BOIKE
PROFESSIONAL BUILDING
The Counseling Place

Dennis E. Boike, Ph.D.
Licensed Marriage and Family Therapist
Phone 585 394 1442 ext 300

Patient Information **Today's Date**_____

First Name_____ Middle Initial ____ Last Name_____

Address Line 1 _____

Address Line 2 (Suite, Apt #, PO Box) _____

City _____State _____ ZIP Code _____

Date of Birth _____ SSN # _____

Phone (Home) _____ (Work) _____ (Cell)_____

Is it okay to leave messages at: Home __Yes __ No; Work ___ Yes __ No; Cell __Yes __No

Patient's Sex (choose one) ____ Male ____ Female _____ Transgender Male (F to M)

_____Transgender Female (M to F) _____Other _____ Choose Not to Disclose

Marital Status and Family Information

____Single ____Married (# of years) ____Legally Separated (# of years) _____ Divorced (# of years)

____ Domestic/Life Partner (# of years) Spouse/Partner Name _____

Are there any children in the household? ____ Yes ____ No If yes, please complete…

Name	DOB	School	Grade	Residence

If divorced/separated, who has custody of children? _____

Stepmother's Name (if applicable) _____Stepfather's Name(if applicable)_____

Complete this section only if the patient is a minor child:

Mother's Name _____	Father's Name _____
Mother's DOB _____	Father's DOB _____
Mother's SS# _____-____-_____	Father's SS# _____-____-_____
Mother's Address _____	Father's Address _____
City _____State ___ Zip_____	City _____ State ____ Zip_____
Mother's Home Phone _____	Father's Home Phone _____
Mother's Cell Phone _____	Father's Cell Phone _____
Mother's Occupation _____	Father's Occupation _____
Mother's Employer _____	Father's Employer _____
Mother's Work Phone _____	Father's Work Phone _____

Are you employed? ____ Yes ____ No ____ Retired ____Disabled **If yes, please complete the following:*

Occupation _____ Full Time _____ Part Time _____

Employer Name _____

Employer Address _____City _____ State ___ Zip Code _____

Employer's Phone Number _____

Spouse's/Partner's Occupation _____ Employer _____

Are you a student? ____ Yes ____ No **If yes, please complete the following:*

Name of school _____Grade/Major _____

Full time ____ Part Time ____ Teacher's Name (if child is in grades K-6)_____

Primary Care Physician and Health Information

First Name_____ Last Name _____

Address Line 1 _____

Address Line 2 (Suite, PO Box, Building) _____

City_____State _____ ZIP Code _____

Phone _____

Current Health Issues/Concerns _____

Current Medications _____

Allergie**s** _____

Reaction (i.e. hives, trouble breathing, stomach upset, etc.)_____

Have you ever received counseling before? ____Yes ___ No

If yes, when? _____ With whom? _____

Who referred you to our office? _____

May we share information regarding your treatment with your primary care physician? ___ Yes ___No

*****If yes, a separate consent form will be provided to you for your review and signature. ALL INFORMATION PROVIDED BY YOU IS CONFIDENTIAL AND WILL NOT BE DISCLOSED WTIHOUT YOUR EXPRESS WRITTEN CONSENT, UNLESS OTHERWISE ALLOWED BY LAW.***

Patient Name:_____Date of Birth:_____ Chart #:_____

Primary Insurance Information

Name of Insurer _____ **Insurer Phone (on back of card)**_____

Please select your current plan type:
Excellus:
Blue Cross Blue Shield ____ Blue Choice ____ Simply Blue Plus _____ Blue Choice Medicare Advantage _____ Blue Point ___
Federal Blue Cross Blue Shield _____ Child Health Plus _____Blue Choice Option _____ Essential Plan _____

Fidelis _____ MVP _____ MVP Essential Plan _____Aetna ____ Aetna Community Plan _____ Empire Plan _____ NYSHIP ____
POMCO _____ Cigna ____ MultiPlan ____ Tricare _____

United HealthCare:
United Behavioral Health _____ United HealthCare Community Plan _____

Group Number _____ **Subscriber ID #** _____**Effective Date** _____

Subscriber Information
First Name _____ Middle Initial _____ Last Name _____

Subscriber Date of Birth _____

Subscriber Relationship to Patient (circle one): Self Spouse Domestic/Life Partner Parent Other

