peach
THERAPY

Peach Therapy.com

Thank you for contacting our office and scheduling your initial visit. I look forward to meeting with you on your first visit. Because your session time should be spent talking about things that are important to you, and not "paperwork details," downloading a new patient packet from our website, at Peach Therapy.com will answer some of your questions, provide patient forms, directions and save you office time. I think you will find the information very helpful and easy to complete. If you prefer a copy mailed to you, let us know, or if you are unable to complete the forms prior to your appointment, please arrive 10 minutes earlier to do so. The patient packet consists of (3) documents that you need to fill out and sign and then (2) that are important to read and keep for your records. They are as follows:

Patient Information / Policies and Procedures
Patient Health Information / Consent
Credit Card Authorization
Notice of Privacy Practices
Insurance Help Form and Directions

Please be aware that we are non-participating with all insurance providers. If you will be submitting claims to your insurance carrier, the questions on the insurance help form will assist in verifying your eligibility for out-patient mental health benefits. You are encouraged to contact your insurance carrier prior to your first visit for details of your coverage and how to submit for reimbursement since we will not be billing your insurance company. If you need additional help with insurance questions, you may want to talk with Beth Rogers at x3 or email her at beth@peachtherapy.com.

If you need further information or have any questions prior to our first meeting, please do not hesitate to call me at 443. 797.0144.

I look forward to seeing you soon!

Kristie Evans, M.A., LGPC
Psychotherapist

Paula Ehrmann and Associates, Inc.
443.797.0144

303 International Circle
Suite T125
Hunt Valley, MD 21030

Patient Information

First Name: _____ MI_____ Last Name_____

Street Address: _____

City: _____ State: _____ Zip: _____ Is it okay to receive mail at this address: Y / N

Cell#: ___-___-_____ Work#: ___-___-_____ Home#: ___-___-_____ DOB: ___/___/_____

Email: _____ Gender: M / F

Emergency Contacts:

Name: _____ Relationship : _____

Cell#: ___-___-_____ Home#: ___-___-_____

How were you referred to PeachTherapy? _____

Paula Ehrmann & Associates, LLC is a NON-PARTICIPATING PROVIDER (out of network) with all insurance plans. We do not bill any insurance companies. It is very important to call your insurance carrier and know what your out-of-plan benefit is for outpatient mental health.

Have you contacted your insurance? Y / N **If precertification is required, have you done so? Y / N**

Do you plan to submit your sessions for reimbursement from your insurance company? Y / N (if yes, we need copy of card)

YOUR SIGNATURE BELOW ALSO AUTHORIZES RELEASE OF INFORMATION TO YOUR INSURANCE CARRIER IF REQUIRED

Payment Policy

Answers to some of your questions may be found in section titled, **Policies and Procedures.** Please read carefully: Your signature at the bottom of this page indicates that you understand these policies, received our **Notice of Privacy Practices** and consent to treatment. ***Kristie Evans'*** fee is $140.00 for each 50 minute session and prorated as needed for additional session time. Full payment is due at the time of the service. Our practice securely maintains and charges your credit card on that date. Prior arrangements must be made to change this procedure. ***Should you cancel your session without providing at least 24 hours notice, you will be charged a fee of $140.00.*** Personality testing is requested for most new patients at a cost of $125.00. In addition, a fee of $140.00 per hour will be charged to each patient issuing a subpoena for court proceedings, see policies and procedures for details.

Patient Signature: _____ **Date:** _____

Responsible Party (if applicable): _____

Policies and Procedures

Appointments:
Sessions are by appointment and usually last 50 minutes. 80 minute sessions are also offered as needed.

Cancellations:

If you must cancel, we require 24 hour notice which allows us time to schedule another patient for that time. If cancelling an appointment for a Monday, we must receive notice by 12 noon the previous Friday. Cancelling with less than 24 hour notice (or after 12 noon on Friday for a Monday appointment) will result in a charge for your missed session. In the event of a true emergency this would not apply.

Phone Messages:

To leave a message for your therapist you may call the office number 443-797-0144. Your call will be answered by an automated message which will direct you to an extension to select. Calls will be returned as soon as possible, as time and schedules permit. Please note that Beth (x 3) is available to speak with you about scheduling and routine questions during normal business hours.

Payment:
Our policy is for full payment by credit card at the time of service. A copy of your credit card and authorization will be secured for sessions to be charged. If necessary, we do accept checks and cash.

A fee of $140 per hour will be charged to each patient issuing a subpoena for court proceedings. A minimum deposit of $600 will be due 24 hours prior to court. The balance will be invoiced and due at completion of the trial for all time related, including but not limited to; phone calls, letters, driving, out of office and waiting time.
Any account balances more than 60 days late will be subject to a 20% surcharge monthly thereafter.

