Richard H. Stout, MS, NCC, LMHC

Adult * Child * Adolescent Psychotherapy

Florida Licensed Mental Health Counselor (# MH0003568 , National Certified Counselor (NCC # 38963),
Certified Clinical Criminal Justice Specialist (#14018) by the National Assoc of Forensic Counseling,
Certified Traumatologist (#1103)
Florida Supreme Court Certified Divorce Mediator (# 4938F)

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Website: richardstout.com
Appointments, Re-schedules, Cancellations email: rstouteap@aol.com
Business Office, Billing email: Richardstoutadm@aol.com

Dear New Patient,

Welcome! I commend you for seeking our services.

It is important that you complete these forms and bring them with you to your appointment.
When you arrive for your initial visit, we will make a copy of your Insurance Card and Driver's License, or if possible, please make copies ahead of time and bring them.

We will also collect any fees or co-pay for services at the time of your session.

Patient: ____

Appointment Date & Time: ____

Day: MONDAY / TUESDAY / WEDNESDAY / THURSDAY / FRIDAY / SATURDAY

We are located in ***Park Place***, **2605 West Lake Mary Blvd., Suite 115, Lake Mary FL 32746.**

Traveling from Hwy. 17-92 we are just past Country Club Road and immediately past/next to Lake Mary Elementary School, on the left side.
You will need to go just past the school and make a U-turn at S. Fifth St.

Traveling from I-4, shortly after passing Longwood-Lake Mary Rd., we are on your right, just past S. Fifth St, but before Lake Mary Elementary School.

If you must cancel this appointment, ***kindly give 24 hour notice***.
I look forward to meeting with you!

Sincerely,
Richard H. Stout, MS, NCC, LMHC

PLEASE NOTE!

** Many Insurance and EAP (Employee Assistance Program) providers **require Pre-authorization for coverage of Mental Health services.** Please **call** the phone number on the back of your insurance card to obtain **your authorization number**, and bring it with you to your session.

****** If Pre-authorization is required, but not obtained, you will be responsible for the full session rate.***

Welcome to the Office!

Information about the Patient

First Name ____________________________________ ***MI*** ______ ***Last*** ____

Date of Birth ________ /________ /_________ ***SSN*** ____

Please circle for Patient *[MALE - FEMALE]* *[SINGLE - MARRIED - SEPARATED - DIVORCED - WIDOWED)*

Address ____

City ____ *State* _________________ *Zip* ___________________________

Best Contact Phone Number ____ *May we leave a message at this number?* ***YES / NO***

****If this is a cellular number, do we have your permission to* ***TEXT*** *'APPOINTMENT-ONLY' information to this number?* ***YES / NO***

Email Address (please print legibly!): ____ *May we contact you at this email?* ***YES / NO***

Please list Employer <u>Providing Coverage</u> ____

******* Emergency Contact Person Name AND Phone Number* ____

Information about the Insured / Responsible Person *(IF DIFFERENT FROM PATIENT)*

First Name ____________________________________ *MI* _______ *Last* ____

Relationship to Patient ________________________________ ***EMPLOYER*** ____

Date of Birth ___________ /___________ /___________ ***SSN*** ____

Patient's Insurance / EAP is through: _____________________ *COPY (BOTH SIDES) OF* ***YOUR INSURANCE CARD attached?*** _____

(OR *Write* ***<u>Insurance Co. Name & ID#</u> Here*** ____***)***

Were you given an ***AUTHORIZATION Number****? If so, please write it here* ____

RELEASE OF INFORMATION

I authorize release of any information necessary to expedite payment of insurance claims. I understand that I am ultimately responsible for any/all charges, regardless of coverage, and understand that any unpaid charges will be sent to Medical Collections.
I authorize payment of medical benefits to the office of Richard H. Stout., MS, LMHC.

Signed *(Patient, Parent or Guardian)*____ *Date* _______________________

CONSENT for PSYCHOTHERAPY TREATMENT and STATEMENT OF UNDERSTANDING

I certify that I have the authority to legally consent to Psychotherapy treatment with Richard H. Stout MS, LMHC, and by my signature below, I am giving this consent. Further, I understand and agree that the first office visit is purely for evaluation purposes, and that the counselor is not obligated in any way to continue to treat me. I hereby give Richard H. Stout permission to perform this evaluation and conduct further treatment as deemed necessary. I understand that I am ultimately responsible for any/all charges, regardless of coverage, and understand that any unpaid charges will be sent to Medical Collections. I agree to give at least 24 hours notice of cancellation of any appointment - Otherwise I understand that I will be billed the FULL charge for the session that was reserved for me.

