Dr. Peter Temple & Associates, P.C.
Clinical & Performance Psychology
1250 Executive Place, Suite 404
Geneva, Illinois 60134

INSURANCE INFORMATION

I. INSURED PARTY INFORMATION (person providing the insurance, not necessarily the client)

NAME OF INSURED PERSON/POLICY HOLDER: ____________________

BIRTHDATE: ____________________ SS #: ________/________/________

HOME ADDRESS: ____________________

____

HOME PHONE: ____________________ WORK: ____________________

EMAIL: ____________________

EMPLOYER: ____________________

II. INSURANCE INFORMATION (We can make a copy of your insurance card if you have it)

INSURANCE COMPANY: ____________________

CLAIMS MAILING ADDRESS: ____________________

____

PHONE: ____________________ DEDUCTIBLE MET? YES ________ NO ________

ID NUMBER: ____________________ POLICY/GROUP NUMBER: ____________________

AUTHORIZATION

I authorize, by my signature, the release of clinical information necessary to process claims made from this office on my behalf. I further understand and agree that it is my responsibility to pay any deductible, co-insurance, and/or any other balance due not paid by my insurance, including failed sessions. This authorization will remain in effect until revoked by me in writing.

____________________ ____________________
Signature of Responsible Party Date

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TODAY'S DATE: ____________________

I. CLIENT INFORMATION

NAME: ____

BIRTHDATE: ______________________ SS#: ________/________/________

HOME ADDRESS: ____

____

HOME PHONE: ______________________ WORK: ______________________

CELL PHONE: ______________________ E-MAIL: ______________________

MAY LEAVE MESSAGE: YES ________ ONLY THAT YOU CALLED ________ NO ________

MARITAL STATUS: ______________________ SPOUSE'S NAME: ______________________

CHILDREN – NAME (AGE): ____
Or
SIBLINGS – NAME (AGE): ____

PARENT NAMES (MINOR CLIENTS): ______________________ ______________________

II. GENERAL INFORMATION

NAME OF PHYSICIAN: ______________________ LAST CHECK UP: ______________

REFERRED BY: ____

PREVIOUS COUNSELING EXPERIENCE: ____

LIST MEDICATIONS: ____

CONSENT FOR TREATMENT
I hereby authorize by my signature, Peter R. Temple, PsyD and/or his associates to evaluate, diagnose, and render appropriate health services to me or, in the case of a minor, my child. This consent is knowingly and freely given. I further understand that ALL information given by me or any member of my family to Dr. Temple and/or his associates is CONFIDENTIAL and WILL NOT BE RELEASED except by my written permission.

____ ______________________
Client Signature Date

____ ______________________
Signature of Responsible Party Date

____ ______________________
Dr. Peter Temple, Dr. Treva Anderson, Dr. Julia Cunningham, Dr. Romita Sillitti Date

Contacting Me
We are often not immediately available by telephone (232-7245). While we are usually in the office between 9 A.M. and 9 P.M., we usually will not answer the phone when we are with a client. When we are unavailable, a confidential voicemail system, which we monitor frequently, answers the telephone. If your situation is an emergency, the voicemail system will provide instructions for you to follow. In non-emergency situations, we will make every effort to return your call on the same day you make it with the exception of weekends and holidays. If you are difficult to reach, please leave some times when you will be available. If you cannot reach us, and you feel that you cannot wait for us to return your call, you should call your family physician or the emergency room at the nearest hospital and ask for the psychologist or psychiatrist on call. If we are unavailable for an extended time, we will discuss the implications and plan for my absence.

Professional Records
Both law and the standards of my profession require that we keep appropriate treatment records. You are entitled to receive a copy of the records, unless we believe that seeing them would be misleading or emotionally damaging, in which case we will be happy to provide them to an appropriate mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or can be upsetting, so we recommend that we review them together so that we can discuss what they contain. We are sometimes willing to conduct such a meeting without charge. Clients will be charged an appropriate fee for any preparation time, which is required to comply with an information request.

Minors
If you are under 18 years of age, please be aware that the law may provide your parents with the right to examine your treatment records. It is our policy to request an agreement from parents that they respect your rights and needs regarding confidentiality. If they agree, we will provide them only with general information about our work together unless we feel that there is a high risk that you will seriously harm yourself or another, in which case we will notify them of our concern.

