Laura Tripet Dodge LLC

Laura Tripet Dodge, MS, *Licensed Psychologist*

P: 952.933.3121 | F: 952.933.3511

DATE_____

LAST NAME	FIRST NAME	MIDDLE INITIAL	BIRTHDATE	AGE

MARITAL STATUS: ***S***____ ***M***____ ***W***____ ***D***____ ***SEP***____ ***LIVE WITH PARTNER***_____

ADDRESS_____ **EMAIL** _____

_____ **PHONE** _____

_____ **(Cell)** _____

EMPLOYER / SCHOOL_____**OCCUPATION**_____

IF MINOR, NAME OF GUARDIAN_____**PHONE #**_____

PERSON RESPONSIBLE FOR BILL_____
(relationship)

ADDRESS (if different)_____

EMERGENCY CONTACT_____**PHONE #**_____
(relationship)

****

INSURANCE INFORMATION—Please show your insurance card and ID

BLUE CROSS BLUE SHIELD ID #_____ ***GROUP #***_____

POLICYHOLDER'S NAME_____
(RELATIONSHIP TO CLIENT)

POLICYHOLDER'S BIRTHDATE_____ ***PLACE OF EMPLOYMENT***_____

ANY ADDITIONAL INSURANCE?: YES_____ NO_____ If so, please provide secondary policy information.

MEDICAL ASSISTANCE #_____

****

HOW DID YOU LEARN ABOUT MY PRACTICE?_____

REFERRED BY:_____

(DIAGNOSIS)

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CONSENT TO PSYCHOLOGICAL/ MENTAL HEALTH EVALUATION AND TREATMENT

I authorize and voluntarily consent to treatment by Laura Tripet Dodge, M.S., L.P., including diagnostic procedures (e.g. psychometric tests and diagnostic interview) and treatments (e.g. psychotherapy and marital therapy). I am aware that psychological/ mental health assessment and treatment sometimes entails emotional pain, stress, and life change. I am aware that the practice of psychology is not an exact science. I affirm that no guarantees have been made to me regarding the outcome of the diagnostic or treatment procedures**.**

RELEASE TO SUBMIT REQUIRED INFORMATION FOR BILLING

Your insurance company requires information about your care in order to process your claims. I authorize the release of information from my record that is required by my insurer in order to submit claims for my care.

CONSENT FOR COORDINATION OF CARE

Your insurance company may request that your care is coordinated with your MD or primary care provider.

I authorize coordination of care with _____.
(provider's name)

RELEASE TO CONTACT REFERRAL SOURCE

I authorize Laura Tripet Dodge, MS LP to contact the professional, individual or agency by whom I was referred with the information that I am or will be receiving services.

RELEASE FOR NON-SECURE COMMUNICATION

Many common forms of communication (*email, text, SMS*) present potential risks to your protected health information. In order to communicate in a manner that best protects your privacy, it is recommended that you communicate with me using telephone, my confidential voicemail or send information via US mail or FAX.

Email in its standard form is not secure, and may present a risk to your privacy. Please be advised that if you choose to use email to communicate with me, third parties who have access to your email or device (tablet, phone, computer) may also have access to the information you send. This might include your employer, if you use your work email. *Your signature below authorizes Laura Tripet Dodge MS, LP to respond to your email.*

Please note that Laura Tripet Dodge LLC *does not* have the ability to receive text messages.

RECEIPT OF CLIENT INFORMATION

I have received information about Laura Tripet Dodge LLC's procedural guidelines, policies and practices to protect the privacy of health information, emergency procedures, fees, and competencies.

Please cross out and initial any of the above to which you <u>do not</u> consent

_____ _____ _____
Signature of Client Date Signature of Parent / Guardian

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FEES FOR SERVICES

I understand that the fee for the initial one hour assessment or consultation appointment is *two hundred dollars* ($200). Subsequent individual psychotherapy sessions typically consist of either a 40-45 minute clinical hour charged at a rate of *one hundred sixty-five dollars* ($165) or a 55 minute clinical hour at *one hundred eighty dollars* ($180). A brief 25 minute appointment for check in or follow up purposes is charged at *one hundred dollars* ($100). Fees for other services will be discussed at the time of scheduling. When sessions are arranged for a longer or shorter period of time, the fee will be adjusted based on these rates. You will be provided notification of any additional charges or rate changes ahead of time.

FINANCIAL CONTRACT

I guarantee payment to Laura Tripet Dodge LLC for all charges incurred or to be incurred for services rendered to me or to others at my request. *All fees due are to be paid at the time of service*, with the exception of clients utilizing their Blue Cross Blue Shield of MN insurance coverage, and clients with coverage through Minnesota Medical Assistance. *Please note that not all Blue Cross Blue Shield policies cover my services, so it is important for you to verify your coverage.* Any co-payment is due at the time of service. For these instances only, claims will be submitted to your insurance for reimbursement.

For all other insurances, I acknowledge that I have the responsibility for submitting claims to my insurance company and I understand that I will pay at the time of each session. I understand that my insurance company may not regard my treatment to be medically necessary and on this basis may refuse payment of my bill. Knowing this, I choose to receive treatment and understand that I will be responsible for payment for services not covered by my insurance.

I also understand that my appointment time is reserved for me, and that I will be charged a full fee for my appointments not canceled with 24 hours notice. I will pay this charge even though my insurance plan does not reimburse for late cancellations or “no shows”.

Interest, in the amount of one and one half percent (1.5%) will be added to unpaid balances. Unpaid bills may be turned over to a collection agency. I agree to pay all costs of collection, including disbursements and reasonable attorney’s fees.

