FINANCIAL TERMS

Insurance billing is the responsibility of the patient/responsible party. Dr. Sanicola is a **not** a member of any insurance plan (e.g. PPO). As a courtesy, the office can bill the insurance for the patient. The doctor *may* be paid directly by the carrier. Often the carrier will send reimbursement directly to the insured. The patient/responsible party is responsible for the charge at the end of the session. Should the doctor be reimbursed directly by the insurance carrier, the amount will be credited to the account along with any applicable deductibles, co-payments, as well as any charges for services not covered by the carrier. Interest will be added to unpaid, past due balances. *Should the account be turned over to collections/an attorney, the responsible party will be responsible for all collection fees.*

CANCELLED/ MISSED APPOINTMENTS

A scheduled appointment means that the time is reserved only for you. If an appointment is missed or cancelled less than **24 hours notice**, you will be billed for the scheduled fee. The **only exception** to this is when less than 24 hours notice is given and we are able to fill the time.

CONSENT FOR TREATMENT

I authorize and request that **LINDA C. SANICOLA, Ph.D.** carry out psychological examination, treatments, and/ or diagnostic procedures, which now, or during the course of my care as a patient, are advisable. I understand that the purpose of these procedures will be explained to me upon my request and are subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

CONFIDENTIALITY

All information between doctor and patient is confidential unless:

1) The patient authorizes release of information with his/ her signature.
2) The patient presents a danger to self.
3) The patient presents a danger to others.
4) Child/ Elder abuse/ neglect is suspected

In the latter two cases we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I authorize the release of information for claims, certification, case management, and other purposes related to the benefits of my health plan.
I authorize my insurance company to make payments directly to my doctor for services rendered.
I understand and agree to all of the above information.

_____

PATIENT (or parent/ guardian) name PRINTED

_____ _____

PATIENT (or parent/ guardian) Signature **DATE**

PRESENTING PROBLEM:
Please describe your reasons for seeking treatment at this time: _____

Was there a particular event which made these issues or problems surface?: ____Y ___N

Please indicate which of the following problems you would like help with at this time:

__ Depression	__ Loneliness	__ Family Conflict
__ Anxiety	__ Problems Coping	__ Behavior Problems
__ Stress	__ Abuse	__ Drugs/Alcohol
__ Loss of Loved One	__ Financial Problems	__ Eating/Weight
__ School Problems	__ Legal Matters	__ Other
__ Work Problems	__ Marriage/Relationships	__ Sexual Issues

PLEASE INDICATE THE DEGREE TO WHICH YOUR PROBLEMS ARE AFFECTING THE FOLLOWING AREAS:

	No Effect	little effect	some effect	significant effect	
Marriage	1	2	3	4	NA
Family	1	2	3	4	NA
Job/School	1	2	3	4	NA
Friendships	1	2	3	4	NA
Finances	1	2	3	4	NA
Physical Health	1	2	3	4	NA
Nerves	1	2	3	4	NA
Mood	1	2	3	4	NA
Eating Habits	1	2	3	4	NA
Sleeping Habits	1	2	3	4	NA
Sexual Functioning	1	2	3	4	NA
Concentration	1	2	3	4	NA
Temper Control	1	2	3	4	NA

Are you taking any medications: ____YES ____NO
If so, please specify: _____
_____
Any other information you believe is pertinent: _____
_____

Have drugs or alcohol ever been a problem for you or your child? ____Yes ____ No
Please describe: _____
Have you ever received substance abuse treatment before? ____ Yes ___ No
Have you ever experienced withdrawal symptoms? ____ Yes ____ No
Have you ever experienced blackouts or seizures? ____ Yes ____ No

Have you or your child ever received psychiatric or psychological treatment? ____ Yes ____ No
___ Inpatient? _____ Outpatient?
When: _____ Where: _____

With whom: _____

How is your overall health?_____
Any medical conditions? _____

With whom do you live: _____
Marital status: ___S ___M ___D ___W

What type of work do you do? _____

Education completed: ___ high school ___some college ___ college graduate
___ advanced degree

Current legal issues: _____

When seeking consultation for children:

Do parents agree as to the existence or extent of the problem?_____
_____
Do you think the child is aware of the problem?:_____
Was pregnancy planned: _____ Was pregnancy desired: _____
Was mother physically well during pregnancy? _____
Any alcohol or drug use during pregnancy? _____
Describe any difficulties: _____
Was baby full term? _____ About how long did labor last? _____ Any difficulties? _____
_____
Was baby breast or bottle fed: _____ To what age: _____ Any feeding difficulties:
_____
Were developmental milestones achieved within a normal time frame (e.g. walking, talking, potty training); if not, please explain:
_____

Any serious health concerns, accidents, surgeries: _____

THANK YOU

PHYSICIAN PATIENT ARBITRATION AGREEMENT

ARTICLE 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to where any medical/psychological services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompletely rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provided for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration.

ARTICLE 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the psychologist including the spouse or heirs of the patient and any children whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.
All claims for monetary damages, exceeding the jurisdictional limit of the small claims court against the psychologist, and the psychologist's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the psychologist to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the psychologist, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

ARTICLE 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, together with the others expenses incurred by a party for such party's own benefit.
Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.
The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.
The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion or summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

ARTICLE 4: General Provisions; All claims based on the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitration shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

ARTICLE 5: Revocation: This agreement maybe be revoked by written noticed delivered to the physician/psychologist within 30 days of signature and if not revoked will govern all medical services received by the patient.

ARTICLE 6: Retroactive Effect: If the patient intends this agreement to cover services rendered before the date it is signed (including but not limited to emergency treatment) patient should initial below:
Effective as of the date of the first medical services. _____
Patient's or Patient's representative's Initials

If any provision of the arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.
NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOUR ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

BY: _____ **BY: _____**
Psychologist's or Duly Authorized Representative's Signature **Patient's Signature (date)**

_____ **_____**
Print or Stamp Name **Patient's Name**