Mary DuParri, MA, LPC

Office Use Only: DSM
Axis I: _____
II: _____
III: _____
IV: _____
V: GAF_____

ADULT INTAKE

NAME: _____ AGE: _____

SSN: _____ BIRTHDATE: _____ GENDER: M F

ADDRESS: _____
CITY STATE ZIP

HOME PHONE: (____)_____CELL PHONE: (____) _____

EMPLOYER: _____ WORK PHONE: (____)_____

SPOUSE NAME: _____ BIRTHDATE: _____

SSN: _____EMPLOYER_____WORK PHONE (____)_____

INSURANCE INFO: (attach copy of insurance card)

Insurance Co: _____ Policy No: _____

Insurance Group No: _____ Insurance Phone No: __(___)_____
(Mental Health)

Name of Insured: _____ SSN of Insured: _____

Address of Insured (If different from client's): _____

(Include city, state & zip) _____

Employer of Insured: _____ Birthdate of Insured: _____

REFERRED BY: ☐ **Physician/Counselor** ☐ **Friend/Family**

Web: ☐ **maryduparri.com** ☐ **Yellowpages.com** ☐ **Psychologytoday.com**

☐ **Yellow Pages** ☐ **Other _____**

MAY I THANK HIM/HER? ☐ **Yes** ☐ **No** **Referral Name: _____**

I hereby authorize the release of any medical or other information reasonable or necessary to process claims to my insurance company. I also hereby authorize payment of medical benefits from my insurance company to Mary DuParri, MA, LPC for services provided.

_____ _____

Signature of Responsible Party **Date**

FULL PAYMENT OR CO-PAYMENT IS DUE AT THE TIME OF EACH VISIT.
MAKE CHECKS PAYABLE TO MARY DUPARRI.

EMERGENCY CONTACT: _____ PHONE: _____

RELATIONSHIP: _____

CHILDREN:

Name	Age	Natural	Adopted	Other
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

OTHER INDIVIDUAL/S RESIDING IN HOME:

_____ _____

PHYSICIAN NAME: _____

Address: _____

City State Zip

Phone: (_____)_____ Date of Last Physical Check-up: _____/_____/_____

Medical Problems:_____

MEDICINE(S) CURRENTLY TAKING: _____

ANY HISTORY OF ALLERGIES (explain): _____

PREVIOUS PSYCHOLOGICAL HELP: Yes_____ No_____

Therapist Name: _____ Phone: (____)_____

Psychiatric or Psychological Hospitalization: Yes_____ No_____

Where? _____When? _____

CURRENT TOBACCO USE: _____

CURRENT NON-PRESCRIPTION DRUG USE:

Daily Amt: _____Weekly Amt: _____Monthly Amt: _____

CURRENT ALCOHOL USE:

Daily Amt: _____Weekly Amt: _____Monthly Amt: _____

Mary DuParri, M.A., L.P.C.
INFORMATION AND POLICIES

Confidentiality
The privacy of your therapy and counseling is considered to be of the utmost importance to your therapist and staff. There are times, however, when information must be shared with others. These are:

1. **Insurance –** A medical or psychiatric diagnosis is required in order to justify payment.
2. **Managed Care –** All HMO's, most POS' and some PPO's require a detailed treatment plan before authorizing additional sessions beyond the original authorization. A typical Treatment Plan contains:
    a. A statement of the problem for which you sought treatment;
    b. Your psychiatric diagnosis;
    c. Your symptoms to justify the psychiatric diagnosis;
    d. Your alcohol or drug use;
    e. Your history of previous mental health treatment;
    f. Your current medications;
    g. Your treatment goals;

    Your managed care plan usually requires us to keep your primary care physician informed of your treatment.
3. **Legal and Ethical Issues –** Missouri Law requires therapists to report any suspected cases of child abuse to the Division of Family Services. Whenever a therapist has concerns that you may present a danger to yourself or others, legal and ethical standards require that steps be taken to ensure the safety of those in danger. Most of the time, this can be done within the privacy of the treatment room. However, there are occasions when your family, your doctor, hospital, the potential victim, or the police must be notified.

