Jonina D. Bolton, Ph.D.
Licensed Psychologist

WELCOME

The process of psychotherapy is an investment in your future. It is an opportunity to gain greater understanding of yourself and to aid you in making the changes you want in order to increase the satisfaction in your life.

THERAPEUTIC CONTRACT: Psychotherapy works best with consistent sessions on a regular basis. Should we choose to work together, we both make a commitment to the therapeutic process. Your commitment includes identifying goals, bringing issues to therapy, providing feedback and keeping appointments. I, in turn, commit to helping you clarify your goals, facilitate the therapy process, and make your therapeutic progress my priority.

APPOINTMENTS: Sessions last 45-55 minutes. I make every effort to begin sessions on time and I ask that you also be available to start on time. It is also necessary to conclude sessions on time in order to leave enough time to make payments, schedule subsequent appointments, and escort people in or out of the building for appointments after 5:00 pm. Thank you for your cooperation. Please turn off cell phone ringers during your session.

EMERGENCIES: This is a private practice. In a private practice, clients are assumed to be responsible, autonomous and interested in growth. Many emergencies can be best handled by talking with family, friends or your medical doctor. Although I do my best to return all calls within a timely manner, I do not offer 24-hour crisis services. In cases where there is an immediate threat to you or someone else's safety, please call 911. If you need to speak to a mental health crisis clinician, you can also call First Call for Help by dialing 211.

FEES: The standard fee is $150.00 for each therapy session, unless you are utilizing insurance benefits. Psychological testing fees start at $200.00 for each hour of testing. The cost for other services such as consultations and lengthy report writing will be provided upon request. Fees are subject to annual increases. You will be asked to read and sign a Financial Agreement that describes your financial responsibilities. PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

CANCELLATIONS: If you need to cancel an appointment, then 24-hour notice is required to avoid being charged a $50.00 fee. There are no exceptions to this policy. Your scheduled time is set aside for you and generally cannot be filled on short notice. If you are unable to attend a scheduled appointment, then please call the office immediately to let me know.

In the event of multiple missed appointments or excessive cancellations, I reserve the right to refuse to schedule future appointments. Should you wish to terminate therapy, please discuss this with me. It is important to have a final session in order to smooth any transition.

CONFIDENTIALITY: This office is in compliance with HIPAA standards. You will be given a copy of this office's procedures regarding your privacy. Please familiarize yourself with this document. Should you have any questions, please fell free to speak with me.

I look forward to working with you.

Dr. Jonina D. Bolton

Name of client(s): _____

Signature of client(s): _____ Date: _____

_____ Date: _____

Signature of parent/guardian if patient is a minor: _____ Date: _____

Dr. Jonina D. Bolton's signature: _____ Date: _____

4731 Highway A1A
Vero Beach, Florida 32963
(772) 234-7100

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Application for Clinical Services

Please Answer Each Question Completely Today's Date: _____

Client's Name: _____ Date of Birth: _____

Parent's Name (If Client is a minor): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone: (_____) _____ Work: (_____) _____

Cell Phone: (_____) _____ E-mail Address: _____

Relationship Status (Please circle one): Single Engaged Married Partnered Widowed

Name of Significant Other and/or Emergency Contact: _____

Relationship to Client: _____ Telephone: _____

****

Place of Employment or School: _____

Occupation/ Grade: _____

****

Primary Care Physician: _____ Telephone: _____

Current Medications and Doses: _____

_____

Allergies or adverse Reactions to Drugs/Medications: _____

_____

Please List Any Previous Therapists' Names: _____

_____

Referred By: _____

** May Dr. Bolton send a Thank You note to this person? Yes _____ No_____

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Please check any of the problems that apply to the Client now or in the past or in the family.

