is because normally it takes 2 mos. To get paid by insurance and if our office has to rebill it, then it will take 4 mos. To get paid. Thus, if you have had 6 sessions billed incorrectly. You will be personally responsible for 6 x $50 = $300 late fees assessed to your account. ___________ *(Please Initial)*

Phone Consultations Phone Consultations Any phone consultation under 10 minutes is at no charge. Fees from 11-20 minutes is $60 and 21-30 minutes is $100 This includes if I have to consult on your behalf with another doctor to coordinate your care. Phone calls from 31-60 minutes are charged at $200 per hour to your credit card on file and may not be paid by insurance.

___________ *(Please Initial)*

Cancellation/No-Show Fees If you find that you need to cancel an appointment, please give as much notice as possible **with the reason for your cancellation**. Otherwise, You will be personally charged $100 for appointments not canceled at least 24-48 hours in advance either by phone or text messages or $100 for no-show appointments. Insurance companies do not pay for unattended appointments, and this is YOUR responsibility.

___________ *(Please Initial)*

Fees/Payments The cash fee for your initial 60-minute visit is $200 and for each therapy session thereafter is $200. Most insurance companies will pay for a portion of outpatient mental health services unless you have not met your deductible. If you have United Healthcare or UMR, the initial appointment is $127.57. 45-minute follow-up appointments are $82.80. 60- minute follow up appointments are $124.21. If you have Blue Cross, their fees are as follows: Initial appointment: $163.08., 45- minute follow up appointments are $87.58, 60-minute appointments are $116.77. If you have Aetna, the first appointment is $151.41 and 45 minute follow-up is $116.97. A 60 minute appointment is $135.57. However, their fees are subject to change. With your approval by signature, I will bill your insurance company, and have the payments sent directly to me. ***You will be responsible for paying all deductibles and co-pays in full at each visit by credit card.*** If seen in person and you pay by check and it is returned, a $35 service fee will be charged for all returned checks and future payments will need to be paid by cash or credit card. You will need to pay any collection or attorney's fees for non-payment.

___________ *(Please Initial)*

Confidentiality All information regarding the specific nature of your therapy is considered confidential, unless specified by you in writing. However, I do reserve the right to make a consultation with another therapist, psychiatrist or an attorney as needed in regard to your case. Your confidentiality is still protected. Therapists are required by law to break confidentiality and warn person(s) when a client behaves in such a way that poses a threat of physical harm to another identified person or to self. Arizona law also requires professionals to report suspected incidents of child abuse, elder abuse or neglect to the proper protective service agency. Parents are not privilege to the specifics of their child or adolescents therapy, except in cases of abuse or risk of self-harm.

___________ *(Please Initial)*

I am consenting to the use of unencrypted texting, and unencrypted email as a form of communication. I understand that there may be risks of hacking to my PHI**.** If someone hacks into the therapist's phone, computer, virtual session or email I will not hold Dr Sharon von Lentz or Crossroads Counseling liable.

___________ *(Please Initial)*

Emergencies My confidential voicemail (602-334-3776) is always available for leaving messages or texts when I am in session or out of the office. If an emergency arises when I am not available to speak with you, please call the EMPACT Help Line (480-784-1500), which provides 24-hour crisis intervention services. The emergency room of the closest hospital is also another resource in time of crisis. Phone calls are generally returned within 24-48 hours.

___________ *(Please Initial)*

Other Professional Fees which may not be covered by your insurance: Fees may include charges for other professional services such as:

- Report Writing $50 per page
- Consulting with other professionals $200 per hour
- Psychological testing with report $50 per page plus $80 for scoring
- Copies of records $50 or treatments summaries $50 per page
- Legal proceedings, including preparation time and transportation
- $200 per hour

___________ *(Please Initial)* *Generally you will be given an estimate in advance unless it is an emergency*

Patient Rights (HIPAA) HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of Protected Health Information (PHI). These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of PHI that you have neither consented to nor authorized; determining the locations to which PHI disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, and the HIPPAA Notice Privacy Form. I am happy to discuss any of these rights with you. Full HIPPA disclosure can be read at drsharonvonlentz.com. If you have a complaint, Please speak to me first so that we may resolve it. ___________ *(Please Initial)*

Consent for Treatment and Consultation

I authorize and request that Sharon von Lentz Psy.D., carry out behavioral health treatment, and/or diagnostic procedures in order to bill my insurance during the course of my care. I understand the purpose of these procedures will be explained to me upon my request and are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, it may at times be uncomfortable.

