Catalyst
BEHAVIORAL HEALTH

Name (Last) _____ (First) _____ (Middle) _____
Address: _____ Phone # ( ) _____-_____ Cell # ( )_____-_____
City: _____ State: _____ Zip: _____
Date of Birth: _____/_____/_____ Soc. Sec#_____-_____-_____ Male: [] Female: []
Race: _____ Ethnicity: [] Hispanic or Latino [] Not Hispanic or Latino Preferred Language:_____
Single: [] Married: [] Separated: [] Divorced: [] Widowed:[]

Email Address: _____

Parent/Spouse's Name: _____ Soc. Sec#_____-_____-_____
Purpose of Visit: _____
Emergency Contact: _____ Phone: ( ) _____-_____
Primary Care Physician: _____Phone: ( ) _____-_____

Do You Have Medical Insurance? Yes [] No [] (If Yes Please Answer **ALL** Questions Below)
Primary Insurance Company_____
Policy #_____ Group#_____
Does your insurance require authorization prior to the first session? Yes [ ] No [ ] If yes have you contacted the company? Yes [ ] No [ ]
Policy Holder's Name & Relationship_____
Policy Holder's Soc. Sec#_____-_____-_____ Policy Holder's Date of Birth_____/_____/_____
Policy Holder's Employer's Name_____ Employer's Phone #: ( ) _____-_____
Employer's Address_____

Secondary Insurance Co._____
Policy #_____Group #_____
Policy Holder's Name & Relationship_____
Policy Holder's Soc. Sec #_____-_____-_____ Policy Holder's Date of Birth_____/_____/_____
Policy Holder Employers Name: _____ Employer's Phone ( ) _____-_____
Employer's Address_____

Responsible Party or Guarantor (if other than patient): _____
Address: _____ Phone: ( ) _____-_____

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature of this document authorizes my physician to submit claims for benefits for services rendered for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I authorize and assign payment of all/any insurance benefits to Tracy List Kalnins, Ph.D., LLC that is otherwise payable to me for her services as described on the assigned payment forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Tracy List Kalnins, Ph.D., LLC will be credited to my account in accordance with the above assignment.

_____ _____ _____
(Print Name of Patient) (Authorized Signature of Patient/Parent/Guardian) (Date)

Note: If the patient is under the age of 19, the parent or guardian must sign all legal documents.

Tracy List Kalnins, PhD.
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Creating Positive Change

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Authorization for Treatment
I acknowledge that I have been given the opportunity to review the Consent to Treatment and Confidentiality Statement. I may obtain a current copy upon request. I am aware this authorization to treat does not include court testimony by my provider. I understand that Catalyst Behavioral Health (CBH) has the right to change the Authorization for Treatment at any time.

Acknowledgement of Receipt of Privacy Notice
I acknowledge that I have been given the opportunity to review the Notice of Privacy Practices for Protected Health Information. I may obtain a current copy upon request. I understand that CBH has the right to change the Notice of Privacy Practices at any time.

Office hours and Phone calls
Office staff is available 9am-4pm Monday through Thursday, and Friday, 9am-12:00pm to address any questions or concerns you have. We will make every effort to return a phone call as soon as possible, but if your call is urgent, please note that with our office staff or when you leave a message on our confidential voice mail.

Appointment No-Show Fee
I have been advised that this office requires a 24-hour prior notice on all appointment cancellations and I have reviewed the CBH billing policy. I have been advised that there will be a $50.00 no show fee for appointments that are canceled with less than 24-hour notice. This fee is not covered by any insurance plan and must be paid prior to my next visit. I understand that three no-show/late cancellations in one year may be cause for automatic discharge from the clinic. Exceptions to this policy are solely based on Dr. Kalnins discretion.