Now	Past	Family	Problem
_____	_____	_____	Depression
_____	_____	_____	Anxiety/Worry
_____	_____	_____	Suicidal Thoughts/Attempts
_____	_____	_____	Loneliness
_____	_____	_____	Irritability/Anger
_____	_____	_____	Aggression/Violence
_____	_____	_____	Impulsivity
_____	_____	_____	Appetite/Eating Problems
_____	_____	_____	Self-Confidence
_____	_____	_____	Sleeping/Nightmares
_____	_____	_____	Physical/Medical Problems
_____	_____	_____	Alcohol/Drugs/Gambling/Internet
_____	_____	_____	Child Abuse
_____	_____	_____	Sexual Abuse
_____	_____	_____	Domestic Violence
_____	_____	_____	Grief/Loss
_____	_____	_____	Older Adult/Parent Problems
_____	_____	_____	Relationship/Divorce
_____	_____	_____	Legal Problems
_____	_____	_____	Child Problems
_____	_____	_____	School/Academic/Work Problems
_____	_____	_____	Psychiatric Hospitalizations

Other Problems of Concern or Important Information: _____

_____

****

Client Statement

I understand that I am voluntarily seeking psychological services and that I am giving my consent for Jonina D. Bolton, Ph.D. to provide services to me and/or my family member(s). Name(s) of person(s) receiving services:

_____

_____

Signature(s) of each person receiving services or parent/guardian of minor(s) and in agreement with the Client Statement:

_____ Date: _____

_____ Date: _____

Dr. Jonina D. Bolton's Signature: _____ Date: _____

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THIS NOTICE OF PRIVACY PRACTICES (NPP) DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Commitment to Your Privacy

Dr. Bolton is dedicated to maintaining the privacy of your personal health information as part of providing professional care. Dr. Bolton is required by law to keep your information private. These laws are complicated, but she must give you this important information. This document is a shorter version of the legally required Notice of Privacy Practices or NPP, which you can refer to for more information. However, this form can't cover all possible situations, so please talk to Dr. Bolton about any questions or problems that arise.

Dr. Bolton will use information about your health, which she gets from you or from others, mainly to provide you with treatment, to arrange payment for services, and for some other business activities, which are called, in the law, health care operations. After you have read this NPP, Dr. Bolton will ask you to sign a Consent Form to let us use and share your information. If you do not consent and sign this form, she cannot treat you.

If you or Dr. Bolton wants to use or disclose (send, share, release) your information for any other purpose, we will discuss this and Dr. Bolton will ask you to sign an Authorization form to allow this communication.

Dr. Bolton will keep your health information private, except when the laws require her to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. Dr. Bolton will only share information with a person or organization which is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires her to do so.
4. For Workers Compensation and similar benefit programs.

1. You can ask Dr. Bolton to communicate with you about your health and related issues in a particular way or at a certain place that is more private for you. For example, you can ask her to call you at home, and not at work, to schedule or cancel an appointment. She will try her best to do as you ask.
2. You have the right to ask Dr. Bolton to limit what she tells people involved in your care or the payment for your care, such as family members and friends. While she doesn't have to agree with your request, if she does agree, she will keep the agreement, except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information Dr. Bolton has about you, such as your medical and billing records. You can even get a copy of these records but she has the right to charge you a fee for copies.
4. If you believe the information in your records is incorrect or missing important information, you can ask Dr. Bolton to make some changes (called amending) to your health information. You have to make this request in writing and send it to the Privacy Officer. You must tell Dr. Bolton the reasons you want to make the changes.
5. You have the right to a copy of this notice. If Dr. Bolton changes this NPP, she will post the new version in the office and you can always get a copy of the NPP from her.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with the Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care Dr. Bolton provides to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact the Privacy Officer, Dr. Jonina D. Bolton. She can be reached at 772-234-7100. The effective date of this notice is April 1, 2009.

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Consent to Share/Disclose Medical Information

I have received and reviewed the Notice of Privacy Practices (NPP) on the previous page provided by Dr. Bolton. My signature below indicates my consent to treatment for myself and/or my minor child(ren) with the understanding of the ways in which Dr. Bolton is legally allowed or required to share or disclose personal health information pertaining to me or my child(ren).

Name of Client(s): _____

Signature of Client(s):_____ Date: _____

_____ Date: _____

OR

Name of Parent/Guardian if client is a minor: _____

Signature of Parent/Guardian if client is a minor: _____

Date: _____

POLICY REGARDING DOCUMENT REQUESTS

Any request for documents, including creation or preparation of letters or copies of test reports, must be made at least 48 hours in advance. Dr. Bolton requires sufficient time to prepare appropriate documents and to research any necessary information pertinent to the situation. If Dr. Bolton requires additional time, then she will notify you at the time that your request is made. If your request involves the disclosure of clinical information directly to a third party, then an authorization form must be signed by the client or responsible party before the document(s) can be released.