Secondary Insurance Information

Name of Insurer _____ **Insurer Phone (on back of card)**_____

Please select your current plan type:
Excellus:
Blue Cross Blue Shield ____ Blue Choice ____ Simply Blue Plus _____ Blue Choice Medicare Advantage _____ Blue Point ___
Federal Blue Cross Blue Shield _____ Child Health Plus _____Blue Choice Option _____ Essential Plan _____

Fidelis _____ MVP _____ MVP Essential Plan _____Aetna ____ Aetna Community Plan _____ Empire Plan _____ NYSHIP ____
POMCO _____ Cigna ____ MultiPlan ____ Tricare _____

United HealthCare:
United Behavioral Health _____ United HealthCare Community Plan _____

Group Number _____ **Subscriber ID #** _____**Effective Date** _____

Subscriber Information
First Name _____ Middle Initial _____ Last Name _____

Subscriber Date of Birth _____

Subscriber Relationship to Patient (circle one): Self Spouse Domestic/Life Partner Parent Other

Is This a Medigap Policy? _____Yes _____ No

Please Indicate Plan Letter _____ (A, B, C, D, E, F, etc.)

Emergency Contact Information

First Name _____ Middle Initial ____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Phone (Home) _____ (Work) _____ (Cell) _____

Relationship to patient (circle one): Spouse Domestic/Life Partner Parent Other

Responsible Party Information

First Name _____ Middle Initial _____ Last Name _____

Address Line 1 _____

Address Line 2 (Suite, Apt #, Bldg, PO Box) _____

City _____ State _____ Zip Code _____

Phone (Home) _____ (Work) _____ (Cell)_____

Date of Birth _____ Social Security Number _____-_____- _____

Please be advised we do not get involved with divorce decrees regarding payment of fees for services for minors. The parent or person who brings the child in for appointments is responsible for payment of copays, coinsurance, deductibles or private fees (if uninsured) at the time of service and will have to seek reimbursement from the other parent. A receipt of your payment for services will be provided to you at the time of payment.

I _____ have been provided with a copy of the provider's financial policy regarding payment of this account which includes fees for appointments canceled less than 24 hours of appointment time and failure to show for appointments. I understand that unless prior payment arrangements have been made, there will be a $10.00 billing fee added to my account for any balances not paid at the time of service as outlined in the provider's financial agreement and an outstanding balance charge of 1.5% of the total bill will be charged for each month that the bill remains unpaid.

_____ _____
Signature of Responsible Party Date

_____
Relationship to Patient

_____ _____
Witness Date

Patient Name:_____Date of Birth:_____ Chart #:_____

AUTHORIZATION TO BILL INSURANCE

I, _____, hereby give my consent for Dennis E. Boike, Ph.D. to bill my/my child's insurance carrier for the services rendered to me/my child by the above-named provider. In addition, I agree to pay the provider any deductible, copay, coinsurance, or charges for non-covered services in accordance with my health care plan at the time of service as outlined in the provider's financial policy.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature (if patient is a minor) Date

ASSIGNMENT OF BENEFIT

I authorize my/my child's insurance carrier to pay medical benefits directly to Dennis E. Boike, Ph.D. for all eligible services rendered to me/my child in accordance with my health care plan.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature (if patient is a minor) Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INSURANCE CARRIER

I, _____authorize Dennis E. Boike, Ph.D., to release necessary medical information to my/my child's insurance carrier and/or to their designated managed care company as required by my/my child's insurance carrier to process my/my child's insurance claims.

I understand that my express consent is required to release any health care information related to testing, diagnosis, and/or treatment for HIV/AIDS virus, sexually transmitted diseases, psychiatric disorders/mental health, or alcohol and/or substance abuse. You are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

_____ _____
Patient Signature (if >13 years of age) Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

Dennnis Boike, Ph.D.
Marriage and Family Therapist

CONSENT TO DISCLOSE/OBTAIN INFORMATION

I, _____, give *Dennis Boike, Ph.D.* my permission to disclose and/or exchange the following information:

( ) Psychiatric/Psychological ( ) Alcohol/Drug ( ) Medical

Regarding: _____ Date of Birth: _____

The information may be ( )Released to: and/or ( )Received from:

NAME: _____

ADDRESS: _____

PURPOSE AND NEED FOR DISCLOSURE:
( ) Treatment
( ) Treatment Coordination
( ) Discharge Planning
( ) Disability Planning
( ) Legal Services
( ) Other

THIS INFORMATION MAY BE RELEASED BY :
( ) Written
( ) Fax
( ) Verbal Exchange
( ) Electronic Information Exchange
( ) Completion Of Any Type Of Form
( ) Other

INFORMATION TO BE RELEASED SHALL INCLUDE:
( ) Assessments
( ) Progress Notes
( ) Psychological/Psychiatric Information
( ) Discharge Summary
( ) All Of The Above
( ) Treatment Plans
( ) History
( ) Education Information
( ) Progress In Treatment
( ) Other

I fully understand that my records are protected under the Federal regulations governing Confidentiality 42 C.F.R. Part 2, and cannot be disclosed without my signed consent unless otherwise provided for in the regulations. Further release of information is prohibited by law. I also understand that I may revoke this consent in writing at any time to the extent that action has been taken in reliance on it. To revoke this consent, I must provide written notification to my treating clinician.

I hereby declare that I am the ( ) Patient ( ) Parent ( ) Legal Guardian/Representative

_____ _____
Patient Signature and Date of Birth ***Today's Date***

_____ _____
Parent/Guardian/Representative/Significant Other ***Today's Date***

_____ _____
Witness ***Today's Date***

This consent shall expire: ( ) 90 Days From Date of Consent ( ) 1-Year From Date of Consent

3180 West Street
Canandaigua, NY 14424
(585) 394-1442

DENNIS BOIKE, PH.D.
Marriage and Family Therapist

Please read and sign the following financial agreement, which explains our fees and payment arrangements.

Responsible Party's Name: _____ Home Phone: _____
Patient's Name: _____ Work Phone: _____

- Co-Payment is requested in full at the time services are rendered. The adult who brings a minor to an appointment is responsible for that day's payment
- In the event that your insurance company fails to pay for an office visit, you are responsible for making the full payment.
- A $95.00 fee will be charged if you fail to keep a scheduled appointment or if an appointment is canceled less than 24 hours in advance.

I, _____, understand that I am responsible for paying the co-payment indicated below for each 50 minute psychotherapy/psychological session. I also understand that payment is due upon date of service. If at anytime I cannot pay the noted fee, I will notify Dennis Boike to make arrangements for payment. In the event your account is turned over to a collection agency, you will be responsible for all collection fees. **Patient co-pays listed here are an estimate. After we receive payment from your insurance company, the co-payment amount may change. We suggest you contact your insurance company and verify your outpatient mental health coverage.**

Financial Agreement

	Initial Visit	Follow-Up Visit
Professional Fee:	_____	_____
Less Insurance Benefit	_____	_____
Patient's Co-Payment	_____	_____

I certify that I have read, understand, and agree with the Office Financial Policy and Financial Agreement.

_____ _____
Signature of Responsible Party **Today's Date**

_____
Social Security Number

_____ _____
Witness **Today's Date**

Effective Date, Restrictions, and Changes to Privacy Policy

Dennis E. Boike, P.h.D.

I have been offered to review the HIPAA form in this office and reserve the right to change the terms of this notice and to make the new notice provisions effective for all Public Health Information that I maintain. I will provide you with a revised notice by mail or in person.

Your signature below serves as an acknowledgment that you have received or have been offered the HIPAA notice form.

_____ _____

Signature Date

_____

Print Name

Courtesy Reminder Phone Calls and HIPAA

New HIPAA privacy rules went into effect on September 23, 2013, to add further security to your Public Health Information. We are now asking your authorization to leave appointment reminder information with anyone who may have access to your phone. By signing this form, you are giving us permission to leave a message with someone other than the patient regarding your appointments here at Boike Counseling if they answer the telephone number(s) that you have provided

We make every effort to leave all messages on your phone number listed as personal or home phone, but occasionally we may call your work phone if you have asked to be put on a cancelation list for last-minute appointments, and we have been unable to reach you at your personal number(s).

I authorize Boike Counseling to leave appointment reminders at any personal number I provide. I understand that messages may be left on work phones if necessary for last minute cancellations that I have requested.

