JEFF BERNAT, PhD, P.C.

Licensed psychologist (SC# 934)

107 E Park Ave, Greenville, SC 29601

Tel: (864) 990-5227 Fax: (864) 271-8712

CLIENT INFORMATION

Client Name ______________________________ Date of 1st Appt. ________________
Must be full, legal name

Address ______________________________ ____________ ______ ________
Street or PO Box City State Zip Code

Date of Birth ____________ Gender M F SS# ______________________

Home Phone ________________ Y N Client Marital Status Married Single Other
May I leave a message?

Work Phone ________________ Y N Client Employment Status Full Time Part Time None
May I leave a message?

Cell Phone ________________ Y N Client Student Status Full Time Part Time None
May I leave a message?

Email ______________________________ Y N May we send you emails for appointment reminders?

Billing/Responsible Party Information * Only complete information that is different from the client

Name ________________________ Home Phone ________________

Address ________________________ Cell Phone ________________
Street or PO Box

________________________ Relationship to Client ________________
City State Zip Code

Insurance Information (BCBS and Tri-care only) * A copy of the insurance card MUST accompany this form

Insured's Name ________________________ Insured's Date of Birth ____________
As appears on the card

Client Relationship to Insured Self Spouse Child Other ____________

Insured's Address ________________________ Home Phone ________________
Street or PO Box

________________________ Cell Phone ________________
City State Zip Code

Insured's Employer ________________________ Insured's SS# ________________

Therapist to Complete

Insurance ________________ Number ________________

Authorization Dates ____________ Diagnosis ________________

Authorization Number ____________ Benefit Year ________________

Deductible Information ________________ Co-Pay ________________

Additional Client Information

Emergency Contact: Name ____ Relationship _____________________

Address ______________________________________ Phone ___________________________

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List all of the people who live in your household (not including yourself)

Name ___________________________________ Relationship ___________________ Gender ________ Age ______

Name ___________________________________ Relationship ___________________ Gender ________ Age ______

Name ___________________________________ Relationship ___________________ Gender ________ Age ______

Name ___________________________________ Relationship ___________________ Gender ________ Age ______

Name ___________________________________ Relationship ___________________ Gender ________ Age ______

List any current health conditions and all current medications ____

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Reason for seeking therapy or psychological testing / evaluation at this time _____________________________________

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Describe any other professional involvement (example: physician, psychiatrist, attorney, social service agency, etc.) or any current or anticipated court involvement.

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PROFESSIONAL DISCLOSURE STATEMENT / OFFICE POLICIES AND INFORMATION

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully, and let me know any questions you might have so that we can discuss them at our next meeting. As in any relationship, a therapeutic relationship involves mutual understanding and respect. Included here are some of the expectations I have of you, the client, and some of the things you can expect from me. When you sign the attached pages, it will represent an agreement between us.

Psychological Services: Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and the client, and the particular problems you bring forward. There are many different methods I may use to deal with the problems you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about during our sessions and at home. You have the right to choose a therapist with whom you feel comfortable, and to ask questions about the services you are receiving. I encourage you to be an active participant in the therapy process.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, and loneliness. On the other hand, psychotherapy often leads to significant benefits and improvements in people's lives. People often modify their emotions, attitudes, beliefs, and behaviors; make changes in their relationships or other significant aspects of their lives; develop solutions to specific problems, and experience significant reductions in feelings of distress.

Although there are no guarantees, I am honored to get to know you, to watch you grow as you learn more about yourself, and develop ways to effectively solve problems, resolve past traumas, cope with stress, become healthy and balanced, and ultimately have the highest quality of life you desire.

Appointments: I normally conduct an initial evaluation that will last from 1 to 2 sessions. During this time, we can decide if I am the best person to provide the services you need in order to meet your treatment goals. After we agree to start psychotherapy, I usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time that we agree upon, although some sessions may be longer or more frequent. Once an appointment is scheduled, you will be expected to pay the full session fee unless you provide 24 hours advance notice of cancellation. If possible, I will try to find another time to reschedule the appointment. Please understand that sessions will generally start on time. On rare occasions, I may run a few minutes late due to unforeseen circumstances. On these occasions, I will add time to the end of your appointment to allow for your full appointment. If you are less than 20 minutes late, I will be happy to see you for the time that remains for your appointment. However, if you are more than 20 minutes late and have not called me at (864) 990-5227, I cannot guarantee that I will be in my office and you will be charged for the full session.