Signed *(Patient, Parent or Guardian)*____*Date* _________________________

Statement of Understanding

(Effective 3/1/2013)

Welcome to the office of Richard H. Stout, MS, LMHC, Florida-Licensed Psychotherapist. Our primary focus is to provide a safe, confidential and therapeutic environment in which you may effectively and efficiently deal with your issues. With this goal in mind, and to eliminate any misunderstandings, the following are general practice guidelines for your review and signature(s). Suggestions and/or questions are welcomed anytime. Thank you for the opportunity to participate in your care.

PRACTICE GUIDELINES

Your first office visit is purely for evaluation purposes. While you should expect to benefit from this treatment, understand that due to factors beyond our control, particular outcomes cannot be guaranteed. The patient understands and agrees that consistent and regular attendance, along with compliance with treatment assignments and recommendations will produce the maximum benefits. The patient has the right to ask any questions about their care.

I/we understand I/we am/are free to discontinue treatment at any time. If you decide to do so, you will notify this office at least two (2) weeks in advance so that effective treatment planning for continued care can be implemented.

FINANCIAL INFORMATION AND BILLING POLICIES

Initial Evaluations are billed at $150, and subsequent sessions are billed at $110 per 45-50 minute clinical hour. Therapy services provided in different time durations, Report /Letter Writing and/or Crisis Calls are pro-rated at the rate of $110 per clinical hour.

I, the patient, understand that I am responsible for payment of services rendered, regardless of whether that service is covered by an insurance policy, and I agree to pay these costs regardless of any disputes with my Insurance Company. While it is our pleasure to bill your Insurance or EAP as a courtesy, final payment for our services is ***ultimately your responsibility.*** ****INITIALS*** ☐

I understand that I ***will be charged for appointments not cancelled 24 hours prior to the appointment time.*** I understand that past due debts may be forwarded to a Medical Collection Agency for recovery. ****INITIALS*** ☐

Per Office Policy we obtain CREDIT CARD PRE-AUTHORIZATION for Co-Pays & Deductibles at Point of Service, And/or Card Will Be Charged for Missed Appointment Fees or Balances Due over 30 Days.

****You may revoke this authorization at any time by written request.*

If you prefer to pay for services by check or cash, please bring payment with you to EACH SESSION.

Name on Card: ____

Card#: ______________________________________ Exp. Date: ______________ SEC CODE ________

Signature: ____

Our office contracts with many Insurance Companies, and sometimes the patient must obtain ***PRE-AUTHORIZATION for services to be covered. Please contact your insurance company to determine any such requirements PRIOR to your first session***. We request co-pays or deductibles be ***paid at time of each session.*** ****INITIALS*** ☐

CONFIDENTIALITY

No one will reveal information concerning your psychotherapy care, except as follows: (1) You consent in writing, (2) Your life or safety is threatened, (3) disclosure is required by law, or (4) information is required by your Insurance Company regarding a claim for our services. ANY AND ALL INFORMATION - PERSONAL, MEDICAL OR OTHERWISE - WILL BE HELD IN THE STRICTEST CONFIDENCE.

I have read and understand this Statement of Understanding, and will abide by all the above guidelines.
A copy of this signed sheet will be provided to me upon request.

Patient Signature: ________________________________ **Date:** ________________

Witness: ____ **Date :** __________________

NOTICE OF PRIVACY PRACTICES
Receipt and Acknowledgment of Notice

Patient Name: ____

DOB: ___________________________ **SSN:** ____________________________

As a patient, I understand that I have certain rights and responsibilities as it relates to my privacy and healthcare. I understand it is important to know those rights and responsibilities.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of "Notice of Privacy Practices" of the Offices of Richard Stout, M.S., L.M.H.C. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Richard Stout, M.S., L.M.H.C., at P.O. Box 953443, Lake Mary, Florida 32746

____ ____________________________________

Signature of Patient/Client ***Date***

OR:

____ ____________________________________

Signature or Parent, Guardian or Personal Representative * ***Date***

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.) ______________________________

OR:

❑ **Patient/Client Refuses to Acknowledge Receipt**:

____ ____________________________________

Signature of Staff Member ***Date***