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

Clinical Psychology

Licensed Psychologist/PY 8553

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## New Client Information

Date: _____

**Patient's Name:** _____

Date of Birth: _____ Age: _____ Gender: _____ Ethnicity: _____

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

Street Address: _____

City, State, Zip: _____

Preferred Phone: _____

Voice message at this number OK? ☐ yes ☐ no _____(initial your consent)

SMS text at this number OK? ☐ yes ☐ no _____(initial your consent)

By providing a telephone number and submitting this form you are consenting to be contacted by SMS text message from Steven S Minter PsyD LLC. Message frequency may vary. Message & data rates may apply. Reply STOP to opt-out of further messaging. Reply HELP for more information. See our Privacy Policy at https://www.minterpsych.com/uploads/1/3/2/5/13259248/1.0-new-difc.pdf. ***Per federal law, your information will not be shared, sold, or conveyed to third parties for marketing or promotional purposes.***

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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**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:** Initial 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 may be 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 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 note that the law treats information conveyed to me by family members of a client as actionable.

- 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. Please consult an attorney for further information.

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 copy from Dr. Minter, or download the information at www.minterpsych.com. _____ (initial)

## 2. *Psychological assessment and psychotherapy are healthcare procedures. All healthcare procedures have both potential risks and potential benefits.*

Our first two conversations constitute your 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. Psychological assessment and therapy can have unanticipated results. On the other hand, most people find these interviews helpful as they feel free to shift in a safe space.

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 may result in one of the following:*

- You may not feel comfortable working with me, and 1) seek a referral; or 2) simply not return
- You may wish to schedule a follow-up conversation, and continue with development of a treatment plan
- You may prefer to think about our conversation before deciding how to proceed

In addition:

- I may decide that I'm not the best person to treat you and offer you a referral if you wish
- I may suggest alternatives to individual therapy for you to consider
- I may decide to offer you another conversation in which we could brainstorm a treatment plan

*I acknowledge the limits of confidentiality, understand the risks and benefits of assessment and therapy, and I am aware of the potential outcomes of this conversation. I have been encouraged to ask questions regarding these matters.*

_____ _____

Signature Date

_____

Print Name