Fees and Payment – A full session is 45-50 minutes. The fee is $110.00 per session. Payment must be made at the time of service. We accept cash or checks. We will provide you with a receipt that you can use for insurance reimbursement. In the case of minor children, the parent bringing the child in for treatment will be held responsible for payment at the time of service. THERE ARE NO EXCEPTIONS TO THIS POLICY. Unpaid balances over 120 days may be turned over to a collection agency.
If you are a member of a managed care program, co-payment and/or deductible must be made at the time of service. If your program requires pre-authorization, you need to supply the necessary information to us prior to your visit.
Consultations Outside the Office-The fee for consultations outside the office is $150.00 per hour.

Cancelled and Missed Appointments – An appointment is reserved for you. To cancel or reschedule, you must call the office at least 24 hours in advance to avoid a Missed Appointment Fee. The Fee is $60.00 for the first missed appointment and $110.00 for each missed session thereafter. Repeated missed appointments or late cancellations may result in your therapy being cancelled.

Telephone Contacts – Making or changing appointments, discussing bills, etc., can be handled by leaving a message on my voice mail. Therapy on the telephone will be charged our standard fee of $110.00 per 45 minutes, or a minimum of $25.00 for each clinical call of less than 15 minutes. There is no charge for calls for administrative purposes.

Preparation of Written Documents – Preparation of reports, clinical summaries and letters **requested by you** will require a fee based on the time spent in its preparation. The minimum fee is $25.00, for reports taking less than 15 minutes preparation time.

Termination of Therapy - The therapy process is a combination of support and challenge. When you are ready to leave counseling, for whatever reason, I want to help you leave well and that works best if you give me advance notice. Several weeks is sufficient, although some long-term clients may give several months notice. When leaving is handled this way it turns out to be a productive time in therapy for my clients.

In case of emergency, call me at 314-607-0132. This number is on my 24-hour voice mail message. If I am away from the area I arrange for a colleague to handle emergency calls, and give that person's name and phone number on my voice mail as well as information on when I will return. In life-threatening emergencies, you should report to the nearest hospital emergency room.

Colleagues -All psychotherapists and professionals in the offices at 14323 South Outer Forty, Suite 512 S, Chesterfield, MO 63017 are solo practitioners who operate independently and not as a group practice. Each maintains separate professional and business records and assumes no liability for the services or business practices of other professionals in the office. The terms of all professional, business and financial agreements are between the client and the individual psychotherapist.

I have read and understand the above information and agree to these policies. I understand I am responsible for all charges regardless of insurance coverage. I agree to receive psychological services and I authorize release of information to my managed care company and/or my insurance company necessary for reimbursement.

_____ _____
Client's Signature Date

Consent for Uses and Disclosures of Protected Health Information

This is an agreement between me, _____ (print client's name), and Mary DuParri, MA, LPC.

By signing this Consent form, I consent to the use and disclosure of my protected health information by Mary DuParri to carry out treatment, payment, or health care operations. Federal law requires my consent prior to using or disclosing my protected health information to carry out treatment, payment, or health care operations.

This consent is voluntary. I may refuse to provide the requested consent, but I cannot be treated unless I provide the requested consent.

I have the right to review Mary DuParri's "Notice of Privacy Practices for Protected Health Information" prior to signing this Consent. I should refer to the Notice of Privacy Practices for a more complete description of the uses and disclosures covered by this Consent.

☐ I acknowledge receipt of Mary DuParri's Notice of Privacy Practices dated 04/14/2003.

(please initial)

Mary DuParri reserves the right to change the privacy practices described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices from her website at www.maryduparri.com.

I have the right to revoke this Consent at any time by notifying Mary DuParri. My revocation must be in writing and is effective except to the extent she has acted in reliance on my prior Consent. She may decline to continue treating me if I revoke my Consent.

I have the right to request that Mary DuParri restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. She is not required to agree to a requested restriction, but, if she does agree to a requested restriction, the restriction is binding on her.

Written revocation of this Consent or any other matters regarding your treatment should be directed to:

Mary DuParri, MA, LPC
14323 South Outer Forty
Suite 512 S
Chesterfield, MO 63017

_____ _____

Signature of client or client's personal representative Date

_____ _____

Printed name of client's personal representative Relationship to client

_____

Mary DuParri, MA, LPC