

## **CLIENT DATA FORM**

Date: \_\_\_\_\_

Name: \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_ DOB \_\_\_\_\_

City/State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone: (h) \_\_\_\_\_ (cell) \_\_\_\_\_  
(work) \_\_\_\_\_

Email: \_\_\_\_\_

### **COUPLES INFORMATION:**

PARTNER'S NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

DOB: \_\_\_\_\_

Emergency contact: Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

### **Insurance Information:**

Responsible party for payment. Circle one:

HMO/PPO(COMMERICAL)    CENTENNIAL CARE(MEDICAID)    PRIVATE PAY

If insurance card is available skip to next section, INSURED PARTY.

Primary: \_\_\_\_\_ Secondary: \_\_\_\_\_

Member # \_\_\_\_\_ Member: \_\_\_\_\_

Group # \_\_\_\_\_ Group # \_\_\_\_\_

Policy #: \_\_\_\_\_ Policy #: \_\_\_\_\_

If **INSURED PARTY** is other than the client, please give the following information:

Insured person's name: \_\_\_\_\_

Insured person's DOB: \_\_\_\_\_

Insured person's relationship to client: \_\_\_\_\_

**OFFICE USE ONLY:**    CLIENT ID \_\_\_\_\_ THERAPIST \_\_\_\_\_  
Patient Portal Verification Code: \_\_\_\_\_

# Bosque Mental Health Associates Inc.

5310 HOMESTEAD RD NE SUITE 300, ALBUQUERQUE, NM 87110

Name of person who referred you: \_\_\_\_\_

Referral's Contact Information: \_\_\_\_\_

Do we have permission to inform your referral source of your treatment here?

YES NO

Initials \_\_\_\_\_

Name of Primary Care Physician: \_\_\_\_\_

Phone #: \_\_\_\_\_

Name of Psychiatric MD: \_\_\_\_\_

Phone #: \_\_\_\_\_

Do we have your permission to be in contact with your Doctors? If "YES" you will be asked to sign a Release of Information form.

YES NO

Initials: \_\_\_\_\_

## Past Medical and Behavioral Health Diagnoses:

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## Issues you wish to addressed in therapy:

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## MEDICATIONS

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name	dose	When taken?
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name	dose	When taken?
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name	dose	When taken?
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name	dose	When taken?
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name	dose	When taken?
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name	dose	When taken?
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# Bosque Mental Health Associates Inc.

5310 HOMESTEAD RD NE SUITE 300, ALBUQUERQUE, NM 87110

## Outpatient Services Contract:

Welcome to BMH! This document contains important information about our professional services and business policies. Please read it carefully and ask if you have any questions or concerns. We will be happy to discuss and clarify it with you.

Psychotherapy is a process that works from within the client. There are many different approaches that are used to help alleviate or resolve difficulties you may be experiencing. Unlike visiting a medical doctor, psychotherapy requires a very active effort on your part. To be most successful, you must work on things we talk about during our sessions and sometimes, between sessions.

Your first session(s) will involve an evaluation of your needs. By the end of the evaluation, we will be able to offer some initial impressions of what our work will include and an informal treatment plan if you decide to continue. Because therapy involves a large commitment of time, money and energy, it is important that you feel comfortable working with your therapist. If you are not, please let us know. We will find another suitable therapist for you. Our intention is to have a working relationship that will be a productive and positive experience. All the guidelines that follow are meant to create clarity and prevent misunderstandings. Please tell us if you are ever uncomfortable with any aspects of the therapy or business arrangements.

**Confidentiality:** In general, law protects the confidentiality of all aspects of our work together. With your written consent, you can request that we share confidential information with others of your choice. If you become involved in a legal matter, the court can subpoena your records from us and we are required to comply with the court order. If, at any time, we feel you are a danger to yourself or others, we are required by law to inform appropriate people and agencies to protect you and other parties from danger. If we were to become aware of the physical, mental or sexual abuse of a child, the elderly or disabled persons we are required by law to report the situation to Protective Services. If you have a medical emergency while visiting us we are legally obligated to contact emergency services.

Your initials: \_\_\_\_\_

**Contacting Your Therapist:** We are sometimes not available by phone. During regular business hours, we may not answer the phone while we are serving other clients. When we are unavailable, you will receive our voice mail system. We will make every effort to return your call on the same day except for weekends and holidays. Be sure to leave a clear message with a name and phone number where you can be reached. You also have access to your therapist through our Patient Portal Secure Messaging system. It is set up through our front office staff at the time of intake. If Secure Messaging takes more than 10 minutes of your therapist's time you will be charged \$10 per 10 minute units of time. This is not covered by insurance and will be due at the time of your next appointment.

