Jennifer K. Paweleck-Bellingrodt, Psy.D.
Licensed Clinical Psychologist

Patient Information Form

Identification

Name:_____ Today's Date: _____

Date of Birth:_____ Age: _____ SSN:_____ Sex:_____

Address:_____ City:_____

State:_____ Zip:_____ Home Phone: _____

Cell Phone:_____Marital Status:_____ Number of Children:_____

Employer/School:_____ Phone:_____

WHERE do you prefer to be called? _____ WHERE may we leave a message? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Medical and Psychological History

Why are you seeking treatment? _____
_____

List previous counseling. _____
_____

List any current or past medical conditions and/or procedures. _____
_____

List current medications. _____
_____

Living Arrangement

How long have you lived in the local area? _____

List all others living with you:

Name	Age	Relationship

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CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

TO MY PATIENTS: This form is an agreement between _____ (patient) and Jennifer K. Paweleck-Bellingrodt, Psy.D. If you are a parent or personal representative acting on behalf of the patient, please print your name here: _____. This agreement is based on the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This form describes how identifying information that I obtain about you, known as protected health information (PHI), may be used and disclosed and tells you how to obtain access to that information if desired. This agreement is very important, so please read it carefully and ask any questions you have.

MY COMMITMENT TO YOUR PRIVACY: I am required by law to maintain the confidentiality of your health information. You need to be aware of the following circumstances that may require me to use and disclose your PHI:

- For purposes of diagnosis, treatment, or referral and obtaining payment for services rendered to you
- For the treatment, payment, or health care operations activities of another health care provider who treats you
- For health care and legal compliance activities
- To a relative, friend, or other individual involved in your care if I obtain your verbal agreement to do so and in certain other circumstances where I am unable to obtain your agreement and believe the disclosure is in your best interests
- To a public health authority in certain situations as required by law (such as to report abuse, neglect, or domestic violence)
- For health oversight activities including audits or government investigations, inspections, disciplinary proceedings, and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system
- For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process
- For law enforcement activities in limited situations, such as when responding to a warrant or if you are under the custody of a law enforcement official
- For military, national defense and security, and other special government functions
- To avert a serious threat to your health and safety or that of another person or the public at large
- For workers' compensation and similar purposes

YOUR RIGHTS: You should be aware of your rights with respect to your PHI:

- You may inspect and obtain a copy of most of the health information about you that I maintain. You must submit your request to me in writing. I will normally provide you with access to this information within 30 days of your request. You may be charged a reasonable fee for copies of information. In some circumstances, I may deny you access to your medical information if I think that the release may be harmful or otherwise not in your best interest.
- You have the right to ask me to amend written health information that I have about you. Your request must be in writing and must include the reason(s) for your request. I am permitted by law to deny your request to amend your medical information in certain circumstances, like when I believe the information you have asked me to amend is correct.
- You have the right to request that I restrict how I use and disclose the medical information I have about you. I am not required to agree to any restrictions you request, but any restrictions agreed to by me in writing are binding.
- You may file a complaint if you believe your privacy rights have been violated. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
- You have the right to be notified and provide your written authorization for uses and disclosures not stated in this agreement or permitted by law. You may revoke your authorization at any time, in writing, except to the extent that I have already used or disclosed medical information per that authorization.
- You may obtain a copy of this notice and may ask questions regarding this notice or my privacy practices.

I acknowledge that I have read and understand this consent to use and disclose my health information. I further acknowledge that I have asked any questions I have pertaining to this agreement and the use of my information.

