Jennifer Pechenik, MPA, LCSW, PsyD
Licensed Psychologist

Intake Information

Please Print Clearly **THIS SHEET MUST BE FILLED IN COMPLETELY**

Date_____ Client's Social Security #_____

Client's First Name_____ Last Name_____ MI_____

Address_____ City_____ State_____ Zip_____

Telephone (Home)_____ (Work)_____(Cell)_____

Can messages be left on these telephone numbers? Yes/ No (Circle Response)

E-Mail:_____Can Dr. Pechenik send you information at this address? Yes/ No

Birthdate_____/_____/_____ Age_____ Gender F___ M ___

Marital/ Relationship Status_____
Name of Spouse/Guardian/Partner_____

Person Responsible for Payment_____
Signature of Person Responsible for Payment **X**_____ (Must be signed for services to begin)

Emergency Information

In case of emergency, contact:
Name _____ Relationship_____ Phone_____
Address_____ City_____State_____Zip_____

Current Medications:_____

Allergies:_____

_____

Doctor prescribing medications:_____

Employment Information:
Company:_____

For Current Students:
School_____/ Grade_____

Insurance Information

Name of Insurance Company_____

Primary Insurance ID #_____

Co- Pay Amount (Please refer to your Insurance Card) _____

Insurance Benefits

I authorize Jennifer Pechenik, MPA, LCSW, PsyD, to obtain insurance benefits, submit claims and receive payments of mental health benefits on my behalf. By choosing to use insurance for mental health services, Jennifer Pechenik, MPA, LCSW, PsyD, may be required to release certain information to the insurance company at their request. Information which may be requested includes: types of services, date/ time of services, diagnostic information, treatment plans, progress in therapy and at times a summary of treatment. If it is the case that my insurance company utilizes a managed care company, Jennifer Pechenik, MPA, LCSW , PsyD, may need to discuss my treatment with a case manager. I understand that this may occur and authorize Jennifer Pechenik, MPA, LCSW, PsyD, to comply with the requests of my insurance company.

Client's Signature_____ Date _____

Parent/ Guardian Signature_____ Date _____

Reason for appointment_____

Any additional Information you would like to provide_____

Jennifer Pechenik, MPA, LCSW, PsyD
Licensed Psychologist
o
Consent to Treatment and Recipient's Rights

Client_____ Date_____

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

I, _____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above. Further, I consent to have treatment provided by Jennifer Pechenik, MPA, LCSW, PsyD, Licensed Psychologist.

The Process of Therapy: Participating in therapy can result in numerous benefits, including improving interpersonal relationships and resolving the concerns that led you to seek therapy. Working towards these benefits requires active involvement, honesty and openness on your behalf. While therapy is effective for many people and often leads to significant and lasting changes, there are some risks involved. Therapy can bring up undesirable feelings and subjects. During treatment we will work on the therapeutic process and agree upon objectives and goals of therapy. I am likely to use various therapeutic approaches that include, but not limited to, cognitive-behavioral interventions, psychodynamic, existential or psychoeducational approaches. If you have any questions about any of the procedures used in the course of your therapy, please ask.

Termination: After the initial sessions, I will assess if I can be of benefit to you. I do not accept clients who in my opinion, I cannot help. In such case, I will give you a referral. If I assess that I am not effective in helping you reach therapeutic goals, I will discuss this with you, and if appropriate terminate treatment and/or make an appropriate referral for you. You have the right to terminate therapy at any time.

If you do not attend scheduled sessions and do not maintain contact with me, I will assume that you have terminated therapy and my office will not contact you unless you have an outstanding financial issue.

Client Notice of Confidentiality: The confidentiality of patient records maintained by Dr. Pechenik is protected by HIPAA, Federal and/or State law and regulations. Dr. Pechenik may not say to a person outside the Office that a patient is a client of the office or disclose any information identifying a patient unless: 1) the patient consents in writing, 2) the

disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation 4) the law requires disclosure, such as in the case of child or elder abuse or when court ordered to disclose information.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the Center, against any person who works for the program, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

If any client presents as a danger to self or others, and/ or there is suspected child or elder abuse, Dr. Pechenik, as required by law, will contact the appropriate authorities and file reports as required by law.

