Psychology and Beyond, LLC

Pia Nathani, Ph.D., HSPP
260 S 1st St Suite 2, Zionsville, IN 46077
Ph: 317-498-5751
Fax: 317-204-7666

ADULT INTAKE

Today's Date: _____ Legal Name: _____

Age: ____ Birthdate: ___/___/_____ SS#: _____ Marital Status: _____

Street Address: _____ City: _____ Zip: _____

Home Phone: _____ May Call? _____ Work Phone: _____ May Call? _____

Cell Phone: _____ Permission to Call? _____Permission to leave Voicemail? ___

Employment: _____ Last Worked: _____

Spouse Name: _____ Birthdate: ___/___/_____ Phone: _____

Street Address: _____ City: _____ Zip: _____

Close Friend or Relative: _____ Phone: _____

Previous Professional Help: ____ If Yes, Therapist Name: _____

Location: _____ Date Last Seen: _____

Current Primary Problems: _____

_____

Personal Physician: _____ City: _____ Phone: _____

Medications: _____

Medication Allergies: _____

Children's Name Birthdate Residence Other Information

_____

_____

_____

Psychology and Beyond, LLC

Pia Nathani, Ph.D., HSPP
260 S 1st St Suite 2, Zionsville, IN 46077
Ph: 317-498-5751
Fax: 317-204-7666

Consent for Treatment

I hereby consent and agree to mental health services provided with (a) the scope of the provider's license, certification and training; or (b) the scope of the license, certification, and training of the mental health provider directly supervising services rendered.

I understand (a) all information regarding diagnosis and/or treatment is confidential and will not be released to any other agency/individual without my knowledge and consent except when required by law; (b) my therapist is required by law to report knowledge of elder/child abuse or neglect; (c) my therapist must break confidentiality if there is serious intent to harm myself or another person.

Client Fees

Individual Intake	$225	Individual Therapy 55 mins.	$190
Family or Couple Therapy	$225	Individual Therapy 35-45 mins.	$160
Group Therapy	$100	Psychological Testing/Each Hour	$250
Phone Consultation 10 mins.	$100	75-minute therapy session	$250

Cancellation Policy (Please read)

I hereby consent and agree (a) insurance companies DO NOT COVER COST OF MISSED APPOINTMENTS; (b) ***I will be billed and held responsible for missed appointments without a 24-hour notification***; (c) I may be required to pay $50 for missed appointments prior to rescheduling; (d) I may be charged 1.5% per month service charge on any unpaid balance. If my account is referred to collections, there will be a 40% additional charge.

I hereby consent and agree (a) to authorize Psychology and Beyond, LLC to bill my insurance carrier; (b) to release any information necessary to determine benefits and/or process claims to my insurance; (c) to authorize Psychology and Beyond, LLC to utilize a photocopy of my signature to file with my insurance carrier; (d) to direct my insurance to issue payment/checks for services rendered by psychologists at Psychology and Beyond, LLC directly to Psychology

Psychology and Beyond, LLC

Pia Nathani, Ph.D., HSPP
260 S 1st St Suite 2, Zionsville, IN 46077
Ph: 317-498-5751
Fax: 317-204-7666

and Beyond, LLC; (f) if I do not have insurance, payment must be made in full at the beginning of each session; (g) failure to provide new insurance information will result in patient balance; (h) Psychology and Beyond may charge 1.5% per month service on remaining balance; (i) I am responsible for all service fees rendered to me and my family regardless of insurance benefits, if any; (j) I am responsible for all bad debt, collection fees and costs for me and my family members.

I HAVE READ, UNDERSTAND AND AGREE TO THE FOREGIVEN_____YES_____NO

_____ _____

Full Name of Client Date

_____ _____

Signature of Client Date

_____ _____

Signature of Psychologist Date

This agreement will be attached to your chart. A copy is available upon request.