Billing Policy/Copayments
I acknowledge that I have been given the opportunity to review Dr. Tracy Kalnins' billing policy. I understand that co-pays, if appropriate, must be paid at the time of visit. I understand that I am responsible for all fees not paid by my health insurance. Payment is due 30 days after receipt of statement. Electronic payment is offered as an option and includes a $5.00 convenience fee. To avoid paying this additional fee, please use cash or check made payable to Dr. Tracy Kalnins. A 5% finance charge will accrue on any unpaid balances that are 90 days or more past due. I understand Dr. Kalnins' does offer financial assistance in the form of payment plans. Uninsured clients, or self-pay clients are required to pay for services in full at the time of their appointment before they can be seen. Dr. Kalnins' does reserve the right to submit any unpaid balances to a collection agency for recovery. **Clients are now required to provide a valid credit card at the time of their first initial session for the office to keep in their electronic file**. Once uploaded into our secure system, this information is immediately shredded. This information will be updated yearly or when a card has expired. I understand that if no payment is received within 30 days, a payment will be automatically charged to my credit card on file. Cards will not be charged without prior notification and opportunity to provide alternate payment will be offered at that time. Billing policies may be updated or modified throughout the calendar year. Please direct any questions about insurance, billing, and payment plans to Gina Pashby, our office manager.

Please list your credit/debit card information below:

Patient Name: _____ **DOB:** _____

Account Number: _____

Expiration Date: _____

Security Code: _____

Printed Name (as it appears on card): _____

Client/Guardian Signature: _____

Date Signed: _____

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Tracy List Kalnins, Ph.D., LLC

CONSENT FOR THERAPY AND CONFIDENTIALITY STATEMENT

In compliance with the ethical and legal guidelines delineated by the American Psychological Association and the American Counseling Association, my psychologist/counselor has explained that my participation in therapy is completely voluntary and confidential. In signing this document, I provide my voluntary consent to participate in therapy/counseling for myself and/or my minor child. I understand that I may refuse and/or terminate services for myself and/or my minor child at any point during the counseling process, without adverse repercussions between this agency and myself.

I also understand that Tracy List Kalnins, Ph.D., LLC of Catalyst Behavioral Health, LLC, will maintain protected health information records relevant to therapy, as well as information obtained through consultation with other professionals. I understand that these records are restricted to the internal use of Tracy List Kalnins, Ph.D., LLC and their confidentiality will be strictly maintained at all times. I understand that Tracy List Kalnins, Ph.D., LLC has employed administrative assistants who manage the transcription, billing, scheduling, filing, and other miscellaneous office duties and that these individuals have been bonded to uphold the state and federal guidelines with regard to maintaining confidentiality. Tracy List Kalnins, Ph.D., LLC will release the written or verbal information regarding my intake or counseling sessions only upon receipt of my written consent and only to those specified by myself, except in unusual circumstances. In circumstances where there is risk of danger and/or impending harm to myself or others, child abuse, and/or certain legal situations (for example, court subpoena of your records), Tracy List Kalnins, Ph.D., LLC would be mandated by law to disclose such information for my protection and/or that of others. In such situations, my psychologist will make reasonable attempts to discuss the situation with me and enlist my participation in resolving the matter, if possible. If I have any questions, I understand that I can discuss them freely with Tracy List Kalnins, Ph.D., LLC.

I have had these rights explained to me and by my signature, I indicate my understanding and agreement. I also understand that I have the right to refuse to sign this consent form. By my signature, I authorize that a photocopy or facsimile (FAX) copy shall have the same effect and authority as the original copy of this document.

Client/Parent/Guardian_____ Date_____

Witness_____ Date_____

Children and adolescents may need to discuss information with their counselor in confidence. Often, such information is important for the purposes of providing your child with appropriate assessment and treatment services, but would not be provided to the parent. Catalyst Behavioral Health, LLC requests that you support your child's need for privacy, excluding situations in which there is a risk to the health and welfare of your child. I provide my permission to my child's counselor to maintain the confidentiality of my child _____, except in circumstances in which there is a risk to her/his health or welfare.

Parent Signature and Date _____

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ☐ **Male** ☐ **Female** **Date:**_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child...	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. &	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
VI.	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child ...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			