

**Patient Record**

**Administrative:**

ACCT ID# \_\_\_\_\_

Patient: \_\_\_\_\_ SS #: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_

Sex: M\_\_ F\_\_ Spouse/Guardian/Parent: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_

Address: \_\_\_\_\_ City/St/Zip: \_\_\_\_\_

Phone: Home: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_

*Would you like an appointment reminder call to my: \_\_Home\_\_ Cell I prefer not to be called\_\_*

*Receive email updates about PSHDC, its staff and current Mental Health Topics of interest: Y or N*  
*email address* \_\_\_\_\_

Employer / School: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Emergency phone#: \_\_\_\_\_

**FINANCIAL INFORMATION (must be completed):**

Party responsible for payment: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ SS # of guarantor \_\_\_\_\_

Identification # \_\_\_\_\_ Group # \_\_\_\_\_ Guarantor DOB \_\_/\_\_/\_\_

2nd Insurance Company: \_\_\_\_\_ Policy # \_\_\_\_\_

**Authorization to Obtain / Release Information from Primary Care Physician**

Please check one (**must be completed**):

I **DO** authorize  I **DO NOT** authorize  No PCP

PSHDC, Inc. to release the reason for seeking treatment, treatment plan, diagnosis pertaining to my treatment during the period beginning \_\_\_\_/\_\_\_\_/\_\_\_\_ and ending 1(one) year thereafter. This information is needed for the purpose of coordinating treatment. These records are to be released to my primary care physician.

I have been informed that I have the right to revoke consent at any time by oral and written request, except to the extent that action has been taken in reliance on the authorization. I have been informed of my rights, subject to chapter 7100.111.3 of the Pennsylvania Mental Health Procedures Act and/ or subject to Pennsylvania Drug and Alcohol Abuse Control Act, to inspect the material to be released. This form has been fully explained and I certify that I understand its contents and have been offered a copy.

\_\_\_\_\_  
**Signature of Patient** (or Guardian of Patient if under 18 years of age)

\_\_\_\_\_  
Date

Primary Care physician name: \_\_\_\_\_

Address: \_\_\_\_\_ City/St/Zip: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Fax: \_\_\_\_\_

INSURANCE AUTHORIZATION IS NOT VALID UNLESS ALL SECTIONS ARE COMPLETED.

# WELCOME TO PSHDC, INC.: AN INTRODUCTION TO OUR SERVICES

We are a team of licensed psychologists, social workers and psychiatrists. It is our goal to provide the highest level of competence, expertise, and services to our clients in the areas of family and individual psychotherapy, diagnostic evaluation, corporate consultations, divorce mediation, biofeedback, career counseling, and psychotropic medications. In the following page, we will describe some of the practice procedures, which may affect you. These procedures comprise a significant part of our treatment contract with you unless we mutually agree on specific exceptions.

**Office Hours:** There is a reception staff to answer our phone, (215) 540-5860, 9am - 8pm Monday through Thursday and 9am – 5pm on Friday. At all other times the phone will be answered by our own voicemail system, which will direct your call to the appropriate voice mail of each staff member. We try to return all phone calls within a 24-48 hour period. Please indicate if your call is urgent and needs immediate attention.

**Emergencies:** We are available to our clients in the event of a true mental health emergency. If this is the case and no one is in the office, please leave a message on our emergency voice mail. Monday through Friday from 9am to 5pm it will automatically page the therapist on call for the practice who will provide you with help. After 5pm, on weekends and holidays the call will be forwarded to our on call service providers at Belmont Center who will provide you with help. Patients should recognize that their individual therapist may not always be available to respond to emergency calls. If you have caller ID and need to receive a call back from the emergency on-call staff outside of normal business hours, be sure your caller ID allows calls from phones that have caller ID blocked. Most of our home phones have blocked caller ID so we can serve your needs and still meet our needs for privacy.

**Complaints:** If you have any complaints, please address your grievance to: Dr. Richard P. Johnson at 220 Commerce Drive, Suite 401, Fort Washington, PA 19034 (215-540-5860 ext. 15). In the event your complaint concerns Dr. Johnson, you may contact Dr. Suzanne Robison, at the same address. Your concerns will be answered and resolved promptly.

**Cancellations:** If the need arises for you to cancel an appointment, you **must** give 24 hours notice. Appointments for Monday must be cancelled by 5:00pm the Friday before. If you do not cancel within this time frame, you will be charged a fee of **\$50** for the canceled session. If the cancellation was caused from serious illness or similar unavoidable circumstance, and if this is your first missed appointment, you are invited to discuss an exception to the rule with your therapist. There is a \$25 fee for prescription renewals that should have been done via a regular medication review.