_____ _____

Signature of Client/ Parent/ Guardian Date

_____ _____

Witness

Name_____ Date_____

ADMISSION CHECKLIST Page 1 of 2

Please check any of the following that are currently of concern:

__Depressed mood
__Crying spells
__Sleep difficulties
__Difficulty with motivation
__Irritability
__Impulsivity
__Mood swings
__Suicidal thoughts
__Anxiety
__Frequent worry
__Panic attacks
__Avoidance or procrastination
__Perfectionistic thinking
__Unwanted behavior: habits or compulsions
__Relationship problems
__Sexual concerns
__Grief/Loss

__Problems with eating
__Binge episodes
__Purging
__Body image concerns
__Weight loss or gain
__Physical or health problems
__Recent changes in physical condition
__Menstrual difficulties
__Infertility
__Muscular tension
__Frequent headaches
__Confusion
__Trouble with memory or concentration
__Unusual thoughts
__Easily distracted
__Difficulty completing tasks

__Chemical use
__Problems with anger
__Aggressive or violent behavior
__Self-injurious behavior
__Past experience of abuse or trauma
__Money management
__Work-related concerns
__Problems with school
__Family concerns
__Concerns with parenting
__Legal problems
__Other (specify): _____
_____
_____
_____
_____
_____

How do these concerns affect your ability to function at work, school and/or home? Please describe:

Previous or current therapy: (List any treatment you have or are receiving)

Therapist/Agency	Dates	Purpose	Satisfied with outcome?

Briefly describe what exercise you get each week and how often:

Date of last physical exam:

Any changes in your physical condition?

Physician Name:
Address:

Phone:

List any medical problems you are currently experiencing or for which you are receiving treatment:

List any medications (and dosages) you are presently taking:

Briefly describe your sleep patterns (How much sleep do you get and how restorative?)

How often do you use the following?

Cigarettes: _____ Cocaine: _____
Coffee or caffeinated beverages: _____ Tranquilizers: _____
Alcohol: _____ Stimulants: _____
Marijuana: _____ Other chemicals: _____

Have you or anyone else ever been concerned about your alcohol and/or drug use habits? Yes No
Describe:

Have there ever been concerns about the alcohol or drug use of a significant person in your life? Yes No
Describe:

What brings you into therapy at this time?

What resources or strengths have you used in dealing with the concerns you have identified?

Briefly describe your support system:

Please list your goals for therapy:

Please indicate how long you expect therapy to last: _____

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INFORMED CONSENT CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- If appropriate, we need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and other options for continuing your care will be discussed..

Patient Name:

Signature of Patient/Patient's Legal Representative:

Date:

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Here are a few procedural guidelines for receiving services:

COMMUNICATIONS POLICY

CONTACTING ME

My preferred mode of communication is by phone. Messages can be left on my confidential voice mail on a 24-hour basis, however calls will be returned during business hours Monday through Friday. Please make sure to leave your name, number(s), and times when you can be reached. You can typically expect calls to be returned within 24 hours, with the exception of weekends.

If you wish to communicate with me via normal email, please inquire about the potential confidentiality risks of doing so. Limit the content of your email communication, especially if using work or shared email accounts. I do not communicate via text messages.

If you need to send a file such as a PDF or digital document, it is preferred to FAX it to me at: 952-933-3511

When I am out of town, arrangements will be made with a colleague to cover for immediate needs that may arise. Information and coverage details will be specified on my voicemail message, and I will notify you of planned vacations in the course of appointment scheduling.

IN CASE OF EMERGENCY

If you are experiencing an after hours emergent situation, you may either:

1) call 911, or go to an emergency room of a hospital near you. If you have a psychiatrist, notify their office.
2) Please leave a message to that effect for me, and I will be in touch.

APPOINTMENTS AND CANCELLATION POLICY

Therapy sessions are typically 40-45 or 55 minutes in length, depending upon your treatment plan. Some appointments may be prearranged for longer or shorter periods of time.

If for any reason you should need to cancel or miss an appointment, please contact the office as soon as possible. *Appointments canceled with less than 24 hours notice will be charged at full fee*. I do try to be reasonable with unusual circumstances. Please note that insurance companies do not pay for these late canceled or “no show” sessions.

COMPETENCIES

My professional competencies are posted on my website and are available for your information.

PAYMENT

Payment is due at the time of services using a credit card, FSA or HSA card, or you may make arrangements to pay by check. A receipt will be provided at your request. Insurance billing clients will receive a monthly statement, and you may contact me to make payment by card. Please let me know if you have questions about payment, billing or account issues.

INSURANCE

In choosing to use your insurance benefits it is important to be aware that specific information from your medical record may be required by your insurance company in the process of billing or treatment authorization. Examples would likely include diagnosis, medications, symptoms, treatment plan and related documentation. There may be consequences to having a mental health diagnosis, such as your ability to qualify for certain future health, life, and disability insurance. Not every individual experiences these consequences.

Please remember that services are provided for and charged to you, not to your insurance company. You are responsible for checking with your insurance company to be certain that your policy covers the services provided. Due to the wide variety of types of insurance coverage available, I make no guarantee that any particular company will provide payment for the services that you receive and your insurance carrier will make the ultimate decision about any reimbursement.

I am a preferred provider for Blue Cross and Blue Shield of Minnesota, and will submit claims on your behalf. You will be responsible for all co-payments and deductibles at the time of service. For all other insurance, you are expected to make payment in full at the time of each session and I will provide you with a receipt form. My receipt form contains all the information usually required by an insurance company for reimbursement purposes. Please check with your insurer to obtain specific instructions to submit your claims.