It is Dr. Pechenik's duty to warn any potential victim, when a significant threat of harm has been made.

In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns.

Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not clinical information.

Scheduling of Sessions

The frequency of your session will be based on your needs and your therapy goals. Each session is 50 minutes in duration. Sessions for couples may require extended time and you will be advised in advance. Once an appointment has been scheduled, that time has been set aside for you. Therefore, if you need to change an appointment, you are required to provide 24 hours of advance notice if you must cancel the session. The only exception if there are circumstances beyond your control and that will require agreement between you and this therapist. Sessions that are cancelled in less than 24 hours and do not meet criteria for an "emergency" will result in your full payment for that session. The payment for any missed session that does not meet the aforementioned criteria of "emergency" will be the patient's responsibility and must be paid in full prior to the next scheduled session.

Professional Fees

My hourly fee is $120 for clinical sessions (50 minutes). If you are using health care insurance and I am on your provider panel, I will honor the contracted reimbursement rates for your therapy sessions. Other services outside of the aforementioned clinical hour such as report writing, telephone conversations lasting longer than 15 minutes, preparation of records or treatment summaries, and time spent performing other clinical services, will be billed at the above cited hourly rate. I will pro-rate the cost if I spend less than one hour. Co-payments must be made in full each session.

Please be advised that "other services" as noted in the above paragraph do not include any requests made by you the client or other parties that is associated with civil, criminal, or any other legal matters. If Dr. Pechenik is retained for any forensic services, said services must be agreed upon by Dr. Pechenik and a separate agreement will be signed by the appropriate parties.

Insurance Reimbursement

Please read your health insurance plan and the coverage you are entitled to. If I am submitting a claim on your behalf, your signature on this form permits me to release information needed for billing purposes.

Insurance Benefits

Your signature on this document authorizes Jennifer Pechenik, PsyD to submit claims and receive payments of behavioral health benefits that you have received. By choosing to use insurance for mental health/ behavioral services, Jennifer Pechenik PsyD, may be required to release certain information to the insurance company at their request. Information which may be requested includes: types of services, date/ time of services, diagnostic information, treatment plans, progress in therapy and a summary of treatment or the entire record. It if is the case that the insurance company you use also uses a managed care company, Jennifer Pechenik, PsyD, may need to discuss your treatment plan, and other issues with a case manager. By signing this document, you understand and consent to the aforementioned and authorize Jennifer Pechenik, PsyD to comply with the requests of the insurance company.

Payment for Services

Payments in any form, including co-payments are due on the day of your session. If you are paying with a credit card, the name of the business on your receipt will be "Todays World Consultants" and the service will be identified as "professional services". I cannot assure confidentiality if you use a credit card as your credit card company will receive the above mentioned information. Your signature on this document authorizes Jennifer Pechenik, PsyD/ Today's World Consultants, to use your credit card for the payment of services rendered herein.

E-Mail and text messaging

E-Mail and text messaging should not be used to contact me if you are in an emergency situation or if you want to share confidential information. These types of communications may not be confidential due to issues inherent with internet use. Dr. Pechenik will not be responsible for any breach in confidentiality if you choose to use these methods of communication for routine communication such as scheduling appointments.

Telephone Policy and Emergency Procedures

If you need to contact me between sessions, please leave a message on my voice mail and your call will be returned as soon as possible. When possible, phone support between sessions may be available. However, telephone calls will be billed accordingly: at one half the client's rate after 15 minutes and at full rate after 30 minutes. If an emergency arises and you are in crisis and you cannot wait for a return call within 24 hours, please either go to the local emergency room or call 911 for immediate assistance.

Please be advised that I am a sole practitioner and I am not affiliated with any of the other professionals in the office suite.

I permit a copy of this authorization to be used in place of the original.

I consent to treatment and agree to abide by the above stated policies and agreements.

_____ _____

Client's Signature Date

_____ _____

Parent/ Guardian's Signature Date