Signature:_____ Date:_____

Jennifer K. Paweleck-Bellingrodt, Psy.D.
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Fee Agreement

This form is an agreement regarding fees charged for psychological services rendered by me. My current regular fees are as follows. For an initial evaluation, I charge $200.00. An individual follow-up session is billed at the rate of $150.00, and a conjoint or family follow-up session is billed at the rate of $175.00. Charges for other services, such as hospital visits, consultations, or court-related services, will be based on the time involved in providing the service and will be billed at a standard rate of $200.00 per hour. Routine communications with insurance companies are considered part of your regular care, and you will not be charged for these services. There will, however, be charges for non-routine paperwork or report writing (i.e., disability, legal, insurance, etc.). Charges will be at the standard hourly rate for every hour, or fraction thereof, necessary to prepare, complete, and send any documentation with a minimum charge of $25.00. Some services may require payment in advance. Such fees are generally not paid by insurance companies or requesting agencies and are, therefore, your responsibility.

Payment, including co-payments and deductible payments, is expected at the time services are rendered. If you are using insurance to help pay for your treatment, it is your responsibility to ensure coverage and pre-authorization for services from me. Insurance companies do not guarantee benefit quotes, though, and you are ultimately the responsible party when it comes to your healthcare. Also, be advised that any unreported changes in your insurance coverage or carrier which result in nonpayment will be your responsibility. As a courtesy to you, I will also submit claims to your secondary insurance company if desired.

Most of my patients are very responsible when it comes to their accounts, but there is an occasional difficulty with collection. Please be aware that account balances will accrue interest on a monthly basis. Delinquent accounts will be turned over to a collections agency after an attempt is made to contact you regarding your account and no payment has been received. A claim may also be filed in small claims court. Please be aware that such action can negatively affect your credit and financial situation. I prefer not to use a collection service, but if circumstances make it necessary for me to do so, all collection fees, attorney fees, and interest at the rate of 18% will be added to the outstanding balance. If I have made efforts to work with you to resolve your debt, and payment for the services you receive is still not made, I reserve the right to discontinue your treatment with me. In addition, there will be a charge of $25.00 for a returned check, and payment must be made by credit card, cash, or cashier's check. If you fail to pay, a claim may be filed with the Maricopa County Attorney's Office Check Enforcement Program, which could result in criminal prosecution.

Please be aware that my schedule is very busy, and I strive to provide the best possible service to all of my patients, including maximizing appointment availability. If you are unable to keep an appointment with me, please call my office at least 24 hours before the scheduled appointment so that I may offer that appointment time to another patient. Cancellations for appointments on Mondays must be made no later than the Friday morning prior to the appointment. Cancellations for appointments on the first business day after a holiday must be made no later than the last business day before that holiday. This cancellation policy gives me an opportunity to try to fill the appointment slot before the office closes for a weekend or holiday. **A charge of $35.00 will be billed for missed appointments, appointments cancelled with less than a 24-hour notice, and Monday and holiday appointments not cancelled as noted above.** If you miss multiple appointments, you may be asked to make a deposit before future appointments will be scheduled. Your insurance will not cover these charges, so they are your responsibility. I also reserve the right to discontinue your treatment with me if you miss multiple appointments.

I realize that my fees involve a substantial amount of money, although they are well in line with similar professionals' charges. For you to get the best value for your money, we must work hard and well. If you have any questions about this fee agreement, ask them of me before signing it. You will be notified in advance of any changes to this fee schedule.

My signature below affirms that I have read and understand these requirements and agree to abide by them or pay charges as stated. I further acknowledge that I have asked any questions as needed. I authorize the release of any medical or other information necessary to process healthcare claims on my behalf. I also authorize the payment of my healthcare benefits directly to Jennifer K. Paweleck-Bellingrodt, Psy.D., for services rendered.

Signature:_____ Date:_____

Jennifer K. Paweleck-Bellingrodt, Psy.D.
Licensed Clinical Psychologist

Informed Consent for Treatment

Consenting to treatment should be an informed decision. There are certain things that you need to be aware of as we begin treatment together. In terms of my qualifications, I have a doctoral degree in clinical psychology from Baylor University, whose program is approved by the American Psychological Association (APA). I also completed an APA-approved internship in clinical psychology at Walter Reed Army Medical Center and am currently licensed as a psychologist in the state of Arizona. In our work together, I am bound to uphold the laws of the state, as well as the guidelines of the APA.