Please check Yes if you want to be one of my clients

___YES ___ NO I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions.

___YES ____ NO I understand that insurance is a contract between me, my insurance company and/or employer.

------YES ------ NO I authorize the release of any medical information necessary to process my insurance claims.

------YES ------ NO I authorize benefits to be paid directly to Sharon von Lentz, Psy.D.

-----YES ------ NO I understand that my psychologist may know someone who can help me more. If Dr Sharon von Lentz does not think that she is a good fit for helping me after 3-4 visits, I may be referred to another provider. If after 3 months, I have not improved significantly, I may be referred to another provider. If videotherapy is no longer appropriate.for me because of an emergency,. I will either see . you in the office or refer you to another provider

------YES ------- NO I can receive a copy of HIPPA and privacy practices @ drsharonvonlentz.com.

-----YES ------- NO I understand that there may be times when Sharon von Lentz, Psy.D may need to consult with a colleague or another professional, like an attorney, about issues raised by me in therapy. My confidentiality is still protected during consultation by my psychologist and the professional consulted. I give permission for Sharon von Lentz, Psy.D to consult as needed to provide professional services to me as a patient.

------YES ------ NO ------- NA To protect the confidentiality of my child as a patient, I agree as a parent to waive my right to a. copy of my child's records. I understand that Sharon von Lentz Psy.D may send records to another mental health professional.

------YES ------ NO If for some reason my case becomes a court related case, I understand court testimony or related. matters is charged at $200 per hour. This includes case research, report writing and depositions and is not covered by insurance.

------YES ------ NO I understand that Dr Sharon von Lentz does not specialize in disability cases and does not fill out forms for disability. She will provide records for your claim so another provider can fill out your forms.

______YES ______NO ***Storage Facility*** If I have not been in for therapy for 2-3 months, I give Dr. Sharon von Lentz permission to store my records in a secure storage facility

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS. IT ALSO SERVES AS AN AKNOWLEGEMENT THAT YOU ARE FAMILIAR WITH HIPPAA OR CAN RECEIVE A COPY AT drsharonvonlentz.com

Patient Name	**Printed**	**Date**
Patient Name	**Printed**	**Date**
Patient or Authorized Parent/Guardian Name	**Signature**	**Date**
Patient or Authorized Parent/Guardian Name	**Signature**	**Date**

Informed consent policy for in office & video therapy services: REQUIRED FORM

- At times, the psychologist may need to consult with another provider on your behalf. Your confidentiality is still protected at that time. If the psychologist determines that you need a higher level of care, or an area of expertise that I do not provide, then you may be referred to another provider for care. There are benefits and risks to therapy. In order to feel better, you may need to discuss difficult or emotionally upsetting circumstances. It is important to know that some sessions you will probably feel better and other sessions you may feel worse. Know that this is the path to healing and growth. If there is a report of intention / plan for suicide, plan for serious bodily harm to another person, or a report of child abuse, the psychologist is mandated to intervene for safety and your confidentiality may be breached.

- There are potential benefits and risks of video conferencing (e.g., limits to patient confidentiality) that differ from in-person sessions. Research shows that patients benefit equally from video therapy as in office visits, for most populations.

- Confidentiality still applies for telepsychology services, and neither the patient nor the psychologist will record the session without the permission from the others person(s).

- We agree to use the secure Hippa compliant video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.