Monthly Statements:
A statement of activity will be mailed to you monthly. If you are submitting for insurance reimbursement, you can mail the statement along with your insurance carrier's claim form to your insurance carrier.

Insurance:

Most insurance providers reimburse for some portion of the fee for outpatient psychotherapy. **Our practice does not accept assignment of benefits from insurance carriers and we are not "participating" or "in-plan" with any insurance carriers, HMO or PPO plans.** In instances of insurance reimbursement we ask that each individual pay the session fee and accept reimbursement from the insurance company. Your insurance plan may require: a referral from a medical doctor, precertification, on-going treatment plan, etc. for payment of benefits to be received. This varies widely from one policy to another. Please check your benefit requirements carefully and inform your therapist if our office must provide clinical or other information. NOTE: by law, all claims must be paid or denied within 30 days of submission.

Confidentiality:
Your therapist is ethically bound to guard your confidentiality. No disclosure as to the nature of your treatment will be made without your signed consent. However, the law limits the right of confidentiality under certain conditions. Confidentiality will not be maintained in the following circumstances: child abuse, suicidal or homicidal threat, and criminal or tort issues. **If you wish to utilize your insurance benefits, patient information is required by most insurance companies before they will make payment.**

HIPAA:

We are an HIPAA compliant office and provide to all patients copies of our Notice of Privacy Practices.

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Patient Health Information

≈ **Full Name:** ≈ **Dob:** ____/____/____

≈ **Marital Status:** ≈ **Name of Spouse:**

≈ **Children Names & Ages (if applicable):**

≈ **Job Title:**

≈ **Job Responsibilities:**

≈ **Date of last physical examination:** ____/____/____

≈ **List any physical illnesses and/or concerns:**

≈ **List any current medications you are taking:**

≈ **Name of Family Physician (M.D.):** _____ ≈ **Phone:** _____

≈ **Are you currently seeing an acupuncturist, physical therapist or chiropractor?**

≈ **Briefly describe your reasons for seeking help:**

≈ **Approximately how long have you been concerned about these issues?**

≈ **Please describe or list your goals for therapy:**

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≈ **Using the symptom checklist below, check the current problems you are experiencing:**

☐ ANXIETY	☐ SADNESS	☐ FEARS	☐ MARRIAGE PROBLEMS	☐ STRESS
☐ FINANCES	☐ SLEEP	☐ CHILDREN	☐ WORK	☐ SUICIDAL THOUGHTS
☐ MEMORY	☐ GUILT	☐ DIVORCE	☐ TRANSITION	☐ TRAUMA
☐ PARENTING	☐ ANGER	☐ SELF-ESTEEM	☐ STOMACH PROBLEMS	☐ AGING
☐ ENERGY	☐ WORRY	☐ SELF-CONTROL	☐ LEGAL ISSUES	☐ PAIN
☐ MENOPAUSE	☐ SHYNESS	☐ RELATIONSHIPS	☐ DRINKING	☐ LONELINESS
☐ FRIENDS	☐ EDUCATION	☐ CAREER	☐ SCARY THOUGHTS	☐ CONCENTRATION
☐ OBSESSIONS	☐ CRYING	☐ INSOMNIA	☐ MERCURIAL	☐ STUCK

≈ **Have you ever sought help for these concerns before? If so, describe if helpful, not helpful?**

≈ **Do you drink alcoholic beverages? _____Yes _____No**

≈ **How many? ____1-3 per wk ____3-6 per wk _____> 6 drinks per week**

≈ **Do you use drugs (marijuana, cocaine, ecstasy, prescription, etc.)?**

≈ **Purpose?**

≈ **Frequency?**

≈ **Do you now or have you ever had an eating disorder?**

≈ **If so, please explain briefly:**

≈ **Do you have a history of physical, sexual or emotional neglect or abuse?**

≈ **If so, please explain briefly:**

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≈ **Is there any specific trauma or fear that you are interested in working on in therapy?**

≈ **Have you had previous therapy experience? _____Yes _____No**

≈ **If yes, how was it beneficial?**

≈ **Overall was it positive or negative and why?**

≈ **Are you currently in treatment with a psychotherapist and/or a psychiatrist?**

_____Yes _____No ≈ **If yes, please provide name:_____**

≈ **Please use this space to add any additional information you think I should know about you:**

Thank you for taking the time to complete this form. Please sign below, verifying that the information on this form is true and has been completed by you.

