



**PERSON RESPONSIBLE FOR BILL:** (or "same")

Name: \_\_\_\_\_ Home Ph: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_ Work Ph: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

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

- **I authorize the release of any medical information necessary to process insurance claims.**
- I authorize payment of benefits to Dr. Schenk if full payment is not made at the time of service.
- I understand that I am responsible for missed appointment charges (50% of the full fee for the length of session scheduled) unless Dr. Schenk is notified 24 hours in advance.
- I understand that I am responsible for payment of all services rendered. In the event that payment is not made at the time service is rendered, then I agree to pay my account balance in full within 30 days of the billing date. If timely payment is not made, I agree that I am responsible for all costs of collection, including court costs and reasonable attorney's fees.
- I understand that interest may be charged on outstanding balances more than 60 days old at the rate of 1 % per month.

SIGNED \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**INSURANCE INFORMATION:** (if applicable) *Please check your policy to determine if preauthorization is needed. Please note: Claims for services will be sent to your insurance company each month unless you specifically instruct otherwise.*

Name and address of policy holder (or "same"):

\_\_\_\_\_  
\_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Ph #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

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

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

Member (ID) #: \_\_\_\_\_ Group #: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_

Patient's Relationship to policy holder:

Self       Spouse       Child       Other

I have read [  ] and/or received [  ] a copy of the HIPAA notice regarding Dr. Schenk's office policies and practices to protect my health information. Available at: <http://www.drpaulschenk.com/forms/HIPAA.PDF>

\_\_\_\_\_  
Signature Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



Language spoken in the home if not English: \_\_\_\_\_

Internist \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Permission to talk to internist? Yes \_\_\_\_\_ (Please initial if yes) No \_\_\_\_\_

Have you been in therapy before? Yes [  ]; No [  ]

If *yes*, please briefly summarize (when, how long, goals, results):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If *yes*, please provide the name, address and phone number of your most recent therapist. I will not contact him/her before I obtain a signed release from you.

Therapist name: \_\_\_\_\_

Address \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### **Pregnancy and Birth History**

To the extent known, please complete the following:

Describe any complications that occurred during your mother's pregnancy with you.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe any complications that occurred during delivery (e.g., prematurity, postmaturity, length of labor, special procedures, low APGAR score, etc.).

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Birth Weight \_\_\_\_\_

How long after birth did your parents take you home? \_\_\_\_\_

### **Early Temperament**

Describe your temperament during the first six months (i.e., sleep patterns, colic, eating patterns).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Developmental History**

To the extent known, please list any developmental milestones that occurred early or late. (Walking, talking, toilet training, etc.)

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**Medical History**

List significant sicknesses, operations and injuries. Note history of frequent ear infections, ruptured eardrums, tubes. Include the age when they occurred and severity. Please pay special attention to head injuries, any loss of consciousness, convulsions, or very high fever.

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Did anyone in your immediate family or their close relative have any of the following:

Nervous tics	Yes _____	No _____	Who _____
Seizures (epilepsy)	Yes _____	No _____	Who _____
Depression	Yes _____	No _____	Who _____
Bipolar Disorder	Yes _____	No _____	Who _____
Thyroid problems	Yes _____	No _____	Who _____
Other emotional problems	Yes _____	No _____	Who _____
Hyperactivity/ADHD	Yes _____	No _____	Who _____
Learning problems	Yes _____	No _____	Who _____
Language problems	Yes _____	No _____	Who _____
Mental retardation	Yes _____	No _____	Who _____
Similar problems to you	Yes _____	No _____	Who _____

Does any disease run in the family? If so, what? \_\_\_\_\_

Indicate any medications you are **currently** taking and the prescribing physician. (Include dosage and the reason for taking it.)

Medication	Dose	Physician	Reason for taking

Indicate any medication you have taken *in the past few years for more than a month* and the prescribing physician. (Indicate dosage and the reason for taking it.)

Medication	Dose	Physician	Reason for taking

Approximately when was your vision last examined? \_\_\_\_\_  
Results \_\_\_\_\_

Approximately when was your hearing last examined? \_\_\_\_\_  
Results \_\_\_\_\_

Other special medical tests (EEG, CAT scan, MRI)  
Name of Test \_\_\_\_\_ Date \_\_\_\_\_  
Results \_\_\_\_\_

Have there been any previous psychological, psychiatric or neurological evaluations? Yes [  ]; No [  ] If *yes*, please list the year and provider.  
Please attach any pertinent reports.

\_\_\_\_\_

Height: \_\_\_' \_\_\_" Current weight: \_\_\_ Range during last 12 months: \_\_\_\_\_

Please describe current and past tobacco use: \_\_\_\_\_

\_\_\_\_\_

Caffeine use: # cups coffee/day \_\_\_\_\_; # caffeinated 12 oz. soft drinks/day \_\_\_\_\_

History of alcohol use (1 beer = 6 oz wine = 1 oz hard liquor):

Your current range per week: from \_\_\_ to \_\_\_ drinks.

Past range per week (at your highest usage): from \_\_\_ to \_\_\_ drinks.

When was this? \_\_\_\_\_

Have you ever been in an accident or had a ticket for driving under the influence?