Professional Fees: The fee for the initial assessment is $150. For psychotherapy, my hourly fee is $125. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meeting with other professionals that you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $200 per hour for preparation and attendance at any legal proceeding. My hourly rate for psychological testing is $175. For neuropsychological testing, my hourly rate is $200. Please see my fee schedule provided at the end of this document for further fee information.

Billing and Payments: You will be expected to pay for each session at the time it is held, unless we agree otherwise. Payment schedules for other professional services will be agreed upon when they are requested. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its cost will be included in the claim. Failure to pay bills may result in termination of services.

Assignment of Insurance and Release of Information: Please remember that insurance is considered a method of reimbursing the client for fees paid directly to the provider of the service and is not a substitute for payment. Some companies pay fixed allowances for certain types of services and others pay a percentage of the charge. They do not pay at all for some services. It is the client's responsibility to pay any deductible amount, insurance co-payment, or any other balance not paid by his/her insurance company.

If you have a health insurance policy, it may provide some coverage for mental health treatment, however, please be aware that I am only a provider for the Blue Cross Blue Shield (BCBS) and Tri-care network. If you are a member of the BCBS or Tri-care network, I am in network and will file your claim for you. However, if you have any other managed care plan, I am not on your panel of providers. Therefore, to use your insurance for my services, your insurance will have to provide "out of network benefits," and you will have to file your own claim. I encourage you to contact your health insurance company to determine coverage if you hope to use your insurance to pay for treatment. In these cases, you will be expected to pay for services at the time of treatment, and then you will file the claim with your insurance company, if you so choose. In such cases, I will provide you a detailed receipt with billing codes, diagnosis, and relevant information, and fill out any relevant forms to assist you in receiving the benefits to which you are entitled. However, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

If we are filing your BCBS or Tri-care claim, we will allow 30 days from the billing date for the insurance company to process your claims and make payment accordingly. If payment from your insurance company is not received within that time frame, we will notify you and expect you to contact your insurance company and/or pay the balance of your account and seek reimbursement for yourself directly from your insurance company. Any other arrangement must be made in advance and in writing with Dr. Bernat. Your account may be charged a rebilling fee if you become delinquent and/or slow in paying your balance. Delinquent accounts are defined as accounts that have received no payment for 60 days. Slow accounts are defined as accounts having a balance greater than $200.00 owed by the client. Rebilling fees are $2.50 for each invoice.

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Responsible Party

Your signature below certifies the following: You have read and understand fully this billing policy and agree to make payment in full and/or satisfactory arrangements if asked to do so as specified above. You understand that you are financially responsible for any amount of unpaid deductibles, all charges and/or co-payments whether or not paid by your insurance company. For the purpose of resolving your bill, you specifically grant permission for Jeff Bernat, PhD, PC or his representative to contact you at your work number ____________________ or at the following authorized number(s) ________________________________ for the purpose of resolving your bill, should you be unable to be reached at your primary number. Should your account be referred for collection to an attorney or collection agency, you shall pay reasonable attorney's fees, court fees, and collection expenses. You hereby authorize Jeff Bernat, PhD, PC or his representative to release all information necessary to secure payment. You hereby assign all benefits to which you are entitled, including private insurance, Worker's Compensation, etc. This assignment applies to all charges outstanding as the date of signature and will remain in effect for all current and future charges until revoked in writing and agreed upon by Jeff Bernat, PhD, PC. A photocopy of this assignment is to be considered as valid as the original.

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Client Name – Please Print

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Name of Responsible Party – Please Print
(*If different from client)

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Signature of Client or Responsible Party

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Date

Availability, Contacting Me, & Emergencies: I am often not immediately available by telephone. While I am usually in my office between 9 AM and 5 PM, Monday through Thursday, I probably will not answer the phone when I am with a client. When I am unavailable, my telephone is answered by voice mail, which I monitor frequently. I will 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 me of some times when you will be available.