Before starting treatment, you should be aware of some of the risks and benefits therein. As with any powerful treatment, there are some risks. For example, in therapy, there is a risk that patients will, for a time, have uncomfortable levels of negative emotions such as sadness, guilt, frustration, and anxiety due to the discussion of distressing material or events. This may be necessary for the resolution of psychological issues. Furthermore, you should know that there are some people who hold a negative image of those involved in psychological treatment. Very often, fear and ignorance motivate these impressions. If you would like information for yourself or others that may help dispel some of the myths associated with psychological treatment, I can provide you with an article I authored on the subject. You should also understand that there is no guarantee that you will feel better after a course of therapy. I make no promises of recovery or cure. While you consider these risks, you should know that the benefits of therapy have been documented by scientists in hundreds of well-designed research studies. For instance, people who are depressed may find their mood lifting. Others may no longer feel afraid, angry, or anxious. Relationships, coping skills, and overall quality of life may improve greatly. Personal goals and values may become clearer, and social and family involvement may become more rewarding. Assertiveness and self-esteem may also improve.

Another important part of your consent to treatment is an awareness of expectations. By the end of our first or second session, I will tell you how I see your case and how I think we should proceed. I view therapy as a partnership between us: You define the problem areas you recognize, and I use my knowledge and experience to help you make changes. Therapy requires your active involvement. It requires your best efforts to change thoughts, feelings, and behaviors. From time to time, we will look at our progress and goals. If necessary, we may decide to change our treatment plan and its goals and methods.

An important part of your therapy will be practicing new skills that you will learn in our sessions. I may ask you to practice outside our meetings, and we will work together to set up homework assignments for you. I might ask you to do exercises, to keep records, or to do other tasks that deepen your understanding. You will probably have to work on relationships in your life and make long-term efforts to get the best results. These are important parts of personal change. Change will sometimes be easy and quick, but more often it will be slow and frustrating; and you will need to keep trying. There are no quick fixes or painless cures, but you can learn ways of looking at your problems that will be helpful for changing your feelings and reactions. As with anything worth doing, perseverance is the key to success.

I have read and understand the above and give my consent to treatment with Jennifer K. Paweleck-Bellingrodt, Psy.D. I will work with my therapist in a cooperative manner to resolve my difficulties and agree to notify my therapist if, at any time during the course of therapy, my needs are not being met to my satisfaction. I acknowledge that my choice to engage in treatment is voluntary, and I understand that I may terminate therapy at any time. Further, I understand that Dr. Paweleck-Bellingrodt is not an employee of Palm Valley Behavioral Health, LLC, and I hereby release Palm Valley Behavioral Health of any indemnity arising out of the services provided by Dr. Paweleck-Bellingrodt.

Patient Signature:_____ Date:_____

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HEALTH INSURANCE CLAIM FORM

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Intial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Intial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT'S RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT'S STATUS Single ☐ Married ☐ Other ☐	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code) ( )	Employed ☐ Full-Time Student ☐ Part-Time Student ☐	ZIP CODE / TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Intial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT ? (Current or Previous) ☐ YES ☐ NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	b. AUTO ACCIDENT ? ☐ YES ☐ NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT ? ☐ YES ☐ NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN ? ☐ YES ☐ NO *If Yes,* return to and complete item 9 a-d.
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assigment below. SIGNED _____ DATE _____		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____
14. DATE OF CURRENT: MM DD YY ◀ ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME/SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. _____ 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB ? ☐ YES ☐ NO CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. ____.__ 3. ____.__ 2. ____.__ 4. ____.__		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24 A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS. MODIFIER	E Diagnosis Pointer	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I I.D. Qual.	J RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT ? (For Govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $ / 29. AMOUNT PAID $ / 30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part therof) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. b.		33. BILLING PROVIDER INFO & PH # ( ) a. b.