Aaron Goldner PsyD LP PLLC

Client Information Sheet

Client's Name _____ **Today's Date** _____
Age: _____ D.O.B ____/_____/_____ Social Security # _____
Street Address (include city/state/zip) _____
Reason for seeking treatment _____
_____
Referral Source_____

Client Contact Information
(Client's Cell) _____ Text? Y / N
(Home phone) _____ (email) _____
Occupation or School Grade _____
Employer or School Name _____
Address of Employer/School _____
Spouse/Partner name (Gender M F) _____

Emergency Contact Information
Name _____ Relationship to Client _____
Phone # _____ (Text? Y/N) Address_____

Parent Contact Information (only needed if Client is a minor)
Parent/Legal Guardian 1's Name _____
(Cell) _____ Text? Y/N
(Home phone) _____ (email) _____

Parent/Legal Guardian 2's Name _____
(Cell) _____ Text? Y/N
(Home phone) _____ (email) _____

Custody
If not shared/joint, who has full physical custody of the Client if a minor? _____
If not shared/joint, who has full legal custody of Client if a minor? _____

Insurance Information
Insurance Company _____
Insurance ID # _____ Group # _____
Subscriber's Name _____ Subscriber DOB _____
Subscriber SSN _____

---------- For Dr. Goldner To Complete ----------

Diagnostic Code No	Diagnostic Term

_____ _____
Aaron Goldner, PsyD LP (PLLC) Date

Aaron Goldner PsyD LP PLLC

Fee Agreement and Insurance Information

It is important that the client (or their legal guardian, if they are a minor) verifies the client's insurance coverage benefits prior to beginning treatment. Dr. Aaron Goldner is not responsible for confirming the client's insurance benefits before treatment begins. *****The party enrolled in therapy is responsible for payment for services not paid directly to Aaron Goldner, PsyD LP PLLC by the client's insurance company.*****

1. Charges for services:
    a. **If the Client has Insurance:** If the Client has a valid insurance policy accepted by this practice then the fee for services will be set by the insurance company. The Client will be responsible for any and all co-pays or obligations set by the insurance company. Client should check with the insurance company to confirm their benefits. The therapist is not responsible for ensuring Clients have coverage for services. Fees may change periodically at the insurance company's discretion. If you mistakenly believe you have coverage it may be several weeks into treatment before that fact is discovered. As a result, Client will be responsible for all sessions insurance company will not cover.
    b. **If the Client is paying privately (not using insurance).** The fee for the first therapy session (Intake session) is $200 or $ _____. The fee for each subsequent session (Regular session) is $150 or $_____. Fees may change periodically. You will be given notification well in advance of such an occurrence. Unless other arrangements are made with Aaron Goldner, payment is expected at the time that services are rendered.
2. **If you have insurance:** Insurance only covers the cost of sessions you attend. **A Late Cancelled session (one cancelled less than 24 hours prior to the appointment) or Failed Appointment (failure to appear for a scheduled session but without cancellation or notification) will result in a $100 fee that is your responsibility to pay for.**

    _____ ← Please initial here to indicate that you are aware of the 24-hour late-cancel/failed-appointment policy. Late-cancelled or failed appointments will result in a $100 fee that the Client is 100% responsible for. Insurance will not apply.

    a. If you have a deductible under your health insurance policy, all charges for your therapy are your responsibility until this deductible is met.
    b. When fees for your therapy are paid fully or in part by your insurance company, you might have an annual maximum beyond which your insurance will not pay or a deductible amount that must be met before insurance will pay. In either case, the full cost of treatment becomes your responsibility, including amounts that are part of your deductible or that have exceeded your maximums. If your insurance company pays for a portion of your therapy, the remaining portion (your co-pay) is your responsibility.
    c. Your insurance company may utilize a managed-care company which must authorize any services provided as a precondition to insurance covering these services. Discuss with your therapist whether this will apply to your therapy.
    d. Under some insurance, there is no provision for the direct payment of fees to Aaron Goldner, PsyD LP PLLC. In this case, you are responsible for paying the full fee to this practice. However, upon submission of copies of your paid invoices to your insurer, many companies will reimburse you for a portion of what you have paid. You should contact your insurance company to obtain specific information about reimbursement; this information will not be provided to anyone other than yourself or a member of your family. Dr. Goldner cannot obtain this information on your behalf.
    e. If you are bringing a child to therapy and both you and your spouse have health insurance, it is necessary to clarify to Dr. Goldner which parent's insurance will apply. In a divorce situation, the parent who brings the child for therapy is responsible to Aaron Goldner, PsyD LP PLLC for the payment of any and all charges not paid directly by insurance. This is practice policy! If a divorce decree or other legal document provides otherwise, the parent who brings the child to therapy still must pay Aaron Goldner PsyD LP PLLC but may have legal remedies for reimbursement from another party.
    f. Your insurance company will be billed starting once you give your insurance card and information. Dr. Aaron Goldner PsyD LP PLLC cannot bill retroactively for appointments. Session dates prior to notification of current insurance will be your responsibility.
    g. If it becomes necessary to put your account into collection and that action is successful, you agree to pay for the costs incurred in that action.

Client Name (please print) _____
Client Signature (**If** age 18+) _____ Date_____

*If Client is *under age 18* – **When Possible, it is encouraged that both parents acknowledge the rules governing fees and insurance by signing below.**

Parent/Guardian #1 Name (please print) _____
Parent/Guardian #1 Signature _____ Date_____

*Parent/Guardian #2 Name (please print) _____
Parent/Guardian #2 Signature _____ Date_____

Witness (Dr. Aaron Goldner) _____ Date_____

Authorization for Treatment, Consultation, and/or Therapy & Notification of Client's rights

I understand that my or my child's admission to treatment by **Aaron Goldner PsyD LP PLLC** is done on a voluntary basis. I understand and accept the consequences of treatment as explained to me. I am free to decide to accept or reject any type of treatment, including diagnosis and/or hospitalization, except as required by law, that Aaron Goldner recommends for me or my child. I understand that treatment and its attendant rights and benefits, as listed below, are assigned solely to the individual named as **The Client**, even if that individual is a minor (Under age 18).

