Thank you for taking the time to complete the information below. This information is necessary to open a **confidential** record of your therapy. You may elect to leave blank at this time any information that you may prefer to discuss privately.

Name_____

Address_____

City_____ State_____ Zip Code_____ SSN_____

Home Phone_____ Work Phone_____

E-mail_____ Cell Phone_____

Date of Birth_____ Age_____ Banking Account at _____

Marital/Relational Status_____ Name of Spouse/Partner_____

Your Employer_____Occupation_____

Referred By_____ May I thank them? Yes _____ No _____

Physician_____ Address_____

Emergency Contact Person_____Phone_____

Relation to you_____

Prior therapy experience: No ___ Yes ___ Therapist:_____

Reason: _____ *Dates:*_____

Prior Substance Abuse/Alcohol Treatment: No___ Yes ___

*Name of Program:*_____ *Date:* _____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Signature: _____ Date: _____

(over)

Practice Guidelines and Policies

The following are practice guidelines and policies I have set up in an effort to efficiently manage my psychotherapy practice. This information is offered to bring clarity around mutual responsibilities for the therapeutic relationship you are entering into. There is a positive correlation between clarity in expectations and success of relationships. A helping relationship is equally influenced by such clear expectations and understanding.

Insurance Authorization and Financial Obligation: Prior to your first appointment, please verify your mental health benefits with your insurance provider. Note that most insurance plans require prior authorization for mental health services. It is your responsibility to obtain authorization for these services. Services rendered without proper authorization will be billed in full to you at a "self-pay" status.

Fees: Initial Assessment $165.00. Individual Psychotherapy $125.00 per 45 minute session. Couple/Family Psychotherapy $135.00 per 45 minute session.

Billing: I can provide you with a monthly statement of your account if requested. In most cases in which I am a participating provider, I am able to bill your insurance company directly. In other cases, which we can discuss, it will be your responsibility to submit this information to your insurance provider for reimbursement of payment for which you may be authorized. If you need to submit session information directly to your insurance company, your statement will include all necessary information to assist with filing your claim.

Payment: Payment and/or co-payments, (determined by your insurance company), are due in full at the time services are rendered. Methods of payment may include cash or check (made out to Thomas Fronczak). Payment and/or co-payment is due at time of session. Any payment/co-payment that needs to be billed will be subject to a $20.00 administrative fee. Missed session fees must be paid in full before a follow-up appointment will be scheduled. Whether services are covered or not by your insurance, you must remember that you are ultimately responsible for payment for services. I realize that temporary financial problems may at sometime affect timely payment of your account. If this should occur, I encourage you to contact me promptly for assistance in the management of your account. If your account should go unpaid and be without a payment arrangement, you will be subject to referral to a collection agency and/or legal action, as well as an additional administrative filing fee of $50.00 per incident.

Returned check and interest charge: Returned checks will be subject to a $29.00 service charge. Please note that an interest charge will be applied at a rate of 1.5% per month (18% annual percentage rate) on any outstanding balance you owe over 14 days.

Missed Appointments: I ask that if you need to change or cancel an appointment time that you kindly give **48 hours** notice by phone, as others may be able to utilize that time slot. Regardless of reason, you will be charged $85.00 for sessions canceled or missed with less than **48 hours** notice. I have 24 hour phone service with voice mail available for convenience if you need to cancel or reschedule an appointment. It is important to note that your health insurance will not reimburse for missed sessions. If there are 2 missed appointments without notice your therapy will be terminated with this office and you will be given a referral to other qualified mental health providers.

Emergency/Crisis Contacts: In the event of a psychiatric emergency immediately go to the Emergency Department of the nearest local hospital. You may dial 911 for assistance. My after hours contact number is (401) 431-2953, for **emergent situations** only. Please note professional fees ($125/hr. or prorated) apply for emergent phone contact. If I will be out of the office for an extended period of time, I will have licensed professional backup whose judgment I trust for any urgent need that may arise.

Report, Letter or Email Writing Fees: There will be a professional fee applied ($125/hr. or prorated) for reports, letters or emails reviewed or written on your behalf to other providers, agencies, or organizations. There is no fee for the initial or follow-up letters to your primary care provider around your participation in therapy or coordination of medication management issues. Please note insurance does not cover report or letter writing fees.

Social Media Policy: In an effort to protect your privacy and maintain confidentiality, I have a policy whereby I do not accept friend or contact requests from current or former clients on any social networking site (Facebook, Twitter, LinkedIn, etc). While I appreciate the positive thought behind any invitation, I believe it may blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up and I'd be happy to speak more about it with you.

I acknowledge that I have read and understand Tom's Notice of Privacy Practices and his Practice Guidelines and Policy information (available online or given at first appointment). I authorize: (1) insurance claim reimbursement to Tom Fronczak as well as (2) the release of any relevant medical information to my insurance provider to facilitate claim processing. I understand and agree that, (regardless of insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. Revised: 3/1/2016

_____ _____

Signature Date

Office: 4476 Main Street, Ste 208, Amherst, NY 14226 Phone: 401-431-2953 Email: TJFronczak@aol.com