If you have an emergency when I am unavailable, you should contact your physician/psychiatrist, the nearest emergency room (ask for the psychologist or psychiatrist on call), or call one of the two private psychiatric hospitals in the area: The Carolina Center for Behavioral Health (864) 235-2335 or Greenville Health System—Behavioral Health Center (formerly referred to as Marshall I. Pickens Hospital) (864) 455-8988. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

Counseling A Minor: The degree of parental involvement in sessions with children and/or adolescents varies from family to family. The needs of the child, nature of the concern, and developmental level are always taken into account. Typically, I will check in with the adult at the beginning of each session. If the parent has questions about style of treatment and goals of therapy, I will always be happy to address these. I do ask that you respect that the therapeutic process with minors functions best with confidence that they, too, can have a safe place to disclose their feelings without fear of anyone exposing those vulnerabilities. As a parent, you are vital in our work together and I want you to be a part of our treatment. Please also respect your child's need to privacy and independence during this journey.

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. For adolescents, it is my policy to request an agreement from parents that they give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify them of my concern. I will also provide them with a summary of your treatment when it is complete. Before giving them any information, I will discuss the matter with you, if possible, and do my best to handle any objections you may have with what I am prepared to discuss.

Questions, Referrals and Discontinuing Treatment: As a consumer of services you have the right to choose a therapist with whom you feel comfortable. I encourage you to ask questions about the services you are receiving. If you ever have any questions or concerns, I will be happy to discuss these with you. If I cannot meet your needs or think you would be more comfortable with another provider, I will always provide you with a referral when asked. Please be aware that any complaints about our work together can be addressed to the South Carolina Board of Examiners in Psychology. P.O. Box 11329, Columbia, SC 29211-11329. (803) 896-4664.

Confidentiality and Professional Disclosure Statement: This Professional Disclosure Statement describes how information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

1. I understand that my/my child's sessions are confidential. In general, the privacy of communication between a psychologist and client is protected under the law; and I can only release information about our work to others with your written permission. However, there are some limits to confidentiality that require licensed psychologists to release information without your consent. Those are as follows:

✓ If I reveal that I intend to harm myself or someone else, my psychologist has a legal and ethical duty to warn someone about this possibility. This may involve notifying a family member or significant support person to both protect me and to involve them in making a plan to prevent harm to myself. When potential harm to someone else is involved, this may require that legal authorities and/or the intended victim be notified.

✓ If I/my child reveals information about child abuse or neglect of someone who is currently a minor (or if my psychologist believes a child is being abused), I understand the information must be reported to the Department of Social Services.

✓ I understand that my psychologist and his client records can be subpoenaed to either Family or Criminal Court. Psychologists must respond to these subpoenas, however, they can inform the Court of their reluctance to reveal confidential information without written authorization of their client, or if they believe it is not in their client's best interest. However, if my psychologist is ordered by a Judge to provide information, he must comply. For example, in some proceedings involving child custody and those in which a parent's emotional condition is an important issue, a Judge may order my testimony if he/she determines that the issues demand it.

✓ Please be aware in situations of divorce, both parents (regardless of custodial status) have a right to records pertaining to their child's treatment with me. In situations in which a request for treatment information has been made by a parent, I generally try to inform the other parent(s) involved. Again, a Judge can subpoena my records regarding your child's treatment.

✓ I understand that if I/my child have a medical emergency, my psychologist or his staff may call medical personal to assist me.

✓ If I/my child claim malpractice or breach of ethics, the relevant medical records may be reviewed by those involved in the investigation or Court case.

Those situations have rarely occurred in my practice. I understand that if any involuntary release are necessary, my psychologist will discuss it with me at that time, or in advance, unless doing so would be contrary to his clinical judgment. I also understand that in couple, parent-child, or family therapy, secrets about important information may interfere with therapy, and my psychologist may encourage me to share critical information with those who should know. I understand that in certain instances, it may be difficult for therapy to continue if I chose not to reveal important information.

Consent for Treatment:

You acknowledge that you have read and received copies of a Professional Disclosure / Office Policy Statement from Jeff Bernat, PhD, PC and Client's Notice of Privacy Practice Rights Under HIPAA. Your signature confirms that you understand and accept the information in these documents. You are entering into this treatment contract with Jeff Bernat, PhD, PC, with your full understanding, participation, and consent. You understand that participation in treatment and / or psychological assessment / testing is voluntary and you can terminate your services at any time. While you can expect benefits from treatment, you understand that these cannot be guaranteed. You also understand that you are financially responsible for these services and for any portion of fees not reimbursed or covered by your health insurance or third party payer. You hereby give your consent for Jeff Bernat, PhD, PC to provide treatment for you, and / or treat your minor child listed below.

____ ________________
Client Signature Date

____ ________________
Parent or Guardian Signature Date