ADVANCED PSYCHOTHERAPY SERVICES
Beth Ann Woyshville M.Ed., LPCC
28916 Euclid Ave. Wickliffe, OH 44092 (440) 554-2947
bethwoyshville@gmail.com
**Please print clearly, and provide as much information as possible. Thank you.*

Today's Date _____ Date of First Session_____

Patient Name _____ Date of Birth _____
Last, First Middle Initial

Patient address : _____ City_____ State:_____ Zip code: _____

Patient SSN : _____-_____-_____ Phone (Home/Cell): _____ Work: _____

Is it all right to leave message? At Home: ☐Y ☐N At Work: ☐Y ☐N Email:_____

Presenting Problem: _____ _____ Suicidal? ☐Y ☐N

Insured's name: _____ Insured's DOB: _____/_____/_____

Insured's address: _____ City_____ State:_____ Zip code: _____

Insured's SSN: : _____-_____-_____ Phone (Home/Cell): _____ Work: _____

Is it all right to leave message? At Home: ☐Y ☐N At Work: ☐Y ☐N Email:_____

Insured's employer : _____

Insurance Company : _____ Phone : _____

Claims Address : _____

Insured's ID number : _____ Group number : _____

Preauthorization needed? ☐Y ☐N Doctors referral needed? ☐Y ☐N

Deductible _____ Met? ☐Y ☐N Amount of deductible used? _____

Number of visits per year? _____ Number of visits remaining? _____

Percent of UCR? _____ Co-pay amount? _____ Maximum out-of-pocket? _____

Does insurance reimburse LPCC? ☐Y ☐N In Network Provider ☐Y ☐N

Out-of-Network Benefits ☐ Y ☐N CSR : _____

Benefits are quoted for outpatient mental health benefits. **An insurance quote is not a guarantee of payment**. I understand and agree that I am ultimately responsible for the balance of my account for any and all professional services rendered. No- shows and late cancellations cannot be billed to insurance (but individuals can be billed for this separately). I have been explained the benefits of my insurance and agree to the payment terms. I understand that it is my responsibility to understand my benefits. APS cannot guarantee that insurance information is accurate, or that changes to your policy have not taken place through your provider.

_____ _____
Signature Date

ADVANCED PSYCHOTHERAPY SERVICES
Beth Ann Woyshville M.Ed., LPCC
28916 Euclid Ave. Wickliffe, OH 44092 (440) 554-2947
bethwoyshville@gmail.com

AUTHORIZATION FOR RELEASE OF INFORMATION AND RECORDS

PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NO. _____

I AUTHORIZE ADVANCED PSYCHOTHERAPY SERVICES TO:

RELEASE TO _____ OBTAIN FROM _____ RELEASE FORMAT: Verbal _____ Written _____

This is a one-time disclosure _____ Continuous disclosure for 12 months beginning _____

Attorney _____ Physician _____ Insurance Company _____ Other _____

Facility / Individual: _____

Address: _____

Fax/Email: _____

I authorize the release of the following information which may include treatment for physical and mental illness, alcohol/drug abuse, and/or HIV/AIDS test results or diagnoses:

Circle One: All PHI including Confidential (**OR**) Only information selected below:

____Initial Screening _____ Recommendations for Community Treatment

____Treatment Plan _____Group/Individual Progress Notes

____ Assessment/Evaluation _____ Other _____

PURPOSE OR NEED FOR INFORMATION: _____

_____ _____

Client Signature Date Witness Signature Date

_____ _____

Personal Representative (If Applicable) Date Relationship (Self, Guardian, Parent, Power of Attorney)

If the person or entity that receives the above information is not a health-care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and will likely no longer be protected by federal privacy regulations.

