Sonja Merz, LMFT

REGISTRATION FORM (Please print, fill out and sign)

Instructions: Please fill out this form. You can find most of the insurance information on your insurance card.
For coverage information please call the insurance company, you can find the number on the back of the insurance card.

Today's Date:	Primary Care Physician (doctor):

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

OK to call? ☐ Yes ☐ No	Home Phone:	Cell Phone:	Birth date:	Age:	Sex: ☐ M ☐ F

Street address:	Social Security no.:	Email:

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:

I was referred by:	
Primary Physician's phone number and address:	

INSURANCE INFORMATION

(Please bring your insurance card for the first appointment.)

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance?	☐ Yes ☐ No
Please indicate primary insurance	

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature _Date_

Insurance Coverage:

Please call the Customer Service number on the back of your Insurance card and ask the following questions:

Is Sonja Merz a preferred provider in my insurance network? Yes □ No □

If yes, Sonja Merz is "In Network", what is my mental health copay? $___________

(If no copay), what % am I responsible for? _________%

If No, Sonja Merz is "**Out of Network**" Do I have out-of-network benefits and what are they?

____

____

____

____

What is my annual Deductible? $____________

What is the amount of my deductible already met so far this year? $____________

What % am I responsible for after my deductable is met? _________%

Do I have a maximum out of pocket expense before services are covered at 100%? $_________

What is the maximum out of pocket expense that has been met so far this year? $____________

Is pre-authorization required for outpatient Behavioral Health Services? Yes □ No □

If "Yes" How many sessions are authorized? ______

What is the authorization number? ______

(Please print and sign)

To the clients of **Sonja Merz, MA, LMFT,**

It is my pleasure to welcome you as a new client. The following information will inform you about the practice of psychotherapy.

I am a Licensed Marriage and Family Therapist specializing in working with individuals, couples and families. My experience includes working with adults, adolescents, and children of diverse ages and ethnicities, with issues related to anxiety, depression, stress, self-harm, transition, separation, marital issues, abuse, trauma, addiction, intimacy issues, infidelity, blended families, and parenting issues.

I am a Licensed Marriage and Family Therapist. I provide therapy for families, couples, individuals, adolescents, and children. My theoretical approaches are in Emotionally Focused Therapy, Interpersonal Neurobiology, Attachment Theory, Cognitive Behavioral Therapy, and Object Relations. I also practice EMDR (Eye Movement Desensitization Reprocessing).

Typically, the first sessions will be used to discuss and evaluate the presenting problem, creating a treatment plan, and provides an opportunity to see how the working relationship between us will be. I will discuss my treatment recommendations, including length of treatment. You may at any time refuse treatment, request a different treatment approach, or request a referral to another therapist.

My fee is $140 for 45-50 minute sessions.

Appointments missed or cancelled without 24 notice will be charged $70, splitting the cost of session with the client. Insurance will not cover missed session fees. Payment is due at time of service. If paying with insurance, co-pays or percentage of which your insurance requires you to pay, is also due at time of service. If you have a deductible with your insurance that has not been met, you will be paying out of pocket until your deductible is met. Most health insurance companies will not pay for sessions unless they are pre- authorized, so please check with them regarding coverage. The responsibility for initiating a claim resides with you. If you have difficulty paying at any point, please discuss this with me as soon as possible so we can arrive at a solution. Clients who owe money and fail to make arrangements to pay may be referred to a collection agency. Checks returned without sufficient funds will be charged a $25 bank fee.

Continued on next page….

Everything discussed in therapy is strictly confidential. By law, no information may be released without written consent from the client. However, there are exceptions. The law requires the release of confidential information in situations of suspected child abuse, suspected elder/dependant abuse, indication that you intend to commit a felony, potential suicide behavior, and threatening harm to another person, or if I am ordered by a court of law, or as otherwise permitted by law.
Regarding privacy, if I encounter you in public, I will not acknowledge you unless you acknowledge me first. In couples counseling, I may have some individual sessions with you. Anything revealed in an individual session may be revealed in a joint session and is not held confidential from your partner. I also ask you not to disclose the name or identity of any other client being seen in this office.
For successful treatment, people in a counseling relationship must be able to trust that disclosures made in the course of counseling will be kept confidential to create safety. It is very important that we agree that this will occur. Therefore in the case of legal proceedings for family and couples counseling in signing this Disclosure Statement, both of you agree that you will neither call me as a witness nor seek to have my records of our work together disclosed in any legal proceeding between you. You also agree that I will be authorized to speak to anyone in connection with a legal proceeding between you only if you both sign an authorization permitting me to do so.