Your initials: \_\_\_\_\_

**Emergencies:** If you have an emergency and you feel you cannot wait for us to return your call, please do the following: call 911, or call your Primary Care Physician or the ER at the nearest hospital, asking for the psychiatrist on call. You can also call the **University of New Mexico Mental Health Center Crisis Line at 272-2800**. The UNM-MHC provides high-quality emergency service 24 hours a day, 7 days a week.

Your initials: \_\_\_\_\_

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## Outpatient Service Contract (continued)

**Technology:** Please indicate the best method to contact you (circle one) **Phone** **Email**

Secure emailing can be done through our Valant Patient Portal which you will set up on or before the initial visit. Clinical questionnaires used for therapy will not be charged. Please keep in mind emails taking more than 10 minutes of your therapist's time will be charged and that insurance does not cover this service.

Your Initials \_\_\_\_\_

**Insurance: If your insurance changes and/or terminates at any time during your treatment it is your responsibility to inform the administrative staff and your therapist of any changes.** If these changes result in non-payment by the payer (insurance company) you are responsible for the payment of these sessions. A payment plan can be arranged to pay any visits not paid for by insurance. We are out-of-network with some insurance plans. If your plan is out-of-network, you will be expected to pay at the same rate your insurance company would reimburse us. **If your insurance carrier should deny coverage, you will be responsible for payments of your treatment.** We reserve the right to send outstanding balances to collections after 90 days.

Your Initials \_\_\_\_\_

**Co-pays and deductibles: All Co-pays and deductibles are due at the time of services rendered.** We can verify insurance, however it is only a quote of benefits. It may not be exact or accurate. The most accurate information is given to us in an Explanation of Benefits (EOB) from the insurance company. If the co-pay is incorrect you may pay by credit card, a payment plan can be set up or if you've overpaid, a credit can be issued for future visits. If you have overpaid and services are terminated, a refund will be issued. All services must be paid by insurance companies before a refund check is issued. We reserve the right to send outstanding balances to collections after 90 days.

Your initials: \_\_\_\_\_

**Payment:** We accept Cash, Check, Credit or Debit Cards and HSA Cards for payment of copays, deductibles or private pay. If you chose to use a Credit or Debit Card, we charge a convenience fee of \$1.25 per transaction.

Your initials: \_\_\_\_\_

**Private Pay Fee and Out-of-Network Fee: BMH rate for a 50-min individual session is \$125.00 plus tax. A Couple session is \$150.00 plus tax.** Payment is due at the time of service. There will be a private fee for letters, reports and evaluations that we are asked to prepare on your behalf. Telephone consultations running over 10 min will be billed at the private pay amount. We reserve the right to send outstanding balance to collections after 90 days.

Your initials: \_\_\_\_\_

**Bosque Mental Health Associates Inc.**

## Outpatient Service Contract (continued)

**Records Request:** We charge a \$25.00 plus tax for retrieval and copying fee of all records requests. A Payment and Release of Records form will need to be signed. Please allow a minimum of one week to process any records request. Please be aware that if it has been more than 2 years since you were seen in the office it may take longer to retrieve your records.

**Your initials:** \_\_\_\_\_

**Cancellation Policy:** We anticipate your compliance with scheduled appointments. If you must cancel we require a 24-hour notice unless we both agree that you were unable to attend due to circumstances that were clearly beyond your control. Please note that insurance companies do not cover missed appointments. The fee for an unexcused/missed appointment or late cancellation is \$50.00. These charges will be your responsibility. We ask that a credit card be on file to charge for No Show or late cancellation fees. This information is strictly confidential and will not be shared with any other organizations or entities.

Credit Card Type: \_\_\_\_\_ (Visa, Master Card, AMEX, Discover, Flex Account)

Name on Credit Card: \_\_\_\_\_ Credit Card #: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ CVV Code: \_\_\_\_\_

Patient Signature for Credit Card: \_\_\_\_\_

**Your initials:** \_\_\_\_\_

Your signature indicates that you have read and agree to the policies outlined above.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name of client and/or guardian:** \_\_\_\_\_

**Therapist Signature** \_\_\_\_\_