Lund & Strachan
Evaluations ■ Mediation ■ Psychotherapy
Mary Lund, Ph.D., Clinical Psychologist #PSY8995 ■ ■ Angus Strachan, Ph.D., Clinical Psychologist #PSY8929

INTAKE FORM

BASIC INFORMATION:

Therapist you are here to see: _____

Your Name _____ Date _____/_____/_____

Home Address (including zip code): Email Address: _____

_____

_____

Home # (_____)_____ Work # (_____)_____

Cell # (_____)_____ Fax # (_____)_____

Birth Date _____/_____/_____ SSN _____-_____-_____

FAMILY COMPOSITION:

(List yourself and other members involved in treatment)

Name	Age	Birth Date	Birth Place	Occupation or Current School

Other important addresses and phone numbers (e.g. other parent, therapist, attorney):

_____

_____

_____

_____

_____

PATIENT AGREEMENT AND NOTIFICATION

This document contains important information about my professional services and business practices. Please read it carefully. It explains many of your rights and responsibilities and will represent an agreement between us, unless it is amended or terminated in writing.

PROFESSIONAL SERVICES
Treatment may include discussion of issues that are uncomfortable for you. While I am using my best professional judgment for your well-being, I cannot guarantee that you will obtain the results you seek. You have the right to challenge any aspect of the treatment I recommend. If you believe I have mismanaged your treatment or your privacy please discuss this with me and you may also report any concerns you have to the Board of Psychology at 800-633-2322 and/or the U. S. Department of Health and Human Services at 877-696-6775.

CONFIDENTIALITY
In general, the confidentiality of all communications between a patient and a psychologist is protected by law and I can only release information about your treatment to others with your written permission. However, there are some situations in which I am legally entitled or even required to release patients' protected health information without their authorization. To improve your treatment, I can release this information so I can consult with other professionals. Unless you instruct me otherwise, I will not tell you when I have these consultations. If applicable, I may release information to your insurance company to obtain authorization for treatment, payment or for other purposes, such as for quality improvement programs. In these cases, I will release only the minimum information necessary to accomplish the specific purpose for which the information was requested. In some situations, I can also be compelled to release patient records by the courts and by the Board of Psychology.

In the following situations, I must take action to protect people from harm, even though that requires revealing some information about a patient's treatment. If I believe that a child, an elderly person, or a disabled person is being abused, I must file a report with the appropriate agency. If I believe that a patient is threatening serious bodily harm to themselves or to another, I am required to take protective actions which may include contacting authorities, family members or others who can help provide protection. I will inform you of these reports.

The standards of my profession require that I record and maintain appropriate treatment records. You are entitled to request a copy of any protected health information or any communication from me in a variety of means and locations. You have the right to request that your information be amended or restricted from certain uses and disclosures. While I will seek to honor your requests, I may decide that it is not prudent for me to agree to your requests.

CONTACTING YOUR THERAPIST
Due to our work schedule, we are not immediately available by telephone. While we are usually in the office between 10am and 5pm, the therapists here at Lund & Strachan will not answer the phone. Our telephone is answered by our assistants or by voice mail. We make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform us of some times when you will be available. If you are unable to reach us and feel that you can't wait for us to return your call, contact your family physician or the nearest emergency room and ask for the psychologist on call. If you feel that you need immediate assistance or there is a life-threatening emergency, please call 911 or your local police. If we will be unavailable for an extended time, we will provide you with the name of a colleague to contact, if necessary.

FEE POLICIES AND PROCEDURES

1. Your fee will be negotiated between your therapist and you. Periodically, therapists increase their fees and will discuss any change with you.

2. You may be asked for a deposit and billed monthly for services during the month. If not, payment is expected at the time of your session.

3. You may pay by check, credit card or cash. Please make checks payable to "Lund & Strachan", and give to the administrative staff before your session.

4. We do not bill for insurance reimbursement. Statements will be issued once a month. If you are in psychotherapy, these statements should have all the information necessary for you to submit to your insurance carrier. Please inform your therapist if you wish to do this.

5. We will ask you for authorization for credit card payment of any fees not paid at the end of a calendar month or within one month of receipt of the statement. In the event there is any problem with collecting fees, we will charge interest of 1% per month on the outstanding balance. In the event we must incur costs to collect fees, those costs will be the responsibility of the client.

6. If you find an error in your statement, informing us in writing will help us deal most quickly with your concern.

7. Cancellation Policy: If you need to cancel or reschedule an appointment, please call us as soon as possible and not less than 48 business-day hours in advance to avoid a charge (i.e. canceling a Monday appointment on Friday is not sufficient notice). If you do not cancel at least 48 business-day hours in advance, you will be responsible for the fee for the session. We have this policy because a time commitment is made to you and is held exclusively for you.

8. If the psychotherapists involved in this case are deposed or called to testify in court on any issue regarding this case, they will be treated as expert witnesses, payment will be made seven (7) office days in advance to schedule their testimony time (a minimum of a half-day with no on-call), and they will be paid their hourly fee for the testimony time plus preparation and travel time needed for their testimony.

9. By engaging in treatment you are agreeing to pay the fee for each 50-minute session at the time of service. If it is necessary for me to make phone calls, review documents or write documents as part of my services to you, those services will be charged to you at the same rate as for direct treatment.

Your signature indicates that you have received a copy, read, understood, and are willing to abide by the above agreement.

_____
Client Name

_____ _____
Client Signature Date

_____
Therapist Name

_____ _____
Therapist Signature Date

Patient Information

Your Name: _____

Therapist's Name: _____

Hourly Fee: $ _____ Date of First Session: _____/_____/_____

Send Monthly Statement? ____ Yes ____ No

Person or Persons Responsible for Payment:

Name: _____ % ____ Name: _____ % ____

Special Billing Instructions or Arrangements (e.g. deposits or alternate address):

_____
_____
_____

Please provide your credit card information below. Your card will be charged automatically at the end of each month for services rendered which have not been paid. Please check one:

__ I will pay by the session with a check or with my credit card. Please charge any unpaid charges to my account at the end of each month.

__ Please charge my credit card at the end of each month.

I, the undersigned, have read the above fee policies and procedures and agree to abide by them. I agree to authorize payment for any fees outstanding at the end of any month on the following credit card (Master Card or Visa):

_____ _____
Credit Card Number Expiration Date

_____ _____
Name (printed) Name (signed)

If you want to submit your bills to an insurance provider, please complete the following information:

_____ _____/_____/_____
Patient Name Date of birth

For Therapists only: Diagnosis for insurance: _____

Procedure: Individual Therapy Family Therapy Mediation Consultation

Other: _____