DBT PSYCHOLOGICAL SERVICES of Long Island

Kim Lynn Lehnert, Ph.D.
Brian Hanson, M.A.
5225 Nesconset Hwy. Unit 7 & 8
Port Jefferson Station, NY 11776
www.dbtservicesli.com
*631.828.2082 * 631.504.0476*

PATIENT INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Social Security #: _____-_____-_____

Address: _____

_____

Home Phone #_____ Cell Phone # _____

Work Phone # _____ E-Mail: _____

May we email you at home to confirm your appointments? Yes ( ) No ( )

If not, please indicate the best way to reach you: _____

Patient Status: ( ) Single ( ) Married ( ) Other ( ) Employed ( ) Disabled

( ) Full-Time Student ( ) Part-Time Student

Sex: ( ) Male ( ) Female

Name of Referral Source: _____

Other Source (please state): _____

EMERGENCY CONTACT INFORMATION

Full Contact Name: _____ Relation to Patient: _____

Home #: _____ Cell #: _____ Work #: _____

INSURANCE INFORMATION

Please Note: You are responsible for all amounts not paid by your insurance plan; this includes any deductible required. Please sign below.

Signature: X_____ Date: _____

In order to facilitate prompt insurance claim processing, kindly fill in **all** requested information on this form.

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PRIMARY INSURANCE INFORMATION

Insurance Company Name: _____ ID#:_____

Deductible Amount: _____ Already met? _____

Patient's Relationship to the Insured: ( ) Self ( ) Spouse ( ) Child ( ) Other

Policy Holder's Name: _____ Date of Birth: _____

Policy Holder's Social Security #: _____-_____-_____ Sex: ( ) Male ( ) Female

Policy Holder's Employer: _____

Plan or Group #: _____ Insurance Company Phone #: _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____ ID#:_____

Deductible Amount: _____ Already met? _____

Patient's Relationship to the Insured: ( ) Self ( ) Spouse ( ) Child ( ) Other

Policy Holder's Name: _____ Date of Birth: _____

Policy Holder's Social Security #: _____-_____-_____ Sex: ( ) Male ( ) Female

Policy Holder's Employer: _____

Plan or Group #: _____ Insurance Company Phone #: _____

MEDICAL INFORMATION

Primary Care Doctor's Name & Contact Number: _____

Medications Prescribed & Dosages: _____

Psychiatrist's or Psychiatric Nurse Practitioner's Name: _____

Medications Prescribed & Dosages: _____ _____

_____

Vitamins, Herbs, or any other Over-the-Counter Medications: _____

_____

Allergies to Medications: _____

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CREDIT CARD INFORMATION

Cardholder's Name:_____

Patient's Relationship to Cardholder: ( ) Self ( ) Spouse ( ) Child ( ) Other _____

Card Type: Visa_____ MasterCard_____ Discover_____ American Express_____

Card #: _____

Exp. Date: _____**Security Code:** _____ **Billing Zip Code:** _____

*This card will be charged on the date of service for all the group therapy sessions which are not covered by insurance.	**X**_____
*This card will also be charged for any outstanding balances over $180.00.	**X**_____
*This card will also be charged for any missed individual or group appointments.	**X**_____
***Please be advised – if you are over 18 and the card on file is not your own, you are allowing us to disclose financial information regarding your attendance to the cardholder.**	**X**_____

If you DO NOT want your card charged:

- **You must bring in a payment *on the day of service*;**
- **You must remit payment at the time of your next visit if you have missed a session the week prior; otherwise, this card will be charged and**
- **You must not accrue a balance in excess of $180.00 or this card will be charged.**

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******PLEASE READ CAREFULLY AND SIGN THE FOLLOWING******

I understand that I am responsible for any fee amounts not covered by my insurance carrier, including the deductible.

Signature: X_____ **Date:** _____

ASSIGNMENT OF BENEFITS

I, _____ hereby assign to my treating therapist at **DBT Psychological Services of Long Island**, all major medical benefits to which I am entitled including Medicare and other government-sponsored programs, private insurance and any other health plans.

I understand that I am financially responsible for any charges which are not paid by any aforementioned insurance carrier. I hereby authorize said assignee to release information necessary to secure the payment of said benefits. This assignment will remain in effect until revoked by me in writing.

