MAYA S. ZIEGLER, Ph.D.
Licensed Psychologist # PSY 11215

# NEW CLIENT REGISTRATION

Name:_____ Date of Birth: _____

Address:_____ Today's Date:_____

City:_____ State/Zip_____

Telephone: (Home)_____ (Work) _____ (Cell)_____

Which number should I use to reach you? _____ Email_____

If Client is a minor, list responsible parties: _____

How were you referred to me?_____

Primary Care Physician: _____ Telephone:_____

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Insurance Company: _____ Do you have a secondary policy that covers Mental Health benefits? Yes No

ID#: _____ Group #_____ Authorization #_____

Insured's Name: _____ Date of Birth:_____ Relation to Client: _____

Occupation: _____ Employer: _____

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Are you currently in treatment with any other mental health professionals? Yes No
Name: _____

Are you taking any medications for this problem? Yes No
Please list: _____

Is this visit related to a legal matter? _____ accident? _____ employment? _____

If yes, please explain:_____

***Please read the second page carefully. It provides basic information about psychological services, as well as this office, and financial policies of my practice.***

1151 Dove Street, Suite 160 · Newport Beach, CA 92660 · (856)208-8804

**Treatment:** Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, therapy has also been shown to have many benefits. It often leads to better relationships, solutions to specific problems, and significant reduction in feelings of distress. There are no guarantees of what you will experience. Therapy typically involves regular sessions, usually 50 minutes in length. Duration of treatment varies depending on the nature of the problem and your individual needs. Please note that insurances usually reimburse only for solution oriented, medically necessary treatment. You have the right to terminate treatment at any time, and are obligated only to pay for completed sessions.

**A scheduled appointment means that time has been reserved only for you. If an appointment is missed or cancelled with less than 24 hours notice, you will be charged $50 for each missed/late/or cancelled appointments. Frequent cancellations may result in termination of your treatment. It is important to note that insurance companies do not reimburse for cancelled sessions. Please initial here to indicate your understanding of this policy:** _____

**Confidentiality:**
Today, my office will provide you with a personal copy of my Notice of Privacy Issues. This notice explains your rights, my legal duties, and my privacy practices. It also describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully. In addition to what is listed in this notice, please be aware that I am obligated to break confidentiality in cases where there is suspected child or elder abuse, threats of violence against others, or risk of suicide.

**Contacting Me:**
I am in my office daily; however, if I am with a client, I am unable to answer the phone. I do check messages frequently, including in the evenings and on weekends. If I am busy, or it is after business hours, you will receive my voicemail message. I respond as quickly as possible. If your call is an emergency and I do not call back within a short period of time, please do not wait for a return phone call. In this case, go the nearest emergency room or dial 911.

**Fees:**
If you have accepted insurance, only the co-pay is due at the time of session. Otherwise, payment in full is expected. The fee for the first interview is $175.00. After that, my basic hourly fee is $150. Other services, including report writing, letter writing, telephone conversations longer than 10 minutes, and consultation with other professionals (with your permission) will be billed at the same hourly rate. You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Because of extra costs, training and experience associated with testing, another rate schedule applies. Should you request legal involvement, the difficulty and time required in preparation for, or attendance, at any legal function will be charged at $250 per hour.

Checks returned for insufficient funds will result in a $28 charge. If your account has not been paid for more than 60 days and other arrangements for payment have not been agreed upon, I have the option of hiring a collection agency to secure the payment. If such legal action is necessary, its costs will be added to the claim.

IF YOU WISH TO USE YOUR MENTAL HEALTH INSURANCE COVERAGE, I will bill your carrier and assist with insurance reimbursement. However, please be aware that, in all cases, *charges are the client's responsibility.* In addition, any co-payment necessary should be made at the time of the session. Please initial here to indicate your agreement with this policy: _____

*I have read and understand this statement of office and financial policy and agree to its terms. I hereby give my consent for the evaluation and/or treatment of myself or my child. If I am seeking treatment or evaluation for a minor child, I further certify that I have the legal authority to do so, and will seek to inform the noncustodial parent, or other person responsible for this child, of this treatment. I also acknowledge receipt of the Notice of Privacy Practices.*

Name (printed): _____ Signature:_____

Therapist Signature_____ Date: _____

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## Agreement regarding Prior Authorization and Uncovered Services

I, the undersigned, acknowledge and understand that behavioral health treatment is a specialty service and often requires prior authorization from my insurance provider or a referral from my primary care physician. I acknowledge it is ultimately my responsibility to understand my specific benefit plan with my insurance provider. I understand that any dispute of co-pay and/or deductible amounts is between me and my insurance provider. I understand that Dr. Ziegler does not accept all insurance companies, and that my insurance may not cover the entire range of psychological services. If I switch to an insurance company that Dr. Ziegler does not accept, I will be responsible for the full rate for my visit and my new insurance will not be billed.

I understand that my insurance company does not cover certain services, such as telephone calls to consult with, or reports completed by, Dr. Ziegler. If I wish to avail myself of these services, I agree to pay the charges.

If I change insurance companies, insurance eligibility, contact phone numbers, and/or my address at any time, I agree to inform Dr. Ziegler immediately.

I have read and understand this agreement. By signing this agreement, I know that I am creating a binding contract that is legally enforceable against me by Dr. Ziegler

_____ _____

Client Name

Signature of Client
(or Parent/Legal Guardian)

_____

Date

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# HEALTH CARE COORDINATION

*This form is used as an authorization to allow Dr. Ziegler to exchange information with your health care provider. Its sole purpose is to ensure continuity and coordination of care for you.*
*Please complete Section I **OR** Section II below.*

## I. PATIENT CONSENT GIVEN:

I understand the importance of communication between my health care provider and Dr. Ziegler. I give my consent to exchange information for continuity and coordination of care purposes. I understand that the information on this form will be communicated only with the individual named below, and may be faxed with appropriate care for confidentiality. I may receive a copy of this consent upon request. Further disclosure requires additional authorization, unless allowed for by law.
*This consent expires one year from the date of signature.*

_____ _____
Print Name Date of Birth

_____ _____
Patient/Guardian's Signature Today's Date

**HEALTH CARE PROVIDER INFORMATION:**

_____
**First and last Name** **Street Address (if known)**

_____ _____
**Phone Number** **Fax Number**

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*This section will be completed by Dr. Ziegler*

Dear Healthcare Provider:

I am the licensed psychologist for the above named patient, initially seen in this office on _____.
Current diagnosis code is:_____.

Outpatient care is being provided and the treatment plan consists of the following modalities:
____ Individual Therapy _____ Family Therapy _____ Couples Therapy _____ Other

If you need further information, contact me at 949-553-0595

_____
Maya S. Ziegler, Ph.D.

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## II. PATIENT CONSENT DECLINED

At this time, I DO NOT give my consent to exchange information.

_____ _____
Signature Today's Date