Suzanne R. Benko, MFT, APC

CLIENT INFORMATION

Date___________________________ Referred By:_______________________________________

Patient Information

Name____ Gender ____________________Age______

Address____

City___________________________________ State_____________ Zip________________________

Home Phone_______________________________ May I leave a message? _____________________

Cell Phone _________________________________Which is your preferred contact? ______________

Email Address ____

Date of Birth______________________ Social Security #_____________________________________

Relationship Status (If under 18 years old, include this information on your parents)

Spouse/Partner/Parent Name(s) ____

Married_____ Committed Relationship _____ How Long? _____ Living Together _____

Single _____ Separated_____ Divorced _____ Widowed _____

Children/Siblings

1. ___________________________ _______ 4. ___________________________ _______
name age name age

2. ___________________________ _______ 5. ___________________________ _______
name age name age

3. ___________________________ _______ 6. ___________________________ _______
name age name age

Anyone else living in the home?

Name__________________________________ Relationship ____________________________
Is someone other than patient responsible for this account? No ____ Yes ____
If so, please complete the following:

Name ____ Phone ___________________________

Address____

Emergency Contact

Name __________________________________ Relationship ______________________________

Phone __________________________________

Insurance Information

Please provide all pertinent information regarding your insurance coverage. If you have coverage by more than one carrier, supply information for both carriers. Please list all numbers as shown on your insurance card. Please check your insurance policy regarding waiting periods, deductibles, or pre-existing clauses. IF YOUR COVERAGE IS CONTINGENT UPON A DOCTOR'S REFERRAL, IT IS YOUR RESPONSIBILITY TO OBTAIN THE NECESSARY REFERRAL.

Primary Carrier__________________________________

Address____

____
City State Zip

Phone Number__________________________________

Insured____

Relationship to Patient_____________________________

Insured's I.D. Number_____________________________

Group #____

Insured's SS#____________________________________

Insured's Date of Birth____________________________

Insured's Employer________________________________

Effective Date____________________________________

Authorization # ___________________________________

Co-Pay Amount ________ # sessions per year _______

Secondary Carrier__________________________

Address___________________________________

____
City State Zip

Phone Number_____________________________

Insured____________________________________

Relationship to Patient_______________________

Insured's I.D. Number________________________

Group #___________________________________

Insured's SS#_______________________________

Insured's Date of Birth_______________________

Insured's Employer__________________________

Effective Date_______________________________

Authorization# ______________________________

Co-pay Amount _______# sessions per year _______

I do _____ do not _____ have insurance coverage by a secondary carrier.

____ _________________________________
Signature of Patient or Authorized Person *Date*

In order for us to submit a claim for payment for the services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

I hereby authorize release of information necessary to file a claim with my insurance company and ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE PROVIDER INDICATED ON THE CLAIM. I understand I am financially responsible for any balance not covered by my insurance carrier. A copy of my signature is as valid as the original.

____ _________________________________
Signature of Patient or Authorized Person *Date*

Medical Information

Physician's Name____ Phone _____________________

Date of last physical exam (approx) ________Medical Conditions, Illnesses, Surgeries _______________

____

Current Medications ____

Previous mental health treatment:

Counseling/therapy ( ) yes ( ) no Approx. date ____________

Name of therapist(s) ____

Reason for treatment ____

Psychiatric medications ____

Substance abuse treatment? ____

Family history of substance abuse or psychiatric problems ______________________________

____

Please give a brief statement of current problems and reasons which bring you to therapy at this time.

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Education/Employment

If you are currently attending school:

Name of school ____

Grade ___________________________ Approximate GPA _________________________

If you have completed school:
What was your highest grade or degree you achieved? ______________________________

Employed by _______________________________________How long? _____________________

Title/Position ____

Confidentiality

All personal information is confidential, including the fact that you are a client here. We conform to federal and state laws regarding therapist/client confidentiality. No records of information will be shared with anyone without your expressed written permission to do so. Exceptions to this policy as we are mandated by law to report include the following:

1. If you threaten grave bodily harm or death to another person or yourself;
2. If a court of law issues a legitimate subpoena;
3. If child abuse, sexual abuse, or child neglect is suspected;
4. If physical abuse is suspected with a person 65 years or older;
5. If physical injury, abuse and/or assaultive behavior toward a spouse is suspected.

Financial Agreement

Each of our sessions is scheduled to last fifty (50) minutes. You will not be charged for a session if you cancel your appointment at least twenty-four (24) hours in advance. IF YOU FAIL TO KEEP AN APPOINTMENT OR DO NOT CANCEL WITHIN TWENTY-FOUR (24) HOURS OF THE SCHEDULED APPOINTMENT TIME, YOU WILL BE CHARGED THE FULL SESSION FEE.

I am available to return calls during the day and evening hours. However, in case of an emergency after those hours, you are asked to call 911 if you need immediate attention. If telephone contact is required frequently or for extended periods of time, you may be charged a full session fee.

IT IS CUSTOMARY TO PAY FOR SERVICES AT THE TIME OF EACH SESSION. Payment for services can be made by cash, check, or credit card (VISA or MasterCard). Medical insurance billing is provided by my office as a courtesy only. YOU ARE RESPONSIBLE FOR YOUR ACCOUNT. If payment in full is not possible at the time of service, please discuss arrangements for payment BEFORE your session.

Although I will file insurance claims on your behalf with your insurance carrier, it is important for you to remember that YOU CARRY THE INSURANCE COVERAGE AND PAYMENT FOR SERVICES IS ULTIMATELY YOUR RESPONSIBILITY. If services were rendered to you, then you are responsible for payment of your account regardless of the amount your insurance covers. If your account becomes delinquent, you may be responsible for reasonable attorney's fees, court costs, collection agency costs, and interest at 1.5% per month. For accounts that are past due and delinquent over 90 days, a $25 monthly late fee will be applied to the outstanding balance on each monthly billing cycle.

FEE SCHEDULE:

Service	Fee
New Outpatient Assessment and Evaluation	175.00
Individual/Family/Couple Therapy	150.00
Group Therapy (90 minutes)	75.00
Hospital Individual/Family Therapy	200.00
Forms, letters, reports (prorated 50 minutes)	150.00

I, the undersigned, have read this letter of financial agreement and agree to its terms and conditions.

____
Client   Date

____
Client   Date

____
Therapist   Date

CREDIT CARD INFORMATION AND AUTHORIZATION
(To be completed even if sessions are to be paid by cash, check, or insurance)

I hereby authorize Suzanne R. Benko, MFT, APC to charge my counseling session fees to the account shown below. I understand that I will be charged the full session fee if I do not cancel within twenty-four (24) hours of the scheduled appointment time.

____ VISA

____ MASTERCARD

Name on Card __________________________________ Billing Address Zip Code ____________

Account Number ____

Expiration Date _______________ V Code ______________ (3 digit code on back of card)

Cardholder Signature ____