Toqui Kennedy, LPA
NC Parent Consultants
519 Keisler Dr. #202
Cary, NC 27518
(919) 271-2031

INTAKE PACKET

Client Name: ____

DOB: _______________

Today's Date: ___________

Primary Insurance Name: ___________________________ Policy #:_______________________

Secondary Insurance: __________________________ Policy #: _____________________

SSN: __________________

IDENTING INFORMATION

Home Address: ____ County: ___________

Home Phone: __________________ School/Grade: __________________________________

Legal Guardian Name/Phone: _________________________""""Go ckn<_______________________

Mother's Name: ____________________________ Daytime Phone: ________________

Father's Name: ____________________________ Daytime Phone: ________________

EMERGENCY CONTACT

First Contact: _____________________________ Relationship to Client: _________________

Daytime Phone: _________________ Evening Phone: ________________ Cell: ____________

Physician's Name/Phone: ____

Others in the Home (Names/Relationship to Client/Ages if appropriate): _______________________

____

____

Significant Others Involved with Client: ____

____

MENTAL HEALTH/BEHAVIORAL INFORMATION

Reason for Seeking Services: ____

____

Recent Treatment History (last 12 months): ____

____

Pertinent Medical Issues: ____

____

Client Medications: ____

Other Active Service Providers (last six months): _______________________________________

Court Involvement and/or Pending Charges: ____

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CONSENTS/RIGHTS INFORMATION

I. Consent for Treatment

I hereby give my consent for **Toqui Kennedy** to provide mental health services to me/my child. I have been informed of the scope and purpose of the service, and understand that I may withdraw my consent at any time.   I understand I may also refuse any services offered at any time.

Client/Parent/Guardian: ______________________________ Date: ____________________

II. Financial Release

I understand that **Toqui Kennedy** may use confidential information about me to bill and be paid for services. I hereby consent for **Toqui Kennedy** to release information to the billing agent, **Integrity Support Services** and its contracted clearinghouse, and/or to the funding source, and for the funding source to release information to **Toqui Kennedy** and **Integrity Support Services** for this purpose.

Client/Parent/Guardian: ______________________________ Date: ____________________

III. Permission to Transport

I hereby grant permission for **Toqui Kennedy**, to provide transportation to my child, and agree to hold **Toqui Kennedy** harmless for any accident/injury that results from the provision of transportation.

Client/Parent/Guardian: ______________________________ Date: ____________________

IV. Permission to Seek Emergency Medical Care

I hereby give consent for **Toqui Kennedy**, to seek and sign consent for emergency medical care in the event that I am unable to do so for myself. It is understood that **Toqui Kennedy** will attempt to locate me, or another legally responsible adult, as quickly as is possible in the emergency situation.

Client/Parent/Guardian: ______________________________ Date: ____________________

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V. Client Rights/Grievance Policies (See Handout)

I have received and had explained to me the Client Rights handout. **Toqui Kennedy** gave me this handout and verbally explained my rights as a client.

Client/Parent/Guardian: ______________________________ Date: ____________________

VI. Privacy Rights (See Handout)

I have received and had explained to me the Privacy Rights handout. **Toqui Kennedy** gave me this handout and verbally explained my rights concerning the privacy of information as a client. I understand these rights are designed to protect my privacy.

Client/Parent/Guardian: ______________________________ Date: ____________________

I understand that one of my rights is to be able to choose how I am contacted.
I ***do/do not*** *(please circle one)* give permission for **Toqui Kennedy** to contact me at work. Furthermore, I ***do/do not*** *(please circle one)* give permission for **Toqui Kennedy** to leave voice messages for me at ***home/work/both/neither*** *(please circle one).*

Client/Parent/Guardian: ______________________________ Date: ____________________

I, **Toqui Kennedy**, have explained and provided copies of the following: Client Rights/Grievance Procedure Handout; the Privacy Rights Handout; and the Service Description to the Client/Parent/Guardian of the client to be served.

Signature: ____ Date: ___________________

Toqui Kennedy, Psychologist
519 Keisler Drive Suite 202
Cary, NC 27518

FEE AGREEMENT AND FINANCIAL POLICY

Thank you for choosing Toqui Kennedy, Psychologist. Please review this Fee Agreement and Financial Policy (the "Agreement and Policy"), which describes our schedule of fees for services, charges not covered by insurance, and additional fees. Please be sure you understand the policies regarding cancellations and missed appointments, methods of payment, insurance reimbursement, and past due accounts. If you have any questions about anything, **please ask your provider prior to signing this Agreement and Policy**.

Our service rates and corresponding health insurance billing codes (numbers starting with '90' refer to mental health services) this is not a comprehensive list and reflects the most common services provided by our staff. Additional codes may be used by your provider as deemed appropriate.