Please indicate which method you would like your reminder calls:

Phone/Voicemail_____ Text _____

_____Do not call E-Mail_____

_____**I will take full responsibility for maintaining scheduled appointments myself and do not want reminder phone calls regarding appointments.**

_____ _____

Signature Date

_____ _____

Print Name Patient Name

Boike Professional Building
3180 West Street
Canandaigua, NY 14424
(585)394-1442

Dennis E. Boike, Ph.D.
Jon Grasso, Psy.D.
Diane Hahn, Psy.D.
Nancy Longabaugh, L.C.S.W.-R.
Angela Wright, L.C.S.W.-R
Dorothy K. Marion, L.C.S.W.-R.

Brian Meteyer, Psy.D.
Cynthia Poole, Psy.D.
Judith Taylor, L.C.S.W.-R.
Jana Wachsler, Psy.D.
Jeanne McClung, L.C.S.W.-R.
Deborah Mizma, L.C.S.W.-R.

The therapists listed above take turns covering emergencies for each other after normal business hours. If you have a situation or problem that cannot wait to be discussed until the next business day or your next appointment, call **(585) 453-2278**. Leave a message that includes your name, phone number, and the name of your therapist. Your therapist or the on-call therapist will be notified and he or she will return your call. In a severe crisis, if you cannot reach us quickly enough, go to the nearest emergency room.

In certain situations if your therapist anticipates that you might need to call after hours, some relevant information may be shared about your situation with the therapist on call. In this way, your needs can be better addressed. **If you object to sharing of information, please tell your therapist.**

Please note that these procedures are only for after hours emergency calls. **During normal business hours, please call the office at (585)394-1442.**

I have received a copy of this and my therapist has explained it to me.

I ( ) do ( ) do not wish information to be shared with the on-call therapist.

_____ _____

Patient's Name **Today's Date**

_____

Parent/Guardian

_____ _____

Witness **Today's Date**

BOIKE PROFESSIONAL BUILDING
3180 West Street
Canandaigua, New York 14424
Phone (585) 394-1442 Fax (585) 394-1257

PAYMENT AGREEMENT
MEDICAID CLIENTS

I, _____, agree to pay any portion of my bill that is not covered by an HMO. It is understood services will not be submitted to Medicaid for reimbursement by this office. Payment amounts have been discussed with me and I agree to pay said amount prior to my appointment.

_____ _____
Patient's Name Today's Date

_____
Parent/Guardian

_____ _____
Witness Today's Date

BOIKE PROFESSIONAL BUILDING

3180 West Street
Canandaigua, New York 14424
Phone (585) 394-1442 Fax (585) 394-1257

Welcome to my office!

The following information will familiarize you with some of my procedures.

Sessions are generally 53-60 minutes, although other arrangements may be made. The secretaries can apprise you of the hourly fee for each of the therapists.

Most insurance companies cover mental health services. However, it is your responsibility to contact your insurance carrier prior to you visit to verify this benefit on your plan. Please know that not all of our providers participate with every insurance plan. Our front desk staff will be happy to inform you which plans our providers participate with. If you have more than one insurance plan, please let our office staff know so we can properly bill your insurance. Payment is expected at the time of service.

***PLEASE NOTIFY THE OFFICE STAFF IMMEDIATELY OF ANY CHANGES WITH YOUR INSURANCE COVERAGE, NAME CHANGES, ADDRESS, PHONE NUMBER, ETC. FAILURE TO DO SO MAY RESULT IN YOUR INSURANCE PLAN DENYING YOUR CLAIMS. ***

I do not take telephone calls during counseling sessions unless necessary due to emergency situations. Calls will be returned between counseling sessions or at scheduled times. Calls will be returned as soon as possible, however, please indicate to the secretary should your call demand an immediate response so that prompt attention may be given to it.

IN THE EVENT THAT AN APPOINTMENT NEEDS TO BE CANCELED AFTER OUR NORMAL BUSINESS HOURS (INCLUDING WEEKENDS), MESSAGES CAN BE LEFT ON OUR CONFIDENTIAL VOICEMAIL.*

Please ask our friendly staff if you have any questions regarding our policies. We would like to thank you for choosing Boike Professional Building and look forward to working with you.

X _____