Steven S. Minter, Th.M., Psy.D.

Clinical Psychology

Licensed Psychologist/PY 8553

New Client Information

Date: _____

Patient's Name: _____

Date of Birth: _____ Age: _____ Gender: ❑ M ❑ F Other: _____

Ethnicity: _____

Marital Status (check): ❑ Single ❑ Married/Partnered ❑ Separated/Divorced ❑ Widowed

Street Address: _____

City, State, Zip: _____

Preferred Phone: _____ Alternative Phone: _____

Text at this number OK? ❑ yes ❑ no Text at this number OK? ❑ yes ❑ no
Message at this number OK? ❑ yes ❑ no Message at this number OK? ❑ yes ❑ no

email: _____ Email OK? ❑ yes ❑ no

Who referred you to our office? _____

Responsible Party and/or Legal Guardian: ❑ SAME as patient OR:

Name(s): _____

Relationship: _____

Street Address: _____

City, State, Zip: _____

Preferred Phone: _____ Alternate Phone: _____

Text at this number OK? ❑ yes ❑ no Text at this number OK? ❑ yes ❑ no
Message at this number OK? ❑ yes ❑ no Message at this number OK? ❑ yes ❑ no

Emergency Contact Name: OR: ❑ SAME as Responsible Party above

Name: _____ Relationship: _____

Phone: _____

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Plant City, FL 33563

www.minterpsych.com

Phone: 813.704.4592
Fax: 813.423.6568

FINANCIAL INFORMATION and AGREEMENT

1. Method of Payment: ❑ Self -Pay ❑ Insurance Health Plan ❑ Other: _____

2. Release of Information for Insurance: ❑ Benefits verified ❑ Copy of Insurance Card on file

Release to Medicare or Supplement to Medicare: *I authorize Dr. Minter to release to the Social Security Administration and Health Care Financing Administration, or its intermediaries, any information needed in the processing of my Medicare claims for services rendered by him or associates of Steven S. Minter, Psy.D., LLC and/or Plant City Psychology. I hereby assign payment of Medicare and Medicare Supplement benefits to Dr. Minter for services rendered to me.* ***I understand that I may be financially responsible for any Medicare deductibles, coinsurance amounts and non-covered services.***

All Other Insurance Carriers: *I authorize the release of any medical information necessary to process my insurance claims, and assign payment of benefits of such claims to Dr. Minter.* ***I understand that I may be financially responsible for any yearly deductibles, coinsurance amounts and non-covered services.***

Signature: _____ Date: _____

3. Estimated fee/copayment: **I**nitial evaluation: _____ Therapy Sessions: _____
We do our best to correctly estimate copayments in advance of services received. However, no insurance claim is final until paid, and insurance companies periodically give us incorrect information. Please be aware that this amount may vary from the above, and, if so, we will notify you as soon as we know.

4. Disclosures:

_____ (initial) I understand that Dr. Minter will verify my benefits and file my insurance; however, ***I remain personally responsible for any unpaid balances in the even that claims are denied.***

_____ (initial) I understand that I am personally responsible for costs incurred for completing any paperwork requested by me, including documentation required for FMLA, disability insurance, treatment summaries, and that ***such costs are not reimbursable through insurance.***

_____ (initial) I understand that my appointment time represents a time reserved exclusively for me. To protect Dr. Minter's time, ***the fee for broken appointments and cancellations with less than 1 business days' notice is 75.00.*** *Late charges are not reimbursable by insurance.*

5. Payment Information:
Dr. Minter requires that all clients, regardless of insurance or copayment requirements, keep a credit card on file for charges to the account. These charges could include copayments, Dr. Minter's professional time to complete paperwork requirements for disability requested by the client, late cancellations or missed appointment fees as noted above. These may be charged without notification.

Preferred payment method is by cash or check and receives a 3.95% cash discount. Debit, credit, or HSA cards will incur a service fee recorded as a separate line item.

Payment Method: ☐ Cash ☐ Check ☐ Debit ☐ Credit ☐ HSA

Card # _____ Exp: _____ CCV _____

Zip _____ Name on card: _____

I agree to the above payment information and disclosures and to be responsible for all charges to this account.

Signature: _____

Informed Consent: *Three Important Things to Know Before We Talk*

1. *I will keep our conversation confidential (private). However, confidentiality has limits.*

Florida state law requires all mental health care providers to report instances where there is an imminent danger to anyone, including you. This includes suicidal or homicidal risk, or instances of abuse, exploitation, or neglect of children, elderly individuals, or disabled individuals. This means:

- If I should become aware, through the course of a clinical interview, a mental status examination, or testing, that a child, adolescent, disabled person, or senior adult is being currently abused, neglected, or exploited, I must and will report that to the proper state authorities.

- If at any point I should conclude that you are a danger to yourself, I must and will take action to insure your safety, up to and including informing family members and involuntary psychiatric hospitalization, if deemed necessary in my sole clinical judgment. If I should become aware that there exists a credible threat of harm to an identifiable individual, I must and will warn that individual as well as law enforcement.

- Please be advised that if you should make your mental health an issue in a legal case, the court may order me to release your clinical record without your consent.

Full information concerning your Personal Health Information (PHI), including your rights, is provided in my *Statement of Privacy Practices*. My policies concerning my clinical records are contained in my *Welcome* handout. You are encouraged to read these documents and ask questions. **A NOTICE OF PRIVACY PRACTICES AND HIPAA PRIVACY RULES HAS BEEN MADE AVAILABLE TO ME BY DR. MINTER, AS FOLLOWS:** I may request a hard copy from Dr. Minter, view a copy in the office, or access/download the information at www.minterpsych.com. _____ (initial)

2. *Psychological assessment has both benefits and risks.*

Our conversation today constitutes a psychological assessment. My goal is to understand you as a person, what you're facing, and how I might be helpful to you in achieving your goals. Often I ask sensitive questions. Sometimes painful emotions arise. You may be upset by my clinical opinion of your mental health—or relieved. You are encouraged to let me know if anything in our conversation raises troublesome feelings. These are the risks of this professional interaction. On the other hand, most people find these interviews comforting and encouraging, as they voice feelings, gain perspective, grieve losses, enjoy a deeper understanding of self, and become hopeful that change is possible and plan to make it happen. These are some of the benefits of a psychological assessment.

If you are seeking psychological testing there are additional risks and benefits. For example, the results of the testing may not be what you anticipate or hope for. You may not qualify for the services you seek. You may disagree with my professional opinion of your mental health. On the other hand, testing may provide useful information, inform an opinion or recommendation, or possibly qualify you for some medical, mental health, or financial service. No outcome can be known prior to the evaluation itself. _____ (initial)

3. *This initial conversation is not a commitment to treat you.*

Sometimes I'm not the best person to help you. You may benefit from a specialist, or a therapist of different gender, age, experience, area of expertise, or ethnicity. I also refer people to others when I feel that your needs are outside the areas of my clinical practice. I want you to be under the best care possible. If I cannot treat you myself for some reason, I will offer you referral alternatives.

I acknowledge these limits of confidentiality, understand the risks and benefits of psychological assessment, and consent to an initial interview. I understand that this assessment is not a commitment from Dr. Minter to treat me. I have been encouraged to ask questions regarding these matters.

_____ _____

Signature Date

_____

Print Name