Confidentiality
In general, law protects the confidentiality of all communications between a client and a psychologist, and we can only release information about our work to others with your written permission. However, there are a number of exceptions:

In most judicial proceedings, you have the right to prevent us from providing any information about your treatment. However, in some circumstances such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require our testimony if he or she determines that resolution of the issues before him or her demands it.

There are some situations in which we are legally required to take action to protect others from harm, even though that requires revealing some information about a client's treatment. For example, if I believe that a child is being abused, I am required by law to file a report with the Department of Children and Family Services (DCFS).

If we believe that a client is threatening serious bodily harm to another, we are also required by law to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens to harm him or herself, we may be required to seek hospitalization for the client or to contact family members or others who can help provide protection and insure our client's safety. These situations have rarely arisen in our practice. Should such a situation occur, I would make every effort to fully discuss it with you before taking any action.

We may occasionally find it helpful to consult about a case with other professionals. In these consultations, we make every effort to avoid revealing the identity of my client. The consultant is, of course, also legally bound to keep the information confidential.

Thank you for taking the time to read these policies. It is our hope we can focus fully on the challenges that have brought you to my office by clarifying the "business" of psychotherapy up front.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

______________________________	______________________________
Client	Responsible Party (if client is a Minor)

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Practice Information

Welcome to my practice. I admire the courage it took to come in and look forward to working with you to turn a challenging time into an opportunity for personal growth. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions that you might have so that we can discuss them at our next meeting.

Psychological Services

Psychotherapy is not easily described in general statements. It varies depending on the personality of both the therapist and the client and the particular challenges that the client brings. There are a number of different approaches that can be utilized to address the challenges you hope to transcend. It is not like visiting a medical doctor, in that psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we talk about both during our sessions and throughout the week.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable feelings such as sadness, guilt, anxiety, anger and frustration, loneliness, and helplessness. Psychotherapy often requires discussing unpleasant aspects of your life. Psychotherapy has also been shown to have benefits for people who undertake it. Therapy often leads to a significant reduction in feelings of distress, better relationships, and resolutions of specific problems. But there are no guarantees about what will happen.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, we will be able to offer you some initial impressions of what our work will include and an initial treatment plan to follow, if you decide to continue. You should evaluate this information along with your own assessment about whether you feel comfortable working with me. Therapy involves a commitment of time, resources and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise.

Meetings

Typically we will schedule one 50-minute session (10 minutes at the end of each hour is needed to think about our sessions and write clinical notes) per week at a mutually agreed time. Depending on circumstances, sessions may be longer or more frequent. Once this appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation (or unless we both agree that you were unable to attend due to circumstances beyond your control). If it is possible, we will try to find another time to reschedule the appointment.

Professional Fees

My hourly fee is $175.00 for the initial assessment and $150.00 per session thereafter. In addition to weekly appointments, it is my practice to charge this amount on a prorated basis for other professional services you may require such as report writing, attendance at meetings, consultations with other professionals which you have authorized, preparation of records or treatment summaries, or the time required to perform any other service which you may request of me. Psychological testing and evaluations are billed at the rate of $125.00 per hour.

Billing and Payment

We will be happy to bill your insurance directly once we have all the necessary information. ***We ask that you pay for the initial visit in full at the time the service is rendered.*** Once your benefits have been confirmed we will accept the non-covered portion, or "co-pay", at the time of service and bill your insurance (assuming annual deductibles have been met) for the remainder. We accept cash, personal checks, or credit cards through our website – www.drpetertemple.com. [In the case of psychological testing, clients are expected to pay an initial deposit at the time the assessment is initiated with the balance due when the evaluation is completed.] We do not send monthly statements unless requested to do so. We charge $300.00 per hour for preparation and attendance at any legal proceeding. There is a $25.00 charge for returned checks to cover bank fees. Payment schedules for other professional services will be agreed to at the time these services are requested. In circumstances of financial hardship, we may negotiate a fee adjustment or installment payment plan.] If your account is more than 90 days in arrears and suitable arrangements for payment have not been agreed to, we have the option of charging 1 ½ % interest compounded monthly and/or using legal means to secure payment, including collection agencies or small claims court. [If such legal action is necessary, the costs of bringing that proceeding will be included in the claim.]