



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 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 deductible 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? _____



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 \$150.00 for a 50 minutes sessions.

Appointments missed or **cancelled without 24 notice will be charged a full fee to the client.**

Insurance will not cover missed sessions. 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.



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/dependent 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



(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 or 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 to 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 be provided 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 to whom that information is disclosed.

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

Client Signature

Date

Client/Guardian Signature

Date

OUTPATIENT TREATMENT REPORT

(Please print and fill out)

PATIENT

Name: _____

Phone : _____

DOB: _____

MEDICATIONS

<u>Medication</u>	<u>Psycho-tropic</u>	<u>Medical</u>	<u>Prescribing MD</u>	<u>PCP</u>	<u>Psych-iatrist</u>	<u>Other</u>
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

	<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>		<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>		<u>Mild</u>	<u>Moderate</u>	<u>Severe</u>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obsessions/Compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decreased Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ADLs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Significant Weight Change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family/Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inattention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability/Mood instability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work/School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> In Remission <input type="checkbox"/> Active (if active or focus of treatment complete the information below):							

Substance of choice	Amount	Frequency	Date of Last Use
<input type="checkbox"/> Alcohol	_____	_____	_____
<input type="checkbox"/> Marijuana	_____	_____	_____
<input type="checkbox"/> Heroin	_____	_____	_____
<input type="checkbox"/> Opioids _____ <i>list</i>	_____	_____	_____
<input type="checkbox"/> Cocaine	_____	_____	_____
<input type="checkbox"/> Methamphetamine	_____	_____	_____
<input type="checkbox"/> Prescr. Drugs _____ <i>list</i>	_____	_____	_____
<input type="checkbox"/> 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

Anticipated Modality and CPT Code Completion	Frequency
<input type="checkbox"/> Individual 90806	___ x per <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr ___ (mo(s))
<input type="checkbox"/> Couple/Family 90847	___ x per <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr ___ (mo(s))
<input type="checkbox"/> Other _____	___ x per <input type="checkbox"/> wk <input type="checkbox"/> mo <input type="checkbox"/> yr ___ (mo(s))

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

Axis I _____
Axis II _____
Axis III _____
Axis IV _____
Axis V _____

CURRENT RISK ASSESSMENT

- Suicidal Homicidal
- Ideation Ideation
- Plan Plan
- Intent Intent
- Hx of harming self Hx of harming others
- N/A 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, 13027 NE 70th PI
Kirkland, WA, 98033 - Phone: 206-999-2771