- 90791 Initial Consultation – Individual (50-60 min.) $185.00
- 90837 Individual Therapy (60 min.) $150.00
- 90834 Brief Individual Therapy (45 min.) $125.00
- 90832 Brief Individual Therapy (30 min.) $95.00
- 90847 Couples Therapy* (60 min.) $165.00

CHARGES NOT COVERED BY INSURANCE

- Medical Records Requests $15.00 per request
- Case Management* $150.00 (pro-rated per 15 min.)
  Case Management includes indirect services I provide outside our session times such as writing letters, consultations made at your request (for which a written authorization for disclosure of confidential information is required), coordinating adjunct and Court Advocacy services, and completing forms or reports. On occasion you may request that I testify or be present in court proceedings on your behalf of subpoena from the court the time billed will begin from our arrival at the courthouse to completion of testimony.
- Phone Consultations (11-60 min.) $130.00 (pro-rated per 15 min.)

ADDITIONAL FEES

- Late cancellations/Missed Appointment – fewer than 24 hrs. prior to appointment $125.00
- Non-sufficient funds (bounced) check $25.00
- Past-due accounts – over 30 days $25.00 per month
- Checks returned due to insufficient funds will incur a fee of $45.00

PAYMENT

You will be expected to pay for either each session in full, or your insurance co-payment at the time of services provided under the ***Outpatient Services Agreement***, which will be given to you along with this Agreement and Policy and our ***Notice of Privacy Practices***. Accepted methods of payment are cash, check, or credit cards. Checks should be made payable to *Toqui Kennedy.*

INSURANCE REIMBURSEMENT

Toqui Kennedy MA, LPA accepts and process insurance payments through a variety of insurance providers and Employee assistance plans. If you are using insurance or Employee assistance provider to pay for our services, then we will:

(1) Expect and accept payment of your copayment amount at the time of service;

(2) File your claim with the insurance provider

(3) Receive payment from your insurance provider

4. ***Expect that you will pay your portion due of copay, co-insurance, deductible, or fee difference at the time of your appointment.***

PLEASE NOTE

Toqui Kennedy MA, LPA files insurance as a courtesy to you, and that you (not your insurance company) are ultimately responsible for your bill. If you insurance company denies a claim filed on your behalf, then you are responsible to pay Toqui Kennedy MA, LPA for the difference between the standard rate and the amount previously paid as copay.

I agree to (1) allow Toqui Kennedy MA, LPA to bill my insurance directly for services provided under the Outpatient Services Agreement; (2) Toqui Kennedy MA, LPA permission to release any information the insurance company may require in order to process payment; appoint Toqui Kennedy MA, LPA as my authorized representative to act for me in obtaining payment; (3) assign all of my rights to claims and payment by my insurance to Toqui Kennedy MA, LPA; and (4) agree to assist with the claims process as required by Toqui Kennedy MA, LPA or my insurance provider. I understand that if my insurance plan requires that I meet a deductible amount prior to coverage by insurance, I will be responsible for the full session fee until the required deductible amount has been met. I acknowledge that not all issues, conditions, and problems dealt with in psychotherapy are reimbursed by insurance companies.

Patient name (printed)____

Patient /Guardian signature:____

Private/Self-Payment for Services

I will self-pay for services with Toqui Kennedy MA, LPA. I agree to the fee schedule in this document. I understand that payment for services is due at the time services are provided.

Patient name (printed)____

Patient /Guardian signature:____

CANCELLATIONS & MISSED APPOINTMENTS

Insurance carriers will not pay for late cancellations or missed appointments. Once an appointment is scheduled, that time is reserved specifically for you. Cancellations must be made at least 24 hours in advance. Although 24 hours is the minimum, if you need to cancel or reschedule please give as much notice as possible. You may notify me of cancellation by phone, text or email. Late cancellations (fewer than 24 hours before the appointment) will incur a fee of $125.00.

PAST DUE ACCOUNTS

Amounts past due by more than 30 days will incur a late fee each month of $25.00. If your account has not been paid for more than 45 days and arrangements for payment have not been agreed upon, Toqui Kennedy MA, LPA may resort to legal means to secure payment. This may involve hiring a collection agency, an attorney or going through small claims court. If such legal action is necessary, you will be responsible for those costs.

Patient name (printed)____

Patient /Guardian signature:____

CREDIT CARD ON FILE

Upon scheduling your first appointment you have the option to provide credit card information which will be kept on file to be used as a form of payment for fees incurred for co-pays, co-insurance, deductibles, late cancellations, missed appointments, returned checks, or past due account balances. A receipt will be e-mailed to you at the address you specify below at your request or by email .

Type of card (circle one):

☐**Visa MasterCard** ☐**American** ☐**Express Discover**

Card # 16 Digits:____ ____ ____ ____- ____ ____ ____ ____ -____ ____ ____ ____-____ ____ ____ ____

Expiration: ___________________

Security code:__________

Name on card: Initial here: ____

I authorize Toqui Kennedy MA, LPA to charge this credit card as needed according to the terms specified in this Agreement and Policy.

Signature: ____Date: ________________________________

I have read the Agreement and Policy above, and I have been offered a copy for my records. I understand the policy and by my signature below I agree to be bound by its terms in association with outpatient services provided to me by Toqui Kennedy MA, LPA.

Patient name (printed)____

Patient /Guardian signature:____