≈ **Patient Signature _____** ≈ **Date _____**

Consent for Release of Confidential Information

I, _____, authorize Paula Ehrmann & Associates, LLC to discuss information relevant to my healthcare with the following professionals:

Name of Professional _____

I understand that my records are protected as confidential under federal law and cannot be disclosed without my written consent unless otherwise permitted in accordance with federal law and regulations. I also understand that I may revoke this consent at any time.

≈ **Signature _____** ≈ **Date _____**

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Credit Card Authorization Form

Patient Name: _____

Card Holder Name: _____

Card Type: _____ **Visa** _____ **Mastercard** _____ **Amex**

Card #: _____ **Expiration:** _____

3 Digit Security Code: _____ **usually found on the back, Amex on the front**

Card Holder Address (where your credit card statement is mailed):

_____

_____

I understand that my credit card will be charged on the day of my appointment for the appropriate fee assigned to my service:

Individual or Family Psychotherapy, 50 min	**$140.00**
Personality Testing Packet, *requested for most new patients*	**$125.00**

Other Fees:

InSideOut Enneagram Coaching with Cathy, *60 min*	**$100.00**
InSideOut Enneagram Workshop	**$195.00**
Individual or Family Psychotherapy, *80 min*	**$210.00**
Individual or Family Psychotherapy, *110 min*	**$280.00**
Telephone Sessions, 50 min	**$140.00**
Intervention Services (2 hour minimum)	**$200.00/per hour**
Reports/Letter Requests (half hour minimum)	**$140.00/ per hour**
Subpoena for Court	**$ 200.00/per hour**

(A fee of $200.00 – hour will be charged to each patient issueing a subpoena for court proceedings. A minimum deposit of $600 will be due 24 hours prior to the court appearance. The balance will be invoiced and due at completion of the trial for all time related, including but not limited to: phone calls, letters, driving, out of office and waiting time.)

I also understand that if I do not provide 24 hour notice of a cancellation, my credit card will be charged the full fee. I understand that this would not apply in an emergency situation.

Card Holder Signature: _____ **Date:** ____/___/___

**** PAULA EHRMANN & ASSOCIATES, LLC SECURELY MAINTAINS YOUR CREDIT CARD INFORMATION AND ADHERES TO ALL HIPAA REGULATIONS****

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Notice of Privacy Practices

HIPAA (Health Insurance Portability Accountability Act)

Paula Ehrmann & Associates, LLC is required by law to inform you of how we use your Personal Health Information (PHI) and provide you with a copy of our Notice of Privacy Practices. The following information is important. Please read and keep for your records. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice of privacy practices describes how we may use and disclose your personal health information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. **Uses and Disclosures of Protected Health Information**
   Your PHI may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you and any other use required by law. A *Consent to Release* this information will be provided to you should the need arise. This form is written documentation supporting what information will be released.
   Treatment: We will use and disclose your PHI to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Again, a written *Consent to Release* form would be used.
   Payment: Your PHI will be used as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
   Healthcare Operations: Your PHI may be used or disclosed as needed in order to support the business that directly relates to your care. For example, we may use your PHI to contact you to remind you of an appointment or send statements by mail to your home.

2. **Electronic Storage and Transfer of Information**
   Paula Ehrmann & Associates, LLC uses a number of computer based technologies to manage your information.
   Software: Software-based scheduling and billing systems. This means that your PHI is stored on computer hard drives. This information is both stored at the office and transported with and by office staff only when necessary.
   Email and Fax: Communicates with patients and third party payers by email and fax and uses the following confidentiality statement:

The information contained in this communication is HIGHLY CONFIDENTIAL. It is intended only for the use of the recipient named above, and may be legally privileged. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication, or any of its contents, is strictly prohibited. Any other use is a violation of Federal Law (HIPAA) and will be reported as such. If you have received this communication in error, please return this communication to the sender and contact me immediately. Thank you.

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If Paula Ehrmann & Associates, LLC were to communicate by email it would be a prearranged agreement between you and our staff using these methods. Your information when emailing us may not be secure. We make every effort to secure this information by using an encrypted and password system.

3. **We may use or disclose your PHI in the following situations without your authorization.** Your therapist is ethically bound to guard your confidentiality. As stated no disclosure as to the nature of your treatment will be made without your signed consent. However, the law limits the right of confidentiality under certain conditions. Confidentiality will not be maintained in the following circumstances: child abuse, suicidal or homicidal threat, and criminal or tort issues.

   Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

   You may revoke this authorization at any time in writing, except to the extent that your therapist or Paula Ehrmann & Associates, LLC has taken an action in reliance on the use or disclosure indicated in the authorization.

   Your Rights: The following is a statement of your rights with respect to your PHI.

   You have the right to inspect and copy your PHI. Under Federal Law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to the law that prohibits access to PHI.

