



# IPG INSIGHT

PSYCHOTHERAPY GROUP

\*\*\*\*For Internal Use Only\*\*\*\*

Name \_\_\_\_\_ DX \_\_\_\_\_

Office \_\_\_\_\_ Ins \_\_\_\_\_

Today's Date: \_\_\_\_\_ Referred by: \_\_\_\_\_

**▶Patient Name:** \_\_\_\_\_

Address: \_\_\_\_\_

First Middle Last

Number Street (Apt#) City State Zip

Home Telephone: \_\_\_\_\_ Work/Cell Telephone: \_\_\_\_\_

Social Security No.: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Marital Status:  Single  Married  Domestic Partner  
 Coupled  Divorced  Widowed

**▶If patient is a minor, please complete the following section:**

Parent/Guardian Name: \_\_\_\_\_

First Middle Last

Address: \_\_\_\_\_

Number Street (Apt#) City State Zip

Parent/Guardian Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**▶Patient Medical Information:**

Patient's Physician: \_\_\_\_\_

Name City/State

Office Telephone: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Current Medications: \_\_\_\_\_

For what conditions: \_\_\_\_\_

Allergies: \_\_\_\_\_

**▶Insurance and Payor Information (credit card authorization is on last page of consent):**

Insured Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy or ID #: \_\_\_\_\_

Medical and/or Behavioral Healthcare Organization

Insurance Telephone #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Address: \_\_\_\_\_ Other Contact Info: \_\_\_\_\_

Effective Date: \_\_\_\_\_

**▶Person to contact in case of an emergency:**

Name/Relationship to patient	Address	Phone no.
1522 Katella Avenue, Suite #201 Los Alamitos, CA 90720	3662 Katella Ave, Suite #116 Los Alamitos, CA 90720	5855 Naples Plaza, Suite #302 Long Beach, CA 90803
Tel. 562 431-8822 • Fax 562 431-8875		



**Treatment risks:** Participation in psychotherapy can result in a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek treatment. Psychotherapy does involve some risks, including possible experience of intense feelings such as sadness, anger, fear, or guilt. Please remember that these experiences are natural and normal and an important part of the psychotherapy process. Sometimes in psychotherapy, clients choose to make major life decisions including decisions about family, relationships, employment, and lifestyles. Decisions made during the psychotherapy process may result from calling into question old beliefs and values that may bring about changes not originally intended. The ultimate outcome to psychotherapy cannot be guaranteed by your therapist.

**Patients who are dependents:** As the parent or guardian, you have a right and responsibility to question and understand what occurs in therapy with your child, but please remember that it is also important that your child be able to trust the therapy process. As such, your therapist will use clinical discretion as to what is appropriate disclosure of information. In particular, you can expect that the therapist will disclose information to you that is important to your child's progress and your participation in the treatment. If you are the custodial parent in a divorced relationship with your child's other parent, please provide your therapist with a copy of your court custodial order.

**Fees and insurance:** IPG fees are \$185 for the initial assessment sessions, \$135 for individual psychotherapy sessions, and \$150 for family/couples psychotherapy sessions. If you are using insurance coverage to pay for your therapy, you may still have a co-payment or co-insurance charge due. As a service, IPG can bill your insurance company directly provided you authorize the insurance payment be made directly to IPG. You are responsible to know the limits and specifics, including co-payment amounts and deductibles, of your insurance coverage. Oftentimes this information can be found in your employer's benefits summary booklet. IPG can help you clarify your benefits information and coverage.

***Regardless of your insurance coverage, you are solely responsible for any charges incurred. With most insurance companies, there are procedures you can use to appeal denied charges. If your insurance company denies payment for services, you are responsible for the charges incurred.***

**Confidentiality of information:** You have the right to a confidential relationship with your therapist. Information revealed by you during the course of psychotherapy will be kept confidential and will not be released to any agency or other person without your written permission. There are important exceptions to confidentiality that are required by law and outlined herein:

1. If you threaten to harm someone else
2. If you threaten to harm yourself
3. Where there is any suspected incidence(s) of child abuse, neglect, or molestation
4. Where there is any suspected incidence(s) of physical abuse of an elderly or dependent adult
5. Therapists must release information subpoenaed by the court as appropriate

It is important to remember that confidentiality of session material cannot be guaranteed by your therapist in a family or couples therapy situation. Please understand that each family member participating in psychotherapy has the same responsibility to maintain confidentiality for the other participating members to ensure the best chance for success.

**Appointments and cancellation policies:** Services are by appointment only. The length of an appointment is 45 minutes. Please give your therapist at least 24-hours notice for any appointments you need to cancel. Because each appointment is reserved specifically for you, it is necessary to charge a late cancellation fee of \$50 for appointments which are cancelled with less than 24-hours notice. IPG cannot bill your insurance for a missed appointment or late cancellation. You are responsible for missed appointment and late cancellation fees.