I am qualified as a Licensed Marriage and family Therapist with the State of Washington (#LF 60070301). I earned my Masters Degree (MA) in Counseling Psychology, in 1998, from John F. Kennedy University, in Pleasant Hill, CA. I am a clinical member of both the American and Washington Associations for Marriage and Family Therapy (AAMFT and WAMFT).

I look forward to working with you. Please feel free to ask any questions regarding the information provided or any other questions that may arise.

Kind regards,

Sonja Merz, LMFT

____________________________________ __________
Client Signature Date

____________________________________ __________
Client/Guardian Signature Date

Sonja Merz, LMFT

(Please print and sign)

Financial Policy

To the clients of **Sonja Merz, MA, LMFT,**

This financial policy is a necessary part of assuring the financial resources required to maintain the vital healthcare service for patients and community.
Charges for mental health services (such as copays) are due and payable at the time of treatment unless other arrangements have been made. Cash, check and credit/debit card are accepted.
If you will be using health insurance it is an agreement between you and your insurance company. Your insurance company may request certain records from your file and it release the information requested is required.

YOU ARE RESPONSIBLE FOR

- Knowing your benefits (i.e.: number of psychological sessions allowed per year, if this is a calendar year or a fiscal year, in-network or out-of-network benefit coverage, the amount or your yearly deductible and the co-payment per session etc.)
- Pre-authorizing psychological care by calling your insurance carrier and inform that you will be seeing me. You may also need to provide a referral from your primary care physician.
- Tracking the number of sessions used for any given authorization. Please note that some insurance plans will allow a set amount of sessions per year, which are divided among psychiatrists, psychologists, social workers or any other mental health care provider.
- Tracking any changes in your benefits or insurance coverage and informing me.

A Benefit Verification Form is available to assist you in collecting and tracking this information. If these steps are not taken, your insurance company may not provide payments for your sessions, and you may be held responsible for the bill that accrues.

There will be a $25 charge on any check returned from the back for non-payment. The right is reserved to send negligent accounts to collections.

24 hours' notice for cancellation of appointments is required, or you will be charged for full sessions. **Your insurance company does not cover the cost of missed appointments.**

If you have any questions please feel free to discuss them by calling 206-999-3771 or email sonja@sonjamerz.org.

I have read and agree to this policy

_______________________________________ ____________

Client Signature Date

_______________________________________ ____________

Client/Guardian Signature Date

(Please print and sign)

Privacy Notice

To the clients of **Sonja Merz, MA, LMFT,**

It is required by law to maintain the privacy of your medical information. It is also required to notify you of the legal duties and privacy practices regarding your medical information and to follow the terms of this notice. Your medical information is held confidential but will use it for:

- Treatment – Information may be shared with other medical professionals in your care. Examples include: your primary care physician, nurse, home health provider and pharmacy. Also, information may be shared with a family member of friend who assists with your care, but only if you agree. If you are unable to agree or object information may be disclosed if professional judgment deems it necessary.
- Payment –information may be shared with others to bill and collect payments on your account and obtain eligibility and pre-certification.
- Healthcare operations – Information may be disclosed to improve quality, train medical personnel, to licensure, for audits as well as sending you information.

Other ways information may be disclosed would be to other physicians during emergencies to protect a client in cases of abuse or neglect, for legal proceedings and when required by law.

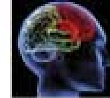
YOUR RIGHTS AS A CLIENT

- **The right to access your records** – clients have the right to view and obtain copies of their own records.
- **The right to request restrictions** – clients can put restrictions on who has access to their records.
- **The right to confidential communication** – clients have the right ot receive communication about their records in a confidential manner.
- **The right to amend the record** – Clients can request amendments to their records when they disagree with the content but at the same time these requests may be denied. If your request is denied a written explanation will provides to you. You may respond with a statement of disagreement, which will be added to the information you want changed.
- **The right to an accounting of disclosures** – Clients have the right to know everyone of that information is disclosed to.

I reserve the right to change the privacy practices at any time.