Signature: X_____ **Date:** _____

Your signature above authorizes the therapist treating you to furnish any necessary information regarding your case to your insurance carrier and to be assigned all benefits and fee amounts not covered by your insurance company.

*******IMPORTANT NOTE*******

You agree to be billed $180.00 for appointments cancelled less than 24 hours before your scheduled appointment as well as for scheduled visits for which you do not show. We provide confirmation emails before your appointment as a courtesy reminder. If you cancel your appointment at the time of the courtesy confirmation email, and it is less than 24 hours before your scheduled visit, you will still be assigned the late cancellation fee.

Signature: X_____ **Date:** _____

In the event that your account is not paid in accordance with this agreement and turned over to our collections agency, you agree to pay all additional fees assessed in the collection of the debt. These fees may include collection agency fees and attorney fees.

CONFIDENTIALITY

Your treatment at ***DBT Psychological Services of Long Island*** is kept in the strictest of confidence. No one will be permitted access to your treatment information unless you specifically put in writing that you authorize release of such information to a specific party, at a particular time.

Times when confidentiality must be breached pertain to your safety, the safety of others who may be in imminent danger, or when your records are subpoenaed by a court of law. In any situation requiring a breach of confidentiality, attempts will be made to contact you beforehand. If you have any questions regarding this policy, or have vague concerning situations, please ask one of our staff members for clarification. Please understand that it is important for you to immediately address this policy if you require clarification.

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PARTICIPATION AGREEMENTS FOR DBT SKILLS GROUP

I agree to attend my assigned weekly DBT Skills Group at *DBT Psychological Services of Long Island* understanding that it will take approximately 12 months to cover all of the skills in the manual.	**X**_____
As a participant in group, I agree to attend all sessions free from the influence of drugs and alcohol.	**X**_____
I agree to be an active participant in the weekly DBT Skills Group. I also agree to practice the DBT skills taught in the group and to complete weekly homework assignments.	**X**_____
In addition to participating in the weekly DBT Skills Group, I agree to attend regular weekly individual DBT therapy sessions.	**X**_____
To abide by *DBT Psychological Services of Long Island* attendance rules, I agree to arrive on time for group as well as individual sessions. Furthermore, I understand that missing 4 consecutive weeks of either individual therapy or DBT Skills Group means that I have "dropped-out" of DBT treatment for the remainder of my contracted period.	**X**_____
I understand that the DBT skills group fee is $90.00 per session and said fees if not paid by insurance are payable on a weekly basis. Being that weekly group participation is expected and considered part of the DBT program commitment, I understand that payment is due regardless of attendance.	**X**_____
I understand that if my insurance company normally covers my DBT Skills Group but I am absent from any group session/s then I, as the participant, will be responsible for the missed group session/s fee because my insurance company cannot be billed for sessions not attended.	**X**_____
*******IMPORTANT NOTE******* **If you miss a group session you will be charged the full $90.00 for the session, even if you do cancel 24 hours in advance.**	**X**_____

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MULTI- FAMILY DBT SKILLS GROUP AGREEMENT

To participate in the *DBT Psychological Services of Long Island* program, I understand that family involvement is *strongly encouraged* as empirical research has clearly indicated that it predicts treatment success in DBT. To fulfill this program requirement, I understand that at least one family member/friend attend the 20 to 25 group sessions that review 5 skills modules: Mindfulness, Distress Tolerance, Emotion Regulation, Interpersonal Effectiveness, and Middle Path Skills. The cost of each Family Skills Workshop is $150.00 and is covered by most insurances that are accepted by our practice. Please note: If a Multi-Family DBT Skills group session is missed, you will be charged a $35.00 missed session fee, even if the practice is notified 24 hours in advance.

X_____

TREATMENT/CONSULTATION TEAM AGREEMENT

It is possible that your treatment may involve more than one practitioner housed within this practice. Your signature below provides consent for communication between said practitioners for consultative purposes and for optimal coordination of care. Kindly understand that although team collaboration may be part of the DBT treatment approach, ultimately each individual therapist involved in your care is held independently responsible for any of his/her treatment decisions made on your behalf.

Our contract is designed to reflect an active interest in your concerns for we are dedicated to assisting you in reaching mutually agreed upon goals.

By signing below, you are indicating that you have read, understand, and are in agreement with all points of this contract in its entirety.

Signature: X_____ **Date: _____**

Witness: X_____ **Date: _____**