   You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your therapist is not required to agree to a restriction that you may request. If your therapist believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to see another Health Care Professional.

   You have the right to request to receive confidential communications from us and the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

   You have the right to have your therapist amend your PHI information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

   You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

   Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and Privacy Practices with respect to PHI.

Our Staff is dedicated to maintaining your privacy.

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PROFESSIONAL DISCLOSURE STATEMENT

In accordance with the Annotated Code of Maryland, Health Occupations, 17-308, Authority granted by license, 17-309, Supervised clinical practice, and 17-507, Professional disclosure statement

Kristie Evans, M.A., L.G.P.C. Licensed Graduate Professional Counselor

Peach Therapy, LLC
303 International Cir T125, Cockeysville, MD 21030
Phone: (443) 797-0144

kevanslicensedtherapist@gmail.com

Maryland Board of Professional Counselors and Therapists ***LGPC # LGP5750***

Education:

PRESCOTT COLLEGE, Prescott, Arizona
M.A., Counseling Psychology & Equine Assisted Mental Health

Authorized to provide services involving the application of counseling principles and methods in the diagnosis, prevention, treatment, and amelioration of psychological problems, emotional conditions, or mental conditions of individuals or groups

Under the Clinical Supervision

of
Paula Ehrmann, LCPC
Licensed Clinical Professional Counselor #LC1516 Approved Clinical Supervisor

Peach Therapy, LLC
303 International Cir T125, Cockeysville, MD 21030
Phone: (443) 797-0144

Fee Schedule:

$140 for 50 minute session

This information is required by the Board of Professional Counselors and Therapists, which regulates all licensed and certified counselors

Maryland Board of Professional Counselors and Therapists 4201 Patterson Avenue Baltimore, MD 21215-2299 / (410) 764-4732

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Insurance Help Form

The information below is designed to guide you when calling your insurance company. For those patients who wish to utilize their out of network benefits, ***it is important to call prior to your first visit to ensure coverage.***
Paula Ehrmann & Associates, LLC is a NON-PARTICIPATING PROVIDER with all insurance plans. We do not bill your insurance company. If you plan on submitting claims, we will send a statement with a procedure code and diagnostic code, which your insurance requires.

Paula Peach Ehrmann, MS, LCPC	***License # LC1516 - Psychotherapist***
Tara M. Johnson Falcone, LCPC	***License # LC5683 – Psychotherapist***
Cara Ebling, LCSW – C	***License # 16276 – Psychotherapist***
Matthew Richardson, LCPC	***License # LC7868 – Psychotherapist***
Kristie Evans, M.A., LGPC	***License # LGP5750 - Psychotherapist***
(Kristie works under the supervision of Paula Ehrmann.)	

The standard services provided are:

Individual Psychotherapy	**CPT code 90834**
Family Psychotherapy	**CPT code 90847**

Insurance Contact: _____ Ins#:_____ Date: ____/____/____

Group#: _____ Policy Effective Date: ____/____/____

Do I have coverage for outpatient mental health psychotherapy and am I eligible for reimbursement for the services provided by this therapist? **Y / N**
What address should I mail my claims to?

_____

Do I have a deductible to be met? **Y / N** If yes, amount $_____
How much have I met? $_____ What % is reimbursed per visit?_____
What is the dollar amount recognize per visit, (usually and customary rate or UCR)? _____
Is on-going treatment plan or authorizations required? **Y / N**
Do I need a special form to submit? **Y / N**
Notes:

Tips:

- **Ask Beth if you need assistance of have questions, she is happy to help!**
- **Check with your insurance company if further documentation is required. Ask if they need a treatment plan. Be sure to communicate with us if a treatment plan is required.**
- **Keep track of the claims you send to your insurance company**
- **Don't be tardy sending in your statements because insurance companies can have time limitations on filing.**

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Directions

From York Road:

- Proceeding NORTH on York Road
- Make a LEFT onto Shawan Road
- Make a RIGHT onto McCormick Road (the light at the Outback Restaurant)

Proceed to **

From I-83:

- Take I-83 NORTH toward Timonium / York PA
- Take the Shawan Road EAST exit- EXIT 20A- toward COCKEYSVILLE
- Move all the way over to your left lane and at the first light make a LEFT onto McCormick Road

  ** **Turn LEFT onto International Circle and continue up the hill**
- Turn LEFT into the entrance for 303 International Circle (at the Confederate Soldier Artwork)
- Make an immediate RIGHT and drive between the pillars and park to the LEFT
- Enter through the side door under the garage area
- Walk straight past the elevators and turn left and follow the hallway all the way down to the end of the hallway to Suite T125

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