_______________________________________ _____________
Client Signature Date

_______________________________________ _____________
Client/Guardian Signature Date



Sonja Merz, LMFT

OUTPATIENT TREATMENT REPORT

PATIENT

Name: ______________________ Phone : __________ DOB: __________

MEDICATIONS

Medication	Psycho-tropic	Medical	Prescribing MD	PCP	Psych-iatrist	Other
____________	☐	☐	____________	☐	☐	☐
____________	☐	☐	____________	☐	☐	☐
____________	☐	☐	____________	☐	☐	☐
____________	☐	☐	____________	☐	☐	☐
____________	☐	☐	____________	☐	☐	☐
____________	☐	☐	____________	☐	☐	☐

If mood or psychotic disorder is present and no medications are prescribed, explain ______________________

MEDICAL CONDITIONS

- ☐None
- ☐Asthma/COPD
- ☐Cancer
- ☐Cardiovascular Problems
- ☐Other ____________
- ☐Other ____________
- ☐Chronic Pain
- ☐Dementia
- ☐Diabetes
- ☐Obesity

TREATMENT HISTORY

☐ Inpatient: ☐ Within past yr ☐ 1 to 3yrs ago ☐ More than 3 yrs ago

☐ Outpatient: ☐ Within past yr ☐ 1 to 3yrs ago ☐ More than 3 yrs ago

SYMPTOMS *if present, check degree*

On Disability? ☐ Yes ☐ No

Symptom	Mild	Moderate	Severe
Anxiety	☐	☐	☐
Decreased Energy	☐	☐	☐
Delusions	☐	☐	☐
Depressed Mood	☐	☐	☐
Hallucinations	☐	☐	☐
Hyperactivity	☐	☐	☐
Hopelessness	☐	☐	☐
ADLs	☐	☐	☐
Family/Relationships	☐	☐	☐
Inattention	☐	☐	☐
Irritability/Mood instability	☐	☐	☐
Impulsivity	☐	☐	☐
Obsessions/Compulsions	☐	☐	☐
Significant Weight Change	☐	☐	☐
Panic Attacks	☐	☐	☐
Sleep Disturbance	☐	☐	☐
Physical Health	☐	☐	☐
Work/School	☐	☐	☐
Substance Use	☐	☐	☐

Substance Use: ☐ In Remission ☐ Active *(if active or focus of treatment complete the information below):*

Substance of choice	Amount	Frequency	Date of Last Use
☐Alcohol	______	______ ____	______
☐ Marijuana	______	______ ____	______
☐ Heroin	______	______ ____	______
☐ Opioids ________ *list*	______	______ ____	______
☐ Cocaine	______	______ ____	______
☐ Methamphetamine	______	______ ____	______
☐ Prescr. Drugs ________ *list*	______	______ ____	______
☐ Inhalants	______	______ ____	______

Is patient currently participating in a community-based support group? (Includes AA, NA, etc.) ☐ Yes ☐ No

If Yes, frequency of attendance ____________

Is there a sponsor ☐ Yes ☐ No

PRESENTING PROBLEM (reason for therapy)

____

DESIRED OBSERVABLE OUTCOMES (goals)

____

STOP Office use only below - STOP Office use only below - STOP Office use only below - STOP Office use only below - STOP Office use only below

PROVIDERS CONTINUED TREATMENT PLAN

Modality and CPT Code	Frequency	Anticipated Completion
☐Individual 90806	___ x per ☐ wk ☐ mo ☐ yr	____ (mo(s)
☐Couple/Family 90847	___ x per ☐ wk ☐ mo ☐ yr	____ (mo(s)
☐Other ____________	___ x per ☐ wk ☐ mo ☐ yr	____ (mo(s)

DSM-IV or ICD-9 DIAGNOSIS *(numeric and description)*

Axis I ____________

Axis II ____________

Axis III ____________

Axis IV ____________

Axis V ____________

CURRENT RISK ASSESSSMENT

☐Suicidal
- ☐Ideation
- ☐Plan
- ☐Intent
- ☐Hx of harming self
- ☐N/A

☐Homicidal
- ☐Ideation
- ☐Plan
- ☐Intent
- ☐Hx of harming others
- ☐N/A

COORDINATION OF CARE

I have communicated with patient's ☐ PCP ☐ Specialist ☐ Psychiatrist ☐ Therapist

My signature confirms that I am providing the requested services

________ Date

________________ Sonja M. Merz, LMFT

Bridle Trails Office: 13027 NE 70th PL
Kirkland, WA 98033 Phone: 206-999-3771