**Melanie S. Rich, Ph.D., L.L.C.**
8115 E Indian Bend Road, Suite 119
Scottsdale, AZ 85250
480.467.0288

## Private & Confidential - Patient Information
# COUPLES / MARITAL THERAPY

Today's date _____ (mm / dd / yyyy)

Names (wife) _____ (husband)_____

Wife Birth date ____ ____ ____ Age_____ (mm / dd / yyyy) Husband Birth date ____ ____ ____ Age_____ (mm / dd / yyyy)

Email (wife) _____ Email (husband) _____

Address_____City_____State_____ Zip_____

Home Telephone _____ _

Wife Cell Phone _____ Husband Cell Phone _____ _____

Prior Marriage(s)? Wife _Y / _N Husband _Y / _N

Number of Children : _____

Names & Ages: _____

_____

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Referred By_____

Person to Contact in Case of Emergency: _____
Relationship_____

Telephone _____

Billing /Responsible Party Address (if Different from Address Above):

Name of Responsible Party_____

Address_____City_____State_____ Zip_____

**Family Physician Address, Phone & Name: _____**

Address_____City_____State_____ Zip_____

Phone _____

***ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE.***

*THERE IS A 24 HOUR CANCELLATION POLICY FOR APPOINTMENTS.*
*THE FULL SESSION FEE FOR THE SCHEDULED APPOINTMENT WILL BE CHARGED IF NOT CANCELLED WITHIN THAT TIME PERIOD.*

*PLEASE INITIAL: _____*

THIS AGREEMENT HAS BEEN PREPARED TO HELP DR. RICH'S PATIENTS UNDERSTAND HOW THE BUSINESS OFFICE OPERATES WITH RESPECT TO THE PSYCHOLOGIST-PATIENT RELATIONSHIP. PLEASE READ ALL OF THE INFORMATION CONTAINED IN THIS AGREEMENT AND INDICATE YOUR CONFIRMATION BY SIGNING THIS DOCUMENT.

**CONFIDENTIALITY POLICY**
PLEASE SEE **PRIVACY POLICY FORM** AVAILABLE AT WWW.DRMELANIERICH.COM

**OFFICE POLICY**
DR. RICH RESERVES THE RIGHT TO DECLINE PATIENT'S SEEKING REPORTS FOR THIRD PARTY OPINIONS, AS WELL AS DISABILITY AND DIVORCE CASES. THE PRACTICE IS FOCUSED ON TREATMENT AND CANNOT SUSTAIN THE AMOUNTS OF ADDITIONAL REPORT WRITING THESE CASES REQUIRES.

**HEALTH INSURANCE PLANS**
ALTHOUGH NOT APPLICABLE TO MARITAL COUNSELING/COUPLES THERAPY IN MOST CASES, DR. RICH DOES PARTICIPATES IN SEVERAL HEALTH INSURANCE PLANS OR POLICIES. PLEASE VISIT WWW.DRMELANIERICH.COM FOR A LIST OF CURRENT PLANS OR CHECK WITH YOUR HEALTH INSURANCE PROVIDER. PATIENTS MAY ALSO ELECT TO FILE CLAIMS INDIVIDUALLY. A 'SUPER BILL'/RECEIPT WILL BE PROVIDED UPON REQUEST AT THE TIME OF VISIT, PROVIDING THE APPROPRIATE MECHANISM FOR PATIENTS TO FILE THE CLAIM WITH THE APPROPRIATE INSURANCE PLAN.

HEALTH INSURANCE POLICIES REQUIRE PATIENTS TO RELEASE ALL ENCOUNTER INFORMATION FOR ANY SERVICE RENDERED AND CLAIMED AGAINST THE HEALTH CARE PLAN. THE DIAGNOSIS AND TREATMENT INFORMATION REQUIRED ON THE CLAIM FORM IS OFTEN FORWARDED BY THE PATIENT'S INSURANCE PLAN TO THE *MEDICAL INFORMATION BUREAU* (MIB). THE PATIENT'S HEALTH HISTORY THEN BECOMES AVAILABLE TO OTHER INSURANCE COMPANIES WITHOUT THE PATIENT'S KNOWLEDGE OR CONSENT. THEREFORE, DR. RICH BELIEVES THAT THE RELEASE OF ANY DIAGNOSTIC INFORMATION THROUGH THE CLAIMS FILING PROCESS MAY PRESENT A POTENTIAL RISK THAT COULD BE PERSONALLY DAMAGING TO UNKNOWING PATIENTS. THEREFORE, DR. RICH WANTS EACH PATIENT TO BE AWARE OF ANY POTENTIAL RISK OF RELEASING MEDICAL INFORMATION SHOULD AN INAPPROPRIATE PARTY HAVE ACCESS TO THE MIB NATIONAL DATABASE.

