319 Vine Street, #110
Philadelphia, PA 19106
www.alternativechoices.com

WELCOME

Thank you for choosing our practice. We welcome the opportunity to work with you and want you to benefit from your time here. Please read the following information before you begin treatment. If you have any additional questions, feel free to ask.

Confidentiality: All information shared in sessions is confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law. Disclosure is required by the law when there is reasonable suspicion of child, dependent or elder abuse or neglect, or when a patient presents a danger to self, to others, or to property. Disclosure may also be required pursuant to a legal proceeding. Disclosure of confidential information may be required by your health insurance carrier or managed care company in order to process claims.

Consultation: The clinicians at Alternative Choices consult regularly with other professionals regarding patient issues; however, patient names or other identifying information are not mentioned. Your identity remains completely anonymous, and confidentiality is fully maintained.

Telephone and Emergency Procedures: If you need to contact your therapist, please leave a voice mail message and your call will be returned as soon as possible. If it is an emergency and your therapist is not available please call the Crisis Intervention Hotline at (215)686-4420.

Payment and Insurance Reimbursement: Payment is expected at the time of each visit. As a courtesy to our patients, we do offer assistance in the submission of insurance claim forms.

Dual Relationships: Therapy never involves sexual or business relationships or any other dual relationship that may impair your therapist's objectivity, clinical judgment, therapeutic effectiveness or can be exploitative in nature.

Cancellations: Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for re-scheduling or cancelling an appointment. The full fee will be charged for sessions missed without such notification. Most insurance companies do not reimburse for missed sessions.

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Initial Interview Form

Name _____ Date of initial visit_____

Address _____ Phone (H) _____
_____ (W)_____
Email _____ (cell) _____

Date of birth: _____ M/F Age _____

Marital status: single living-w-partner married widowed separated divorced

Others living in household	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Highest level of education: _____

Employer:_____ Title:_____
address _____ # yrs. _____

Primary physician: _____ phone _____

Medical/health problems_____
_____
Medication: _____
Drug/alcohol use:_____
Previous treatment:_____
_____
_____

Goals: _____
_____
_____

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Financial Policy

Payment Policy: We are committed to providing you with the best possible care. Payment for services is due at the time of service. Individual sessions are 50 minutes.
Returned checks are subject to additional collection fees.
No-show fees are charged for appointments canceled or broken without 24 hours advance notice. The no-show fee is equivalent to your normal session fee.

Insurance Reimbursement: If you have medical insurance which provides coverage for out-patient mental health care, we will assist you to receive your maximum allowable benefits. We do not routinely accept assignment of benefits (get reimbursed from insurance companies), nor do we participate in managed care insurance plans (HMO's and PPO's). We have found that the extraordinary amount of paperwork required takes away from patient care.

We will be happy to help you to submit your insurance claim form for your reimbursement. Any such request must be accompanied by a completed insurance claim form.

We will gladly discuss your financial needs and answer any questions relating to your insurance. Please realize that your insurance is a contract between you, your employer and the insurance company. Your insurance company makes all final decisions regarding eligibility at the time they process your claim. If you have any concerns about coverage, you should contact them directly. We cannot be held responsible for decisions insurance companies make regarding coverage.

If your company requests a report from us in order to process your claim, we will need to receive our normal hourly fee from you for this service.

Your fee per 50 minute session is: _____. Your payment will be _____.
I have read and understand the above information and agree to the terms.

Signature _____ Date _____

I accept responsibility for payment in full for all services.
Signature:_____ Date _____

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Consent to Treatment

I, _____, give my permission and consent to Alternative Choices to provide psychotherapeutic treatment to me and /or _____, who is/are my dependent/child/children.

I understand that this practice does not provide any emergency services and I have been informed whom to call in an emergency or during weekend and evening hours.

I also understand that confidentiality will be maintained except for the following situations:

1. When the therapist is legally responsible to report incidents of child or dependent abuse, neglect, or molestation.

2. When records are subpoenaed.

3. When the therapist determines it necessary to protect the client from harming themselves or others.

Signature _____ Date _____
(Patient, or parent/guardian if a minor)

Signature _____ Date _____
(Therapist)

ALTERNATIVE CHOICES
319 Vine Street Philadelphia, PA 19106 (215)592-1333

Consent Form

YOUR PRIVATE INFORMATION IS PROTECTED BY LAW

This form is an agreement between you, _____and _____ your therapist at Alternative Choices. When we use the word "you" below, it will mean your child, relative, or other person if you have written his/her name here _____.

When we consult, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information (PHI) about you. We need to use this information here to provide treatment to you. We may also need to share this information with others who provide treatment to you, to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send it to others as needed. The Notice of Privacy Practices (NPP) explains in more detail your rights and the specific and limited ways in which we can use or disclose your protected information. Please read the NPP before you sign this Consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices we cannot treat you.

In the future we may need to change how we use or disclose your information and so may change our Notice of Privacy Practices. If we do change it, you can get a copy from our website, www.alternativechoices.com, or by calling us at 215-592-1333.

You have the right to ask us not to use or disclose certain protected information for treatment, payment or administrative purposes. You will have to tell us what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your requests.

After you have signed this consent, you have the right to revoke it (by writing a letter telling us you no longer consent) and we will stop using or sharing your information from that time on but we may already have used or shared some of your information and cannot change that.

_____ _____
Signature of patient or personal representative Date

_____ _____ Printed
name of patient or personal representative Relationship to patient

Date NPP_____ ____ Copy given to patient/parent/personal representative