Yes [  ]; No [  ] If *yes*, please give details. \_\_\_\_\_

\_\_\_\_\_

If you have ever had moving traffic violations, please describe:

\_\_\_\_\_

\_\_\_\_\_

**Social/Emotional/Behavioral History**

Please list your personality characteristics, both positive and negative:

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**School History**

List previous schools, colleges/universities, technical schools attended:

Years                      School                      Degree (if any)                      Approx. GPA

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Describe any learning/behavioral/social difficulties you had while attending school:

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Describe any special services you received in school or privately (resource room, tutors, remedial reading, speech therapy, etc.):

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Did you ever repeat a grade? \_\_\_\_\_ When? \_\_\_\_\_

What was the problem? \_\_\_\_\_

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I very much appreciate the time and energy you spent in filling out this questionnaire. Please add any additional comments on a separate sheet of paper as needed.

*When you come for your first appointment, please bring a photograph of yourself (and your family if that applies.) I will make a copy and return the originals.*

Signed \_\_\_\_\_

## Insurance Benefits Worksheet

This worksheet is designed to help you get the most from your insurance policy. Some insurance companies require pre-authorization for behavioral/mental health services. Those that do rarely back date an authorization, so please call your carrier before your first appointment to be sure. Some insurance companies use a "third party administrator" or "TPA" to handle mental health benefits. Note: For couples with two different policies, I believe Georgia law dictates that the insurance of the policy holder with the earlier birth date (the birth *month*, not the birth year) will be the primary policy.

Insurance companies like to have providers sign contracts. Providers ostensibly benefit by getting more referrals when they are on the provider list. The tradeoff is that the "allowed" rate contracted providers are allowed to charge has continued to decrease over the past 20 years or so to what I used to charge in 1980. Because of this, in 2012 I terminated my contracts with all insurance carriers except Medicare, Medicaid and Tricare.

Unfortunately, I find it often takes several phone calls to get to the person at the insurance company who can answer the questions that follow.

1<sup>st</sup> #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ x\_\_ x\_\_ x\_\_ x\_\_ Name of Person Contacted: \_\_\_\_\_

2<sup>nd</sup> #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ x\_\_ x\_\_ x\_\_ x\_\_ Name of Person Contacted: \_\_\_\_\_

3<sup>rd</sup> #: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ x\_\_ x\_\_ x\_\_ x\_\_ Name of Person Contacted: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy Holder's ID#: \_\_\_\_\_

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

Please confirm the name and address for mailing mental health claims. It is usually not the address on the insurance card.

Insurance Company Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_

To answer these questions, the insurance company will need to know:

My name: Paul W. Schenk, Psy.D. ("Dr. Schenk, a doctoral level clinical psychologist")

My zip code: 30084

My federal tax id#: 58-1477829

I am an "out of network" provider (except for Medicare, Medicaid and Tricare). Some policies do not cover any out of network services; some have a different deductible.

Is pre-authorization required for mental health visits? [ ] yes; [ ] no

If "yes", ask for the authorization # for the initial visit(s): \_\_\_\_\_

Authorization # for subsequent visits (if provided): \_\_\_\_\_

The number of (additional) visits approved with this authorization: \_\_\_\_\_

Is a separate pre-authorization required for testing? [ ] yes; [ ] no

If "yes", ask for the authorization # for testing: \_\_\_\_\_, or

Ask for the web site URL where they have the form that I must submit. (I have some, but not all of these.)



Is there a separate mental health deductible for the policy?  yes;  no  
 If "yes", how much is it? \$ \_\_\_\_\_ How much has already been met? \$ \_\_\_\_\_  
 If "no", how much is the medical deductible? \$ \_\_\_\_\_ How much has already been met? \$ \_\_\_\_\_  
 Is there a separate deductible for out-of-network services?  
 If "yes", how much is it? \$ \_\_\_\_\_ How much has already been met? \$ \_\_\_\_\_  
 Is your deductible based on a calendar year  or on a different 12 month period? \_\_\_\_ to \_\_\_\_

Getting the insurance company to tell you its Usual and Customary Rate (UCR) is usually challenging. Be persistent if you need to know. Use this list to record how much of my standard fee the insurance company will consider for the services you want. Remember, if they tell you they will cover 80%, leaving you with a co-payment of 20%, that 80% reimbursement rate will be based on their UCR rate, which is probably less than my rate.

For example, if the UCR is \$140 for CPT code 90837, and the insurance company covers 80% (*of the UCR*), they will pay \$112, leaving you a co-pay of \$88 (my actual fee of \$200 - \$112 = \$88).

CPT Code	Type of Session	Fee Schedule: Amount <i>Allowed</i> the "UCR" rate
CPT code 90832	Individual Psychotherapy (30 minutes)	\$ ____ out of \$100
CPT code 90834	Individual Psychotherapy (45 minutes)	\$ ____ out of \$170
CPT code 90837	Individual Psychotherapy (60 minutes)	\$ ____ out of \$200
CPT code 90791	Diagnostic Interview (60 minutes)	\$ ____ out of \$200
CPT code 90847	Family Psychotherapy (60 minutes) (e.g., the client and one or more other family members)	\$ ____ out of \$200
CPT code 90846	Collateral Visit (60 minutes) (e.g., the child is the client but I am meeting with one or both parents <i>without</i> the child present.)	\$ ____ out of \$200
CPT code 96101	Psychological Testing/Evaluation (per 55 minute hour) Can more than one hour (one "unit") of Psych Testing be billed on the same day? <input type="checkbox"/> yes <input type="checkbox"/> no	\$ ____ out of \$200

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