**Appointments will not be rescheduled until payment is received for missed (No Show) appointments.**

**Payments:** Payment is due at time of service. A fee of \$5 will be assessed at the close of each business day for patients who do not pay their co pays. In cases where full payment presents an economic hardship, specific circumstances can be worked out with the therapist. When there is insurance reimbursement, we will expect to be paid after each session. We ask that you read your policy to be sure that you are fully aware of any limitations, co-pays or deductibles of the benefits provided. If after 30 days a balance remains, a \$5 fee will be applied to the patient's account. **Appointments will not be rescheduled until payment is received; if payment cannot be made we are willing to refer you to agencies that provide low cost or no cost services.**

**Health insurance:** This is a partnership between you, your insurance company, and your therapist, depending on the reimbursement agreement. It **is not** a contract between the therapist and the insurance company. Your company may base its allowance in a fixed fee or HMO schedule, which may or may not coincide with our usual fees. In some cases, there are contractual agreements between us and your insurance company concerning fees. **You are responsible for being aware of the coverage your insurance provides, as you are responsible for any fees not covered due to your failure to follow the procedures of your health plan.**

**Returned checks:** There will be a processing fee of \$25 assessed for each returned check to cover the charges we incur.

**Telephone Calls:** Necessary, routine telephone calls to you or on your behalf are part of the practice and free of charge. **Lengthy calls for scheduling or clinical matters will be billed at an hourly rate which is not covered by your insurance company. Calls to renew prescriptions that should have been done via a regular medication review will be assessed at \$25 and will be your full responsibility for payment.**

We thank you for the trust you have placed in us by choosing us for the psychological services you are seeking. We endeavor to earn this trust and hope your experience is beneficial.

Richard P. Johnson, Ph.D. and Suzanne Robison, Psy.D., Co-Directors

Antonio Bentley, Psy.D., LPC Robert Blair, Ph.D. Pauline Doyle, MS Rachel Goren, MA-LPC Laurie Fleishman, LPC  
Linda Jenofsky, MS Ericka Kawamura, Psy.D. Laurie Kennedy, LCSW Jerome Komisaroff, MD Frances Meehan, Psy.D  
Lindsay Phillips, Psy.D. Margaret Preston, LSW, DCSW Debra B. Resnick, Psy.D. Alison Rosenberg, LCSW  
Elbert Saddler, Ph.D. Aviva Schieber, LCSW Alphonso Smith, LCSW Karen Sox, PhD

Please sign below to indicate that you have read the information and agree to be in compliance with the above stated policies.

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Client Signature over 14 years (and Parent if under 18 years)

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Date

Updated 03/23/2011

**Psychological Services & Human Development Center, Inc.**  
**Informed Consent for Treatment**

I have chosen to receive treatment services under a benefit plan managed by my insurance company, or paid for by myself. My choice has been voluntary and I understand that I may terminate therapy at anytime.

I know my treatment is provided by a staff member of Psychological Services & Human Development Center, Inc.

I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between me and my therapist, I will work with my therapist in a cooperative manner to resolve my difficulties.

I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that records and information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information.

I understand that state and local laws require that require that my therapist reports all cases of abuse and neglect of minors or vulnerable adults.

I understand that state and local laws require that my therapist reports all cases in which there exists a danger to self or others.

I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand that I may be contacted by my insurance company, or its managed care component, (I) to ensure continuity and quality of my treatment and/or (II) after the completion of treatment, to assess the outcome of treatment.

I have read and had explained to me the basic rights of individuals, who seek such services.

These rights include:

1. The right to be informed of the various steps and activities involved in receiving services.
2. The right to confidentiality under federal and state laws relating to the receipt of services.
3. The right to humane care and protection from harm, abuse, or neglect.
4. The right to make an informed decision whether to accept or refuse treatment.
5. The right to contact and consult with counsel at my expense.
6. The right to select practitioners of my choice at my expense.

I understand that my therapist, in order to coordinate treatment and provide excellent care, may communicate with other PSDHC, Inc. staff. Reasons for this may include supervision, case consultation, coordination of treatment and crisis management. **I understand PSHDC, Inc. and my insurance company and/or their managed care company may exchange any and all information pertaining to my therapy, to the extent such disclosure is necessary for claims processing, case management, coordination of treatment, quality assurance or utilization review purposes.** I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan. **Please note: If you are divorced or separated and are the parent of a child under the age of 14 seeking treatment for your child and you share legal custody with the other parent; both parents must sign the consent form for the child to receive psychotherapy.**

I have read and understand the above.