1. **The Client** has the right to be served without discrimination as to age, sex, race, creed, color, or national origin.
2. The Client has the right to have the nature of treatment and any specific risks involved carefully explained to them.
3. The Client has the right to participate in the plans for treatment, goals at intake and throughout treatment. The treatment process will be documented in the treatment record.
4. The Client has the right to **confidentiality**. Except as required by law, no information, written or verbal, concerning the Client shall be released or requested without a dated, signed, and witnessed statement made by the Client, or their legal representative in the case of a minor Client, authorizing Dr. Goldner to do so. The statement of authorization shall indicate by name to whom, what specific information, and for what purpose this information will be transmitted, as well as under what condition the release is terminated.
5. **Confidentiality** includes the right for a Client, **including a minor Client (below age 18)**, to have information shared with the therapist kept private from parents, family members and others. In the case of a minor Client, information shared by parents may be shared with the Client at the sole discretion of Dr. Aaron Goldner. This includes the content of phone calls, emails, text, in-person discussions and any other form of communication. Doing so is legal, ethical and necessary to maintain therapeutic trust and effectiveness of the therapeutic relationship. Dr. Aaron Goldner will disclose confidential information without the consent of the Client only as mandated by law, or where permitted by law for a valid purpose such as to (1) provide needed professional services; (2) obtain appropriate professional consultations; (3) **protect the Client, psychologist, or others from grievous bodily harm or death**; or (4) obtain payment for services from a Client, in which instance disclosure is limited to the minimum that is necessary to achieve the purpose.

   _____ Parent 1 ← Please initial here to indicate that you are aware of, understand and consent to the rules of confidentiality.
   _____ *Parent 2 ← Please initial here to indicate that you are aware of, understand and consent to the rules of confidentiality.

6. The Client or legal guardian has the right to be notified if services requested cannot be provided. Each request for service shall be acknowledged by Aaron Goldner PsyD LP PLLC, and if services cannot be provided the Client or their legal guardian will be notified what other resources might be available. The Client can be discharged if services cannot be provided for the Client's condition. Dr. Goldner may refer any Client to another care provider or therapist for failure to comply with his treatment requirements. As stated above, any Client has the right to refuse treatment with Dr. Goldner.
7. The Client (or their legal guardian) has the right to communicate freely with the Client's attorney and/or private physician and have information about the Client's treatment made available to them upon Client written request/authorization.
8. The Client has the right to an individualized treatment plan and periodic review to determine the Client's progress.
9. The Client has the right to have available such treatment as is appropriate to the Client. Should Aaron Goldner PsyD LP PLLC be unable to provide an active and appropriate treatment program, the Client has the right to be discharged.
10. The Client has the right to ethical treatment by the Client's therapist according to the profession's ethical standards.
11. The Client or their legal guardian is responsible for informing Dr. Aaron Goldner of all that is essential for him to perform services and work with the Client.

Client Name (please print) _____
(If age 18+*) Client Signature _____ Date_____

If Client is *under age 18* – ***When possible, it is encouraged that both parents authorize Treatment, Consultation, and/or Therapy, and acknowledge having been notified of a minor Client's rights by signing below.**

Parent/Guardian #1 Name (please print) _____
Parent/Guardian #1 Signature _____ Date_____

*Parent/Guardian #2 Name (please print) _____
Parent/Guardian #2 Signature _____ Date_____

Witness (Dr. Aaron Goldner) _____ Date_____

Aaron Goldner, PsyD LP PLLC

Health Insurance Portability and Accountability Act Notice (HIPAA)

HIPAA is the United States Health Insurance Portability and Accountability Act of 1996. HIPAA seeks to establish standardized mechanisms for electronic data interchange (EDI), security, and confidentiality of all healthcare-related data.

HIPAA guarantees your right to see copies of your treatment records (with some exceptions), have corrections made to your health information, receive a notice that tells you about how your health information is used and shared, and decide whether to give your permission about how your information can be used or shared for certain purposes. You can also get a report on when and why your information was shared, asked to be reached somewhere other than home (within reasonable limits), ask that your information not be shared, and file complaints with your treatment provider, insurer, and/or the U.S. government.

By signing this form, you are acknowledging that you have been informed of the existence of HIPAA and its intention to provide you with protections for your privacy and health records, and have received a copy of the Notice of Privacy Practices used by Aaron Goldner PsyD LP PLLC. The components of the HIPAA rules and regulations are numerous, and you may find it helpful to know that you can learn more by visiting the official website of the U.S. Department of Health & Human Services by entering http://www.hhs.gov/ocr/hipaa/ into a web browser.

You are entitled to contact your provider, insurer, and the U.S. Department of Health and Human Services for more information. You may have rights in addition to those listed above.

By signing this document, you acknowledge that you have received the Notice of Privacy Practices for Aaron Goldner PsyD LP PLLC.

Client Name (please print) _____

(If age 18+) Client Signature _____ Date _____

If Client is *under age 18* – ***When possible, it is encouraged that both parents acknowledge the application of HIPAA to the minor client's treatment by signing below.**

Parent/Guardian #1 Name (please print) _____

Parent/Guardian #1 Signature _____ Date_____

*Parent/Guardian #2 Name (please print) _____

Parent/Guardian #2 Signature _____ Date_____

Witness (Dr. Aaron Goldner) _____ Date _____