Monique A. Belton, Ph.D

New Patient General Information

Patient Name: _____ **DOB:** _____ **Marital Status**_____

Address: _____**City:** _____ **State:** _____ **Zip:** _____

Home #:_____ **Cell:** _____ **E-mail** _____

Occupation: _____**Employer Name:** _____

SS #_____**Work #:** _____***Is it Okay to call work?*** _____
Emergency contact:_____**Referred by:** _____

INSURANCE INFORMATION

Insurance Company & Phone #_____**Secondary Insurance?** _____

Policy Holder's Name_____ **DOB:** _____ **SEX: M** ___ **F**___
Policy Holder's SS #: _____ **ID #:** _____ **Policy #:** _____

SYMPTOMS

Please check all that apply

_____ **Anger Management problems** ____ **Anxiety** _____ **Stress Reaction** _____ **Panic Attacks**
_____ **Attention Deficit Disorder** (*difficulty concentrating, focusing. hyperactive*) _____ **Behavior Problem**
_____ **Depression** ____ **Suicidal Thoughts** _____ **Homicidal Thoughts**
_____ **Alcohol/Drug use** *(which one(s)*:_____**Last use** _____
_____ **Eating Disorder** _____ **Family Issues** _____ **Marital/Relationship Issues**
_____ **Physical Abuse** _____ **Sexual Abuse** _____ **Problem at Work** _____ **Problem at School**
_____ **Other:**_____
List any medical problems that you are being treated for _____
List any prescription medications you are taking _____
Have you been in counseling before? _____ **Purpose/Issues?**_____
What are your goals for the outcome of counseling? Please describe how you hope your life will be differ-en-
t_____
_____

I hereby authorize the written and/or telephone release of any information including, but not limited to billing records, clinical notes, treatment summaries, and diagnostic information necessary to process insurance claims on my behalf.
I also hereby authorize payment of insurance benefits, otherwise payable to me, directly to the provider. I understand that I am financially responsible for any balance not covered by my insurance. This assignment of benefits and release of information will be in effect until revoked by me in writing.

Signature: _____ **Date:** _____
Print/Type Name:_____

Appointments broken with less than 48 hours notice will be billed to the patient.

Office Policies – Dr. Monique A. Belton

This statement contains information regarding my office policies. Please read them and if you have any questions you may discuss them with me. Your signature at the bottom of this sheet signifies that you have read, understand and agree to abide by these policies. This also signifies that you have received a copy of the policies for yourself.

Appointments are 45 minutes long. Your appointment time is held exclusively for you -please arrive on time as you use your own time when you are late. If you are going to be unable to keep an appointment, you are asked to provide at least 48 hours notice or you will be charged for the time as though you attended. Please note that insurance companies will not cover this charge and you will have to pay the entire amount out of pocket.

Emergencies In case of emergency, you may reach me between appointments through my answering machine. The machine will forward the call if necessary and I will call you back as soon as possible. If you need immediate support before I call, you may contact the Long Island Crisis Center at (516) 679-1111 or the Response Crisis Hotline at (631) 751-7500. When I am out of town, another psychologist will be available for emergencies.

Fees The fee for my professional services is $250 for a 55 minute session of evaluation or treatment. Shorter or longer appointments will be pro-rated at that same rate. You will also be charged this same rate for additional services provided at your request or for your benefit (at the request of an insurance company, attorney, etc,) such as report writing, psychological test scoring, consultation with other professionals, hospital visits, phone calls over ten minutes with you or others, court appearances. Payment in full is expected at the time of the visit unless other arrangements are made with me in advance.

Insurance You are responsible to check with your insurance company regarding your coverage and to track this coverage as treatment progresses. Some things to keep in mind are: Are you currently covered? Am I a provider whose services are paid under this plan? What is your annual deductible? What is the percent of coverage? What is the maximum benefit for outpatient mental health coverage? Remember: You are responsible for the entire bill whether the insurance pays or not.

Billing For most clients, there will be no balance at the end of the month. For those who have made other billing arrangements with me, I will expect payment by the end of the month according to our written fee agreement. If such payment is not made, a $10 re-billing charge will be assessed for that month. Ultimately, if you do not pay as agreed, your account may be turned over to an attorney or a collection agency for collection and you will be held responsible for any legal or collection costs incurred. I can now accept major credit cards, and also process checks electronically. This will make payments more efficient and convenient for us both. This will automate our financial arrangements so that we can focus all of our time on our work together. .

Confidentiality and the Release of Information Your participation in treatment and all information about you is confidential and will not be disclosed to anyone without your written consent, The only exceptions are: 1) Cases of suspected abuse or neglect of a child or elder , 2) Cases where I believe the client presents a clear and imminent danger to him/herself or to another person, 3) Cases where a court subpoenas me to testify or subpoenas my records, and 4) Cases Where an insurance company is helping to pay the fee and requires information about diagnosis and/or reports about treatment.

Signature & Date _____

Monique A. Belton, Ph.D
35 Dix Hills Rd. Huntington, NY 11743
(631)549-7314

Notice of Privacy Practices - Patient Acknowledgements

Name of Patient:_____Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

A statement that this practice is required by law to maintain the privacy of protected health information.

A statement that this practice is required to abide by the terms of the notice currently in effect.

Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.

A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.

A description of uses and disclosures that are prohibited or materially limited by law.

A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.

My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

- The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
- The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction. - The right to receive confidential communications of protected health information.
- The right to inspect and copy protected health information.
- The right to amend protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request

Signature:_____Date: _____

Relationship to patient (if signed by a personal representative of patient): _____