\_\_\_\_\_  
**Client Signature** over 14 years (and Parent(s) if under 18 years)

\_\_\_\_\_  
Date

\_\_\_\_\_  
2<sup>nd</sup> Parent Signature

Psychotherapy is not easily described in general statements. It varies depending on the personality of, the therapist and you, the patient and the particular problems which you, the patient, bring. There are a number of different approaches, which can be utilized to address the problems you hope to address. It is not like visiting a medical doctor, in that psychotherapy or psychological counseling requires a very active effort on your part. In order to be most successful, you will have to work on things talked about both during sessions and at home.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger and frustration, loneliness and helplessness. Psychotherapy often requires discussing unpleasant aspects of your life. Psychotherapy has also been shown to have benefits for people who undertake it. Therapy often leads to a significant reduction in feelings of distress, better relationships, and resolutions of specific problems. But there are no guarantees about what will happen.

The first few sessions will involve an evaluation of your needs. At the end of the evaluation you will be offered some initial impressions of what the work will include and the initial treatment plan to follow, if you decide to continue. You should evaluate this information along with your own assessment about whether you feel comfortable working with our practice. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, they should be discussed whenever they arise. If your doubts persist, we would be happy to help you secure an appropriate consultation with another mental health provider.

Updated 03/23/2011

**Psychological Services & Human Development Center, Inc.  
Members' Right and Responsibilities Statement**

**Statement of Members' Rights**

- Members have the right to be treated with dignity and respect.
- Members have the right to fair treatment. This is regardless of their race, religion, gender, ethnicity, age, disability or source of payment.
- Members have the right to have their treatment and other member information kept private. Only by law, may records be released without member permission.
- Members have the right to easily access care in a timely fashion.
- Members have the right to know all about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
- Members have the right to share in developing their plan of care.
- Members have the right to information in a language they can understand.
- Members have the right to have a clear explanation of their treatment options and condition.
- Members have the right to information about Magellan, it's practitioners, services and role in treatment process.
- Members have the right to get information about clinical guidelines used in providing and managing their care.
- Members have the right to information about the providers work history and training.
- Members have the right to know about advocacy and community groups and prevention services.
- Members have the right to provide input on insurance policies and services.
- Members have the right to freely file a complaint, grievance or appeal and to learn how to do so.
- Members have the right to know about the laws that relate to their rights and responsibilities.
- Members have the right to know of their rights and responsibilities in the treatment process.

**Statement of Members' Responsibilities**

- Members have the responsibility to treat those giving them care with dignity and respect.
- Members have the responsibility to give provider information they need. This is so they can deliver the best possible care.
- Members have the responsibility to ask their providers questions about their care. This is so they can understand their care and their role in that care.
- Members have the responsibility to follow their treatment plans for their care. The plan of care is to be agreed upon by the member and provider.
- Members have the responsibility to follow the agreed upon medication plan.
- Members have the responsibility to tell their provider about medication changes, including medications given to them by others.
- Members have the responsibility to keep their appointments. Members should call their providers as soon as possible if they need to cancel visits.
- Members have the responsibility to let their provider know when the treatment plan no longer works for them.
- Members have the responsibility to let their provider know about problems with paying fees.
- Members have the responsibility to not take actions that could harm others.
- Members have the responsibility to report abuse.
- Members have the responsibility to report fraud.
- Members have the responsibility to openly report concerns about the quality of care.

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**Patient Signature (if 14 or above)**

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**Parent(s) Signature (if under 18)**

**Date** \_\_\_\_\_ **MHP Initials** \_\_\_\_\_

## Psychological Services & Human Development Center, Inc.

To better help your counselors assess your psychological and emotional needs, please circle to what degree any of the following symptoms apply to you at this time. You may be asked to complete this form several times during the course of your treatment to monitor your progress.

Name: \_\_\_\_\_ Date \_\_\_\_\_ Acct# \_\_\_\_\_

Please circle the appropriate number: 1 = not at all; 2 = a little; 3 = often; 4 = a lot 5 = usually.

<b>1. Depressed mood, sad, or tearful, most of the day</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>2. Significant decrease in interest or pleasurable activities</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>3. Significant weight loss/weight gain within the past 12 months (circle one)</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>4. Decrease or increase of appetite (circle one)</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>5. Feeling either overly agitated or slowed down movements (circle one)</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>6. Low energy or a feeling of fatigue</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>7. Feelings of worthlessness or excessive guilt</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>8. Difficulty concentrating</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>9. Recurrent thoughts of death</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>10. Excessive worry or anxiety</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>11. More irritable than usual</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>12. Restlessness</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>13. Muscle tension</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>14. Sleeping too much or too little (circle one)</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>15. Self destructive or risky behaviors (ex. Substance abuse, self injury, reckless driving, etc.)</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
<b>16. Other: (Specify)</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>