Empowering Encounters
AT HAGAN HEALTH

WELCOME TO OUR PRACTICE!

At Hagan Health we are dedicated to giving you courteous, caring, treatment. Included in this packet you will find valuable information on the policies and procedures of our office. Please read each page carefully, as it will help us serve you more efficiently and completely. It is strongly recommended that you keep a copy of our payment schedule and policies and procedures for reference should you have questions in the future. Thank you, and again, welcome to our practice!

Our secretarial office hours are as follows:

Monday-Thursday: 8:00 am to 6:00 pm

Friday: 8:00 am to Noon

We are currently located at:

4010 Dupont Circle, Suite 202

Louisville, KY 40207

Payments:

- Payments are due at the time of service. Please be prepared to make a payment before your appointment.
- We accept checks, cash, debit or credit cards.
- Please bring the completed forms & payment with you to your initial evaluation.
- **If you are using insurance, please contact your insurance company to determine benefits prior to your appointment. Be sure to ask what your copay may be and/or if you have a deductible that must be met.

New Psychotherapy Client Paperwork

Basic Information

Last Name:_____ First Name:_____ M.I.: _____

Date of Birth:_____ Gender Identity:_____ Preferred Pronouns:_____

Address:_____

City:_____ State: _____ Zip:_____

Phone: _____ Cell Home (Circle one)

Email:_____

Occupation:_____ SSN:_____

Legal Guardian (if the client is a minor):_____

Marital Status (circle one): Single Married Seperated Widowed

Spouse's Name (if applicable): _____

Communication Preference (circle one): Phone Call Text Email

Do we have permission to leave you a voicemail? Yes No

Emergency Contact

Name:_____

Phone:_____ Relationship to you:_____

Insurance Information

Insurance Co:_____

Policy Holder (if different than client):_____

Relationship:_____ DOB:_____SSN: _____

Policy #:_____ Group #:_____

Psychiatric History

Are you currently prescribed psychiatric medications? Yes No

If so please list them:_____

Who is the prescriber?: _____

Previous mental health diagnoses:_____

Have you ever been hospitalized for psychiatric reasons? Yes No

If so, when and where? _____

Do you have any history of drug/alcohol abuse? Yes No

Have you had any psychotherapy or counseling in the past? Yes No

Have you had thoughts of harming yourself? (circle all that apply)

Never Yes, currently Yes, in the past

Have you had thoughts of harming others? (circle all that apply)

Never Yes, currently Yes, in the past

Have you ever experienced any kind of abuse? (circle all that apply)

Never Verbal Emotional Physical Sexual

Social History

Who do you currently live with?_____

Are you currently:

Single In Relationship Married Divorced Widowed

Do you have children? Yes No

If so, how many and what ages? _____

Have you ever served in the military? Yes No

Are you currently involved in the court system? Yes No

Do you have any religious or spiritual beliefs that are important to you?

_____

Past Medical History

Please list any major illnesses:_____

Please list any surgeries:_____

Please list any major injuries:_____

Have you ever had a head injury? Yes No

Allergies:_____

Who is your Primary Care Provider?_____

For Women

Are you currently pregnant? Yes No

Have you ever struggled with any of the following? (circle any that apply)

Postpartum depression

Premenstrual dysphoric disorder

Fertility concerns

Developmental History

Were you in regular classes in school?_____

Did you experience any learning problems?_____

Were you ever diagnosed with a developmental delay? Yes No

Have you ever been diagnosed with ADHD (or ADD) Yes No

What is your highest level of education? _____

Family Psychiatric History

Has anyone in your family ever struggled with or been diagnosed with any of the following:

(Please circle yes or no and identify relationship to you, if applicable)

Alcohol abuse?	Yes	No	Relationship:_____
Drug abuse?	Yes	No	Relationship:_____
Anxiety?	Yes	No	Relationship:_____
Depression?	Yes	No	Relationship:_____
ADHD (or ADD)?	Yes	No	Relationship:_____
Bipolar Disorder?	Yes	No	Relationship:_____
Schizophrenia?	Yes	No	Relationship:_____
Suicide?	Yes	No	Relationship:_____

Client Financial Responsibilities

Insurance Policies

At this time, only Vern Rickert and Colleen Kidd are in-network with insurance panels. You are responsible for knowing your insurance coverage, including information such as co-pay amounts, deductibles, or necessary prior authorizations. Your insurance does not cover any no-show or late cancellation fees.

Fees for Services without Insurance

The majority of our therapists are self-pay only at this time. The charges are as follows:

60-Minute Therapy Session- $100

Paperwork Fee- $25 *(including accomodation letters, ESA letters, FMLA, etc.)*

Late Cancellation/No Show Fee- $75

*We require 48-hour notice to cancel an appointment. Unfortunately, at this time, we cannot offer services on a sliding fee scale.

Payment Responsibilities

Payment is due at the time of service, to be collected when you check in for your appointment with the front desk. If you are seeing your therapist online, the front desk will be able to check you in and take credit card payment online. Unfortunately, if you are unable to pay for your session, you will have to be rescheduled.

Your therapist can check your balance for you but CANNOT accept payment for you. To make a payment, you can either call the office at 502-326-3011 and pay using a credit or debit card over the phone, mail a check, or pay with cash, card, or check in person at the office during regular business hours.

If you accrue an unpaid balance, your future appointments may be postponed or canceled until your balance is paid off. This is to protect you from running up an overwhelming bill.

By signing below, you are signaling that you have read, understand, and agree to these policies.

_____ _____

Client Signature Date

_____ _____

Parent, Guardian, and/or Legal Representative Signature Date

HIPAA Notice of Privacy Practices

Please see copies of HIPAA Notice of Privacy Practices that are posted in the lobby. You may also ask the front desk for a copy for your records.

By signing below, you are signaling that you have read, understand, and agree to these policies.

_____ _____

Client Signature Date

_____ _____

Parent, Guardian, and/or Legal Representative Signature Date

Permission To Share Information

I give permission to the Hagan Health team to discuss in general terms my diagnosis and treatment with the following people:

Therapist (permission to communicate with your therapist regarding your treatment)

Name: _____

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

Family Physician (permission to communicate with physician regarding your treatment)

Name: _____

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

Family Member(s) (permission to communicate with the following family member(s)

Name: _____

Relationship: _____

Name: _____

Relationship: _____

*If there are any other people or agencies that you would like to share information with, your therapist can provide you with a separate Release of Information form.