**PAYMENT POLICY & TERMS**
**A $25.00 FEE WILL BE CHARGED FOR ANY RETURNED CHECK.** PATIENTS, WHO CALL DR. RICH WITH ROUTINE PROBLEMS OR ISSUES, WILL BE CHARGED A FEE OF $50.00 FOR EVERY15 MINUTES. THE PATIENT AGREES TO PAY ALL CHARGES, IN ACCORDANCE WITH THE PAYMENT POLICY OUTLINED IN THIS AGREEMENT. SHOULD DR. RICH BE FORCED TO INCUR COLLECTION CHARGES OR LEGAL FEES, THE PATIENT AGREES TO PAY THEM IN FULL.

**PATIENT RESPONSIBILITIES**
EACH PATIENT IS RESPONSIBLE FOR PROVIDING ACCURATE CONTACT INFORMATION AS WELL AS BILLING INFORMATION. IF TELEPHONE NUMBERS AND/OR ADDRESSES CHANGE, PATIENTS MUST INFORM DR. RICH'S BUSINESS OFFICE.

I HAVE READ, UNDERSTOOD, AND ACCEPT THE PROVISIONS OF THIS AGREEMENT, AND HAVE NO QUESTIONS ABOUT THE POLICIES OUTLINED HEREIN. I UNDERSTAND THAT IF I VIOLATE ANY PROVISIONS OF THIS AGREEMENT, MY TREATMENT MAY BE TERMINATED. I UNDERSTAND THAT THIS AGREEMENT IS BINDING IN THE STATE OF ARIZONA AND THAT THE PROVISIONS ARE FOR MY PROTECTION AND FOR THE PROTECTION OF DR. RICH. THE ORIGINAL COPY OF THIS AGREEMENT WILL BECOME A PART OF MY PRIVATE MEDICAL RECORD.

_____ _____
SIGNATURE (typing your name is equivalent to signing) DATE mm/dd/yyyy

## Confidential Patient History Patient:

Please briefly describe your family when you were growing up:

_____

_____

_____

_____

_____

Please list any events from your childhood / or adulthood that have had a profound effect on your life:

_____

_____

_____

_____

Highest grade/Degree completed? (Wife) _____ Where? _____

(Husband) _____ Where? _____

How many hours a week are you employed? (wife) _____(Husband)_____

How often do you spend time with others?_____

How many Children do you have?_____ Do they all live with you?_____

Describe the relationship issues for which you are seeking help :

_____

_____

_____

_____

_____

_____

Please Show history of Substance abuse. Please indicate W for wife or H for Husband:

| | Current | Past | | Current | Past |
|---|---|---|---|---|---|
| Alcohol | | | Hypnotics | | |
| Tobacco | | | Diet Pills | | |
| Caffeine (tea, coffee, Soda) | | | Narcotics / Pain | | |
| Cocaine | | | Nerve Pills | | |
| Marijuana | | | Sleeping pills | | |
| Stimulants | | | Others (specify) | | |

**Legal History (if applicable):**

Have you ever been arrested? ___Y ___ N

Are you currently or have you ever been involved in a lawsuit?

_____

_____

_____

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## AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

I, (parent/guardian if patient is a minor) _____, hereby authorize
(print name)

Dr. Melanie Rich to obtain information from and/or release information to:

_____

_____

_____

Regarding Patient:_____

Date of Birth:_____

Portion of record to be released:
__ All
__ Diagnostic Evaluation
__ Summary of Contact with Client
__ Verbal Contact
__ Diagnostic Test Reports

other: (specify)
_____
_____
_____

I understand why this information is needed and I am satisfied that it will be held confidential.

Photocopies of this form will be considered as valid as the original.

This authorization will remain in effect until revoked by me in writing.

Signed: _____
(please sign by hand)

Date: _____
mm / dd / yyyy