- You agree to use a laptop with a webcam, iPad or smartphone during the session. Best results are typically with a laptop, newer equipment, and a strong internet signal.

- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session. Adults with children should be free of their interruptions, unless the session is with a parent and a child. Minors should have a private space free of parents/guardians unless parents/guardians come in at the beginning of the session to set up computer and update psychologist on minor's behavioral progress.

- It is important to use a secure internet connection rather than public/free Wi-Fi.

- It is important to be on time. If you need to cancel or change your video-appointment, you must notify the psychologist 24-48 hours in advance by phone, or text. It is very important to leave the reason for the cancelled appointment. Last minute cancellations will be charged at a fee of $100. Please leave a message requesting a few specific reschedule dates and times.

- This office **must always have your current phone number and address** (e.g., phone number where you can be reached) to restart the video session or to reschedule it, in the event of technical problems. Initiating video therapy from other locations from

your home address is at your own risk. If you chose to do this**, you are responsible for giving the provider the address of your location at the beginning of the session.**

- We need a safety plan in place that includes at least one emergency contact (name, phone number and address and the closest

emergency room to your location, in the event of a crisis situation. Name of facility ---
Nearest emergency room address---
____
Phone number---
:____

- We need the permission of parents or guardians (and their contact information) for minors to participate in telepsychology sessions.

- **You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.**

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS.

________________________________	____	_____________________
Printed Patient Name	**May be electronically signed**	**Date**
Printed Patient Name	**May be electronically signed**	**Date**
Printed Name of Legal Representative	**Legal Representative Signature**	**Date**
Printed Name of Legal Representative	**Legal Representative Signature**	**Date**

For Office to fill out:

Sharon von Lentz PsyD	____	___________________
Psychologist's Name	Psychologist's **Signature**	Date

AUTHORIZATION FOR RELEASE OF INFORMATION

(THIS IS AN OPTIONAL FORM)

(PLEASE PRINT CLEARLY)

Patient Name: ____ Date____________________

(First) (Last) (Middle Initial)

Birth Date: _______ /________ /_________ Age: _______ SS# ________________________ ☐ Male ☐ Female

Address: ____

(City) (State) (Zip)

Home Phone: (_______)__________________________ Cell: (_________)________________________________

I, ____, hereby authorize ***Sharon von Lentz, Psy.D*** to share and exchange information from my case record with:

Recipient Name:____

Address: ____

(City) (State) (Zip)

Phone: (_______)________________________________ Fax: (_______)___________________________________

To release, for the continuity of care and to maintain my medical record, protected health information related to any of the following,

Initial all that apply:

___ Assessments/Evaluations
___ Progress Update Reports
___ Medications
___ Treatment/Service Plans
___ Other (Specify)
___ Psychiatric/Mental Health Information
___ Probation/Parole Requirements
___ Oral Communication
___ Test Results
___ Child Abuse/Neglect
___ Diagnosis/Prognosis
___ Progress Notes

____

I understand that my protected health information may be used and disclosed to carry out treatment, for payment of services, or for health care operations to improve the quality of care by Dr. Sharon von Lentz, Psy.D. I acknowledge receipt of the Sharon von Lentz, Psy.D Notice of Privacy Practices and I understand that I have the right to review the Notice before signing this consent. I understand that any changes in the Notice are available to me upon request. I understand that this authorization is in effect for one calendar year from the date on this form. I understand that I have the right to request in writing that Sharon von Lentz, Psy.D restrict how my protected health information is used to carry out treatment, payment, or health care operations. I understand that Sharon von Lentz, Psy.D is not required to comply with my request.

I understand that I have the right to revoke in writing this authorization to release my protected health information.

_____________________________ _________________________________ __________________

Printed Patient Name | Patient **Signature** | Date

_____________________________ _________________________________ __________________

Printed Name of Legal Representative | Legal Representative **Signature** | Date

(updated 11-10-20 AB)

______________________________	____________________________________	___________________
Printed Name of Witness	Witness **Signature**	Date