

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thanks so much for choosing our office for psychological services. Enclosed, please find several items, as follows:

\* **Intake form**: There is a brief form (pages 2 and 3) requesting information about your current family, living, occupational, mental health, and medical circumstances. Please complete this form and bring it with you to the appointment.

\* **Information for New Patients**: Please read the entire packet carefully. If you have any questions about the information it contains, we will be happy to answer them for you. When your questions about our services have been answered, please sign the Statement of Understanding (page 9 of the packet) and bring with you to the appointment. You may keep the rest of the information for New Patients (pages 4 to 8).

**\* Directions**: Our office is located in brown brick, ranch-style house in a residential neighborhood a few miles south of Martinsville. To reach the office, take State Road 37 south toward Bloomington. From the traffic light at Burton Lane and 37, head south 3.8 miles to Liberty Church Road. The Idle Zone boat repair ship is at this intersection. Turn left on Liberty Church Road. Proceed 0.9 mile (you'll pass Liberty Christian Church). Turn right on Barbara Drive. Proceed about 400 feet and make a "hard" right on Doris Drive. Go one block on Doris and bear left with the street as it becomes Meadows Lane." Once the street becomes Meadows, the office is in the first brick house on the right. There is a small sign in the front yard. Please park in the driveway or, if driveway space is not available, one in front of the building on the same side of the street. *Please do not park on the other side of the street*. *Please note that you will be in a residential area*. Enter through the front door. You do not need to knock, as this is not a residence. If the office is closed when you arrive, please wait. An officer worker will be there shortly. Feel welcome to call the office number (765.318.1225) if you would like to find out when a staff member will arrive.

**\* Your Appointment Time**: We strive to start and end patient appointments on time. However, circumstances arise when a patient will need to wait when the clinicians are running behind. These waits seldom are more than a half-hour. Please bear with us during these periods. If you cannot wait, we will be happy to reschedule your appointment. On your intake form, you are asked if you prefer to receive automatic reminder contacts about your appointment by phone, text, or email. These contacts are used to reduce the number of "no-shows" we encounter by enabling you to indicate if you will be able to keep your appointment. Please understand that it is your right to indicate that you do not want to receive a reminder contact in any these ways. However, if you miss your appointment and do not call us at least 24 hours in advance of the appointment, you must pay a $64.50 missed appointment fee in order to return to this office for services. If a patient misses two appointments within a two-month period, we will ask the patient to seek services elsewhere.

**\* Insurance information**: If you plan to use insurance or state/federal assistance to cover all or part of the fees for the services you receive, please bring your insurance card. Also, be sure to contact your insurance representative if you are not sure whether or not your plan will cover our services. We will help you obtain this information if you wish.

**3630 Meadows Drive, Martinsville, Indiana 46151 (765) 318-1225 (Voice) (800) 596-3681 (Fax)**

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**LPS Behavioral Health, LLC**

**Patient Information**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_**

**Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City and State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race (optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**We typically send automated reminder contacts to patients, by telephone, text, or email. May we send you appointment reminders by:**

Telephone? Yes No

Text message? Yes No (If "Yes," please provide phone number to text: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_).

Email? Yes No (If "Yes, please provide an email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_).

Have you received **outpatient** mental health services in the past? Yes No

If yes, please tell us when and where you received those services:

**Date/s Agency or Professional’s Name City/State Condition Treated**

\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you received **inpatient** **mental health** treatment in the past? Yes No

If yes, please tell us when and where you received those services:

**Date/s Hospital Name and City/State Condition Treated**

\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you treated for **any other medical conditions**? Yes No

If so, please briefly describe the conditions and who treats them:

**Condition** **Treating Provider Name and City** **Dates Treatment Started/Ended**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Who is your regular doctor (or primary care physician)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you: \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widow \_\_\_\_\_ Life Partner

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Name of Spouse or Partner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have children? Yes No If “**Yes**,” please list their names and ages, and whether or not they live with you:

**Name Age Living with you? (List additional children in this space)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ YES NO

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ YES NO

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ YES NO

Please briefly describe the problem/s for which you are seeking assistance. **If this is for a Medicaid, SSI, SSD, Disability, or similar type of assessment, skip this question.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Below, please list and describe all the **mental health** and **pain** medications you are prescribed **now**, *whether or not you actually take them*. Please provide the information requested for each medication, to the extent you know it. List **only** mental health and pain medications. Use the back of this page to list additional medications if needed.

**Medication Dose (mg, mcg) Number of doses Do you actually**

**each time taken each day take this medication?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO

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Now, please list **all other** medications you are currently prescribed **now**. Simply list each medication and whether or not you actually take the medication **now**. If needed, please write any additional medications on the back of this page.

**Medication Do you take Medication Do You Take?**

**this medication? this medication?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES NO

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**LPS Behavioral Health, LLC**

**Information for New Patients**

Thank you for choosing our office. We provide psychological assessment, counseling, psychotherapy, and consultation services to children, adults, and families on a wide range of mental health concerns.

*Please note that, at this time, we are unable to provide* ***counseling*** *to sex offenders. We do provide* ***assessment*** *and* ***diagnostic*** *services for this problem, however.*

The decision to seek counseling is a difficult one for many people. This document is intended to help you better understand the nature of our services, as well as what you may expect from us, and what will be expected of you during your contact with us. If, at any time, you have questions or concerns about the services you are receiving, please do not hesitate to raise them with your counselor.

**What Occurs During Counseling and Therapy Appointments?**

When a client begins counseling here, the clinician will conduct an initial psychological evaluation to assess his or her needs and determine if there are any circumstances that should be addressed when working with the problems presented. The nature and extensiveness of this initial evaluation will vary according to the client's needs and the nature of the problem presented. However, these evaluations almost always include a review of the client's social and family history and an overall assessment of mental health. If needed, your clinician may ask you to complete one or more psychological inventories or scales in order to help in determining sources of your concerns. The initial interview requires from 30 to 90 minutes; testing may require additional time. Please keep in mind that the clinician who conducts your initial evaluation may not be the clinician you see for counseling.

Counseling and therapy generally are conducted in weekly appointments ranging from 25 to 75 minutes (usually 50 minutes). Usually, more than one counseling/therapy interview will be required in order to assist you. On average, our clients remain in treatment here from eight to twelve interviews, although many complete their treatment in less than eight interviews and some require more than twelve. Your clinician may talk with you in considerable detail about the nature of your current problems and ways to deal with them more successfully. At times, your clinician may want to talk about circumstances from your past, the ways in which those circumstances may affect you at the present time, and ways to cope with those past matters more successfully now and in the future. Your clinician understands that these conversations may not be particularly pleasant but they are necessary for therapeutic change to occur. Please be assured that we always will treat you with respect and sensitivity for your feelings as you engage in this process with us.

**Counseling Interviews**

Counseling and therapy sessions with individuals generally last 50 minutes. Depending on the age of the client and the types of concerns presented, sessions may be scheduled for more or less than 50 minutes in consultation with the client or, in the case of a child, in consultation with parents. Appointments with couples and families generally are scheduled from 50 to 75 minutes. Group sessions vary in length according to the purposes of the group.

If you find that you are unable to keep a scheduled appointment, please call (765) 318-1225 as soon as possible. We will make every effort to schedule another appointment at a more convenient time. The telephone is answered 24 hours and if your call is answered electronically, we