**Messages and emergency procedures:** In the case of a life-threatening emergency, please call 9-1-1. If you have a psychiatric emergency, please go to the nearest hospital emergency room and ask for the psychiatrist on duty. If you have a primary care physician, this person may also be contacted to facilitate emergency psychiatric care. If you need to reach your therapist, you can telephone the office confidential voice mail at (562) 431-8822 and leave a message for your therapist at his or her voice mail extension.

**Termination of services:** Termination of psychotherapy may occur at any time and may be initiated by either you or your therapist. Please contact your therapist if you decide to discontinue your psychotherapy so that you can schedule and meet for a final session. Termination itself can be a very constructive process and we encourage you to discuss any plans to end your treatment as soon as is necessary. If any referrals are warranted, your therapist will make them at that time.

**Your rights:** At any time, you may question and/or refuse therapeutic or diagnostic procedures or methods or request additional information regarding procedures. Please do not hesitate to discuss any concerns and/or complaints with your therapist so that we can work toward a resolution. Concerns can also be brought to the attention of the California Department of Consumer Affairs, the California Board of Psychology, and the California Board of Behavioral Sciences.

**► Please complete and sign below:**

**I consent to participation in psychotherapy services with Insight Psychotherapy Group and agree to the policies of this office as detailed in the above paragraphs. I have had the opportunity to ask questions and clarify my understanding of these policies and there are no misunderstandings or disagreements. I have read, understood, and agree to the "Notice of Privacy Practices" and have received a copy for my records.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**I authorize my insurance carrier to pay benefits associated with my care directly to Insight Psychotherapy Group and authorize the release of information necessary to coordinate benefits, treatment, and payment (including quality improvement efforts where applicable).**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**► For minor patients:**

**I am the legal guardian or legal representative of the patient and on the patient's behalf legally authorize Insight Psychotherapy Group to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.**

\_\_\_\_\_  
**Signature of Legal Guardian/Legal Representative      Date**

\_\_\_\_\_  
**Relationship to Patient**

**► IPG Therapist:**

**I have reviewed the above policies and informed consent with the patient and/or parent or guardian.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



### **Appointment and Cancellation Policies**

Psychotherapy services are by appointment only. The length of the appointment is 45 minutes. Please give your therapist **24** hours notice for any appointment you will need to cancel (leaving a voice mail notification on your therapist's extension is acceptable).

Because each appointment time is reserved specifically for you, it is necessary to charge a **late cancellation fee of \$50 for appointments which are cancelled with less than 24 hours notice. The same fee will apply if you fail to show for a scheduled appointment without calling to cancel.** If you are using insurance to pay for your psychotherapy services, please be aware that your insurance will not pay for a missed appointment or late cancel fee.

### **Understanding of Appointment and Cancellation Policies**

**I have read the above statement and understand that if I fail to notify my therapist within 24 hours that I will be canceling my scheduled appointment, or fail to show for an appointment, I will be personally responsible for the \$50 late cancellation or no-show fee.**

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**Credit Card Payment Consent Form**

▶ **Name:**

\_\_\_\_\_

First Middle Initial Last

▶ **Name on card if different:**

\_\_\_\_\_

First Middle Initial Last

▶ **I authorize Insight Psychotherapy Group to charge my credit card for professional services as follows:**

**Initial all that apply**

\_\_\_\_\_ a. All visits in the next 12 months, beginning \_\_\_\_/\_\_\_\_/\_\_\_\_.

\_\_\_\_\_ b. Recurring charges for date(s) of service \_\_\_\_/\_\_\_\_/\_\_\_\_ to  
\_\_\_\_/\_\_\_\_/\_\_\_\_, \$\_\_\_\_\_ monthly, \$\_\_\_\_\_ semi-monthly,  
\$\_\_\_\_\_ weekly, or \$\_\_\_\_\_ per visit.

\_\_\_\_\_ c. To charge my card for the balance of fees not paid for or covered by my insurance company within 180 days of the denial of payment.

\_\_\_\_\_ d. To charge my card for the balance of fees not paid 180 days from termination of service(s).

\_\_\_\_\_ e. To charge my card for any missed appointments or appointments cancelled within 24 hours for the fee of \$50.

\_\_\_\_\_ **f. I understand that a \$2.00 convenience fee (per transaction) will be added to any amount charged. IPG and/or my therapist do not keep this fee and it is paid to help maintain this service.**

▶ Type of card:  Visa  MasterCard Expiration date of card: \_\_\_\_/\_\_\_\_/\_\_\_\_

▶ Credit card number: \_\_\_\_\_ Security code: \_\_\_\_\_

▶ **Card holder's billing address for credit card statements:**

\_\_\_\_\_

Street City State Zip

▶ **Cardholder's Signature:**

\_\_\_\_\_

Signature Date