

**Patient Information – Please print clearly**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Patient's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Sex:  Male  Female

May we leave messages?  **Yes**  at home  at work  on cell phone

OR  **No**, please don't leave messages Employer: \_\_\_\_\_

Marital Status:  Single  Married  Other Referred by: \_\_\_\_\_

**Welcome** to Family Counseling Associates, Inc. We are pleased to be able to offer psychiatric services for children and adolescents provided by Jill Abram, MD. Dr. Abram is a graduate of Indiana University School of Medicine. After completing an internship in family medicine at St. Francis Hospital in Beech Grove, Dr. Abram returned to Indiana University for psychiatric residency and fellowship in child and adolescent psychiatry. A diplomate of the American Board of Psychiatry and Neurology, Dr. Abram has been serving children and adolescents of central Indiana since 1990. She joins FCA to provide integration of psychiatric evaluations and medication management to the children and adolescents served here.

**We are committed to improving your emotional health.** With that in mind, we are aware that rarely is it appropriate to provide medication alone. Your needs will be much better met with a combination of ongoing regular talk therapy with your therapist, in addition to medication management by Dr. Jill Abram.

**You are responsible for scheduling and keeping all of your appointments.** Payment is expected at the time of service. When appointments are not kept, it prevents others from having the opportunity to be seen and benefiting from treatment. Therefore appointments must be cancelled at least 24 hours in advance or a rate of \$45 will be charged and payment will be expected prior to your next session.

**In the event that you have an urgent clinical concern** that you feel cannot wait until your next scheduled appointment with Dr. Abram, you should make every effort to call the office during normal business hours at (317) 585-1060. Our phones are answered 8:30am–4:00pm. You will be asked to leave a detailed message regarding your concern. Dr. Abram will return calls Monday through Friday after 4:00pm. For urgent clinical concerns after hours or on weekends, please call Community Hospital's Crisis Line at 621-5700. Please note that there will be a charge of \$25 per 15 minutes for any phone consultation made by Dr. Abram.

**In the event of a life-threatening emergency,** please call 911 or present yourself to the nearest emergency room.

**As Dr. Abram specializes in outpatient treatment only.** If your condition would require admission to an inpatient facility, your care would be assigned to the Inpatient Psychiatrist on-call at Community Hospital, North – Indianapolis.

**Please know that we are committed to providing secure confidentiality.** Your medical record is confidential to the extent of established professional and legal standards. A signed authorization from you is required to release information from your medical record to sources outside this office.

**Thank you** for selecting Family Counseling Associates. We look forward to working with you.

**Please read, date and sign back of page. Signature and date required.**



# CONSENT FOR PSYCHIATRIC TREATMENT

## HIPAA COMPLIANCE

The staff of Family Counseling Associates (FCA) is committed to providing quality professional care to all of our clients. Your treatment information is handled with the utmost of care to ensure your privacy. Take a few moments to read the Privacy Information Policy (Health Insurance Portability & Accountability Act – HIPAA) you were given and sign this form for our records. FCA works as a group of providers and your confidentiality is extended to all therapists in the organization. If you are working with a Resident Therapist or Intern, that Counselor will review your case with a Licensed Supervisor on a regular basis for recommendations as part of the training provided Residents and Interns.

### THERAPY SESSIONS

#### Fees for Licensed Therapists

25 minute session	\$55.00
50 minute session	\$ 110.00
80 minute session	\$ 145.00
110 minute session	\$ 175.00

### PHYSICIAN APPOINTMENTS

#### Fees for Psychiatrist

Initial Evaluation	\$ 250.00
50 minute appointment	
Medication Management	
30 minute appointment	\$ 125.00
45 minute appointment	\$ 200.00

## ADDITIONAL COSTS

Phone Consultation	\$25.00 per 15-minute unit
Calling a Prescription into a Pharmacy	\$25.00 per call
Filling out Reports for Employers/Insurance Companies, etc.	\$25.00 per report

## PAYMENT

**Payment in full is due and expected at the time of service.** Payment can be made by: **check, cash, VISA, MasterCard, American Express or Discover.** Clients using charge cards may either use their card at each session or sign a document allowing the clinic to automatically submit charges to the charge card after each session.

**PLEASE NOTE: There is a \$20.00 fee for ALL RETURNED CHECKS.**

## INSURANCE CLAIMS

FCA will file insurance claims for Dr. Abram's patients seen at our office. Dr. Abram is not in any insurance network. We will collect full fee at the time of service and will note on the insurance claim form that FCA will not accept insurance assignment, therefore, you will receive the benefit check from the insurance company. (Note: FCA is unable to file claims with Medicaid.)

## AUTHORIZATION FOR TREATMENT AND/OR SERVICES

This signed consent authorizes FCA to provide counseling treatment, psychiatric treatment and/or other services. I understand the disclosures made on this Psychiatric Intake Form.

I acknowledge that I have been given opportunity to review Family Counseling Associates, Inc.'s Notice of Privacy Practices and will be given a copy of the same if I request it.

\_\_\_\_\_  
Signature of Parent of Minor (required)

\_\_\_\_\_  
Date (required)