Psychology and Beyond, LLC

Pia Nathani, Ph.D., HSPP
260 S 1st St Suite 2, Zionsville, IN 46077
Ph: 317-498-5751
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Minor Information Sheet

Today's Date: ___/___/______ Legal Name: ____

Age: _____ Birthdate: ___/___/_______

Address: ____
Number Street City Zip Code

Home Phone: ___________________ Permission to Call: ______ SS# __________________

School: _____________________________ Grade: ________

Parent's Legal Name (and address if different): ____

____
Number Street City Zip Code

Parent's Birthdate: __/__/__ Employment: _________________ SS# __________________

Guardian's Name (and address if different): ____

____
Number Street City Zip Code

Close Friend or Relative: __________________________ Phone: _______________________

Previous Professional Help: _____ If Yes, Professional's Name: ________________________

Location: ____ Date Last Seen: __________

Personal Physician: ____
Name City Phone Number

Medications: ____

Medication Allergies: ____

Siblings' Names Birthdate Address Other Info.

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Consent for Treatment for Minor Patients

I, ____________________________ (name of parent/guardian), being the parent (_____) or legal

guardian (_____), for my son or daughter, _______________________________, hereby consent and agree to his/her mental health treatment at Paul M. Spengler, Ph.D. HSPP, P.C. within (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

Service	Fee	Service	Fee
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

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 48-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 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

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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

______________________________ ______________________________
Parent or Guardian Signature Date Signed

______________________________ ______________________________
Witness Signature Date Signed

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