JPA Center for Integrative Health, LLC
601 Summit Avenue
Jenkintown, PA 19046
Phone: 215.885.1252
Fax: 215.885.1310

Brigette Potgieter, LCSW
Gayle D. Crespy, Psy.D.
Joanne Kaminski, Psy.D.
Joseph DiCondina,Psy.D., LPC

In an effort to complete your file, please complete this form.

Client Name____ Sex_____________ DOB____________
Address_______________________________________ City_______________ State______ Zip___________
Home Phone_______________________ Ok to leave message? Yes_____ No_____
Work_______________________________ Ok to leave message? Yes_____ No_____
Cell_________________________________ Ok to leave message? Yes_____ No_____
Email____
Preferred method of communication:____
Would you like to receive: Text communication from therapist: Yes_____ No_____
Email communication from therapist: Yes___ No____
Emails on general JPA information: Yes_____ No_____

Marital Status: Minor___ Single___ Married___ Divorced___ Widowed___ Separated____
Employment: Full Time_____ Part Time_____ Unemployed____ Disability_____ Minor____
Employer Name____
Employer Address____
If Student: Full Time_____ Part Time_____ School Name____________________________________

Referred By: ____
Family Dr./Pediatrician____

Responsible Party Name____ DOB______________
SS#____ Relationship to Client__________________________
Address_______________________________________ City_______________ State______ Zip___________
Home Phone_______________________ Work______________________ Cell_________________________
Employer______________________________________ Address_____________________________________

Primary Insurance Information - Must be fully completed in order to bill insurance:
Name of Insured__________________________________ Relationship to Client__________________
Insured's DOB___________________ Insured's SS#____
Insurance Company Name____________________________________ Phone_______________________
Address____
ID#_________________________ Group#________________________ Deductible_____________________
Coverage for Outpatient Psychotherapy: Yes___ No___ Max. Benefit Amount___________
Are you covered under your: Basic Plan____ Major Medical Plan____

Secondary Insurance Information:
Name of Insured__________________________________ Relationship to Client__________________
Insured's DOB___________________ Insured's SS#____
Insurance Company Name____________________________________ Phone_______________________
Address____
ID#_________________________ Group#________________________ Deductible_____________________
Coverage for Outpatient Psychotherapy: Yes___ No___ Max. Benefit Amount___________

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Client Agreement

Thank you for choosing our services. This document is designed to ensure that you understand our professional relationship. Please read it carefully.

Treatment Agreement

I am a Pennsylvania licensed clinical provider, professionally trained and experienced. I believe that the work required to achieve a successful outcome is shared by you and me, as your therapist. Your needs and goals will determine the number of therapy sessions required. As a client, you have the right to terminate the therapeutic relationship at any time. I urge you to discuss with me if you seek to terminate therapy prior to your treatment goals being met.

Confidentiality & Patients' Rights

Confidentiality is your expectation that the information you disclose to your therapist will be kept private, including the fact that you are a client at all. As a general rule, outside of peer supervision, your therapist will not disclose information regarding a client unless authorized to do so by the client in writing. One exception to this is if outside services are employed to collect past due accounts; by signing this form you give permission for such disclosure if necessary. There are also legal exceptions to confidentiality; these are described in The Health Insurance Portability and Accountability Act. HIPAA is a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information used for the purpose of treatment, payment, and health care operations. Further information can be found here: http://www.hhs.gov/ocr/privacy/hipaa/npp_fullpage_hc_provider.pdf.

Please understand that all files are kept confidential. Your written consent is required for any release of information. There are important exceptions to confidentiality that are legally mandated. Exceptions include: (1) If your therapist believes the client intends to harm him/herself or someone else; (2) if your therapist suspects child abuse, elder abuse, or neglect; and, (3) if subpoenaed and ordered to share confidential information.

Payment Policy

I agree to provide psychotherapy services to you for a fee. *Fees or co-pays are required at the beginning of each session.* Should you have mental health insurance, you are responsible for any portion of the session fee (beyond co-pay) that your insurance provider does not cover. I do not extend credit/account for session fees. If a session is fee is not provided at the time of the session, payment needs to be remitted prior to the next scheduled appointment.

I accept cash or check. A service charge will be assessed for any returned check.

Please note that insurance companies require information about symptoms, diagnosis and treatment in order to reimburse services. By using insurance, you permit me and JPA Center for Integrative Health (JPA) to communicate confidential information to your insurance company. Please remember that neither I nor JPA have control over, or responsibility for confidentiality procedures employed by other parties.

Cancellations/Office Hours

In the event that it will not be possible for you to keep that appointment, **please provide 24 hours notice by calling me at 215-885-1252.** Please understand that by making an appointment, I reserve that time for you. Late arrivals will not be offered extended time.

If I do not receive sufficient notice of cancellation, you will be responsible for the full cost of the session.

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Emergencies

JPA is an outpatient setting and therefore cannot assume responsibility for a client's day-to-day functioning, as some more intensive treatments are designed to do. In the case of an emergency, when a client and/or parent fears the client will harm him/herself or another, **call 911 or go to your nearest emergency room, as this is not an emergency or crisis facility.**

Local Area Crisis Hotlines:
Montgomery County: 1-888-HELP-414 and 1-800-237-4447
Philadelphia: 215-951-8300
Bucks County: 1-877-435-7709
N. Delaware County: 610-352-4703

Please be advised that should your child, under the age of 14, be in session with me, it is necessary for you, as the parent/guardian, to remain in the waiting area for the duration of your child's session.

In the case of an emergency, it may be necessary for me to contact a member of your family. Please provide your emergency contact information on this following page.

Emergency Contact

Name of contact____Relationship to client____________________

Contact phone ____________________________________or ____

By signing this form, you are consenting to your therapist contacting your emergency person should she deem it necessary to ensure your (or your child's) safety.

____

Receipt and Acknowledgment of Client Agreement

My signature represents that I have read and understand the Client Agreement. I have been given the opportunity to ask for and receive clarification on any/all of the conditions defined in this agreement.

Signature of Client (14yo+) ____Date_________________

Signature of Parent/Guardian____Date_________________

_______Patient/Client Refuses to Acknowledge Receipt

Signature of Provider____Date_________________

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JPA Financial Policy

Thank you for choosing JPA Center for Integrative Health, LLC, where it is our primary goal to ensure that you receive the utmost in therapeutic services. We hope that you understand that our financial policy is a necessary part of assuring that the financial resources needed to maintain this office for you and the community are preserved. Therefore, we ask that all responsible parties read and sign this Financial Policy prior to your first session.

PAYMENT FOR SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED. We accept cash or checks. We are happy to process your insurance claims for any carriers with which we are able to do so. In order to help us complete this task, we ask that you provide us with your current insurance card and any other necessary information that may be needed to file your claim. We also ask that you update us immediately to any changes to your insurance. Please understand that although we participate with many insurance carriers, we may not be listed as a member provider with your insurance company. Therefore, we must inform you of the following:

1. Your insurance policy is between you and the insurance company. We are not a party to that contract.
2. All charges are your responsibility whether your insurance company pays or not. You will be responsible for payment of any uncovered services, any unpaid deductibles, and co-payments at the time of service.
3. In the event that your insurance carrier has not made necessary payment within 45 days, you will be asked for payment in full by either cash or check. It will then be your responsibility to follow-up with your insurance company if you so choose.
4. To avoid an interruption in services, payment will be requested within 30 days of the date of an invoice.
5. Accounts on which checks have been returned for insufficient funds will have a charge of $20.00 added to the balance.

We understand that temporary financial problems may affect payment of your balance. We are able to assist you in arranging alternative means of payment as long as these problems are brought to our attention.

I HAVE READ THE FOREGOING FINANCIAL POLICY, UNDERSTAND IT, AND AGREE TO BE BOUND BY ITS TERMS AND CONDITIONS.

Patient Name____

Responsible Party Signature____ Date_______________________

Insurance Authorization and Assignment: I hereby authorize and assign payment directly to JPA Center for Integrative Health, LLC for any therapeutic services rendered. I further authorize JPA Center for Integrative Health, LLC to release any information necessary to facilitate payment of said services rendered during the course of treatment.

Signature____ Date_______________________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below I, __________________________, acknowledge that I can review JPA's Notice of Privacy Practices at: **http://www.hhs.gov/ocr/privacy/hipaa/npp_fullpage_hc_provider.pdf.**

_____________________________________ _____________________________
Printed name of client Date

____
Signature of client 14yo+ (or legal guardian)

IN ADDITION: I hereby ☐give ☐do not give permission to therapist, ____________________, to communicate with me via email, or cell phone (including texting), recognizing the inherent privacy dangers of these methods of communication.

___________________________________ _____________________________
Signature of client 14yo+ (or legal guardian) Date

___________________________________ _____________________________
Signature of therapist Date

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: ____

Relationship to Client: ____