REVOCATION

This authorization can be revoked by the client named above, or his/her guardian, parent, or durable power of attorney at any time, except to the extent that action has been taken by Advanced psychotherapy Services in reliance on this authorization, by sending written revocation request to: Advanced Psychotherapy Services, 28916 Euclid Ave., Wickliffe, OH 44092

ADVANCED PSYCHOTHERAPY SERVICES
Beth Ann Woyshville M.Ed., LPCC
28916 Euclid Ave. Wickliffe, OH 44092 (440) 554-2947
bethwoyshville@gmail.com
* CONFIDENTIAL *

INFORMED CONSENT FOR TREATMENT

Mental health treatment is a joint effort involving both yourself (or family / child) and your therapist. The success or failure of the therapy is a function of the efforts of both the therapist and the client seeking the service. In general, the benefits of therapy may include increased insight, improvement in self-esteem, improvement in interpersonal relationships, relief of symptoms including decreased anxiety and / or depression, and improvement in your ability to maintain your daily level of functioning. (Specific problem areas and / or needs and therapeutic goals will be addressed on an individual basis with the therapist).

It is possible therapy may provide a temporary increase in your (or your child's) symptoms or stress level due to the need to focus on the problem areas. Diagnostic assessment (with or without formal testing) is an important aspect of treatment to aid in increasing knowledge of personality and / or intellectual functioning as well as an aid in progress in therapy.

Evaluations requested by third parties (i.e., the courts, the Department of Human Services, Bureau of Disability, etc.) to which your consent may reveal information that may be used by said parties to make decisions that could have significant effect on your treatment as well as your future.

In the event of non-payment, an individual's balance, name, address, and phone number may be given to a collection agency for the purpose of collection of payment. Information about clients will be given to third party insurance companies for the sole purpose of billing for services. Clients wishing to access their files must request this in person or by letter to the therapist providing the service. *We cannot guarantee electronic data, such as texting, tweeting, or e-mails, are confidential.*

STATEMENT OF CLIENT CONSENT:

I hereby authorize persons representing Advanced Psychotherapy Services to use any or all of the procedures in treatments customarily employed in mental health facilities in the treatment of mental health and emotional disorders (customary care may include psychological methods such as counseling and psychotherapy, medication and its management, evaluation and aftercare, and testing) in order to provide care and treatment for:

Print Name of Client: _____

Initial where applicable:

_____ I consent to receive mental health / substance abuse treatment services.

_____ I consent for my child, _____ , to receive mental health/chemical dependency treatment or services.

Signature: _____ Date: _____
Relationship to Client: Self / Parent / Guardian / Power of Attorney

Signature of therapist or provider _____ Date: _____

ADVANCED PSYCHOTHERAPY SERVICES
Beth Ann Woyshville M.Ed., LPCC
28916 Euclid Ave. Wickliffe, OH 44092 (440) 554-2947
bethwoyshville@gmail.com

PHI Acknowledgment Form

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protective Health Information (PHI) about you. This information could include psychological test results, your comments made during therapy, and our observations of you during therapy. We need to use this information to decide what treatment is best for you and to provide treatment to you. We may also share this information with others who need to arrange payment for your treatment. Our policies regarding how we protect your PHI are detailed in our Notice of Privacy Practices document. When we share your PHI with other treatment providers outside of our office we will ask you to sign an authorization to release information. You can always ask us where we have released any of your PHI to and we will be glad to inform you. You can also ask for a copy of any authorization form you are asked to sign.

I will use and disclose your protected health information when required by federal, state, or local law. There are certain situations in which as a therapist I am required by ethical standards to reveal information obtained during therapy to persons or agencies ¬ even if you do not give permission. These situations are as follows: (a) If you threaten grave bodily harm or death to yourself or another person, I am required by ethical standards to inform the intended victim and/or appropriate law enforcement agencies; (b) if you report to me your knowledge of physical or sexual abuse of a minor child or of an elder (over 65) or any sexual conduct/contact with a minor, I am required by law to inform the appropriate child welfare or social agency which may then investigate the matter; (c) if I am required by a court of law (court order) to turn over records to the court or if I am ordered to testify regarding those records.

By signing this form, you are acknowledging you are aware of our Notice of Privacy Practices document. You are also acknowledging that you have been informed the full version of the Notice of Privacy Practices is readily available in our waiting room area or from your treating therapist. If you cannot locate this document, please ask your therapist.

_____ _____
Signature of Client (Or Personal Representative) Date

_____ _____
Printed Name of Client (Or Personal Representative) Relationship to the Client

Description of Personal Representatives Authority (If Applicable) _____

Date the information regarding the NPP was given to the client or personal representative _____