Please initial here. _____

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PAYMENT ARRANGEMENTS

Most individuals would like the benefit of working with their therapist for as long as is needed to accomplish their personal goals. The reality is that the manner in which you pay for your treatment may affect the extent of care that you receive. For example,

1. If you pay directly for your psychological services, then you and Dr. Bolton will determine the type of services that will benefit you the most and the length of time that you wish to remain in treatment.

2. Your insurance company may exercise a considerable amount of control over the services that you receive. Your insurance company will require Dr. Bolton to provide a diagnosis and description of treatment services that may determine the number of sessions that your insurance company will approve to cover. Some insurance companies also reserve the right to inspect client records for quality assurance. Additionally, services and diagnoses related to your services are considered part of your medical record and may impact future insurance coverage or insurance rates impacted by pre-existing conditions.

3. You can elect to pay directly for your treatment and then subsequently submit receipts yourself to your insurance company for reimbursement. Your insurance company may require the same treatment information described above and limit the number of sessions for which they will reimburse you.

As the result of the insurance issues described above, many people decide that the direct payment option, without any involvement of the insurance company, is best suited for their needs. The direct payment option allows for a higher degree of confidentiality while providing greater flexibility and autonomy in designing a treatment program most suited to your needs.

If you decide to use your insurance benefits, please be sure to contact your insurance company directly to determine whether an authorization number is required prior to initiating treatment and to address any questions or concerns that you may have, such as:

1. Am I responsible for paying a deductible?

2. What is my co-payment or co-insurance (percent of the fee) at the time of service?

3. How many sessions per year does my policy allow?

Please be assured that Dr. Bolton fully complies with HIPPA requirements.

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FINANCIAL POLICY AND AGREEMENT

Client Name(s):_____ **Date of Birth:** _____

Name of Primary Insurance Holder: _____ **Date of Birth:** _____

The client, or responsible/accountable party (if the client is a minor), is responsible for paying the fee at the time that services are rendered. If you plan to utilize insurance benefits, then please notify Dr. Bolton of your intention to do so, in advance. Dr. Bolton will submit insurance claims on your behalf to companies for which she is an in-network provider only. However, in the event that the claim(s) are denied by your insurance company, you will be held financially responsible for paying the fees in-full and for seeking reimbursement from your insurance company.

If the client or responsible party has scheduled an appointment and chooses for any reason not to use that appointment time, then twenty-four (24) hours notice is required. If inadequate notice is given, or if a client does not show for an appointment that he/she has reserved, then the client or responsible party will be charged **$50.00** and will be held financially responsible for paying the fee. Insurance companies do not pay any portion of the fee for a missed or cancelled appointment. I understand my financial responsibility for reserved appointments, including my responsibility to notify Dr. Bolton with at least 24-hour notice to avoid being charged a fee of $50.00. **Please initial here**. _____

The client or responsible party is required to guarantee payment for services used. In the event that any collection procedures become necessary, the client is responsible for all fees for services rendered, interest accrued, document preparation time, photocopying fees, and all costs of collection, including attorney fees and court fees.

Having been notified of these terms, I/we agree to the following fee arrangements:

EAP services: no co-pay for # _____ sessions (initial here) _____

Insurance pay: Deductible _____

Co-pay of $ _____ per therapy session (initial here) _____

Co-insurance of % _____ per therapy session (initial here) _____

Private pay fee of $_____ per therapy session (initial here) _____

Private pay fee of $_____ per hour of testing (initial here) _____

Private pay fee of $_____ other _____ (initial here) _____

Client Signature(s): _____ **Date:** _____

_____ **Date:** _____

Jonina D. Bolton, Ph.D.:_____ **Date:** _____

*Signature on File: I authorize the release of any clinical information necessary to process claims made on my behalf or that of my family member(s). Please accept a photocopy of this authorization as if it were an original. My signature below acts as the signature on file.

Signature: _____ **Date:** _____

*Assignment of Benefits: I hereby authorize and direct payment of insurance benefits to Jonina D. Bolton, Ph.D. for professional services rendered. I understand that I am financially responsible for all charges not covered by this assignment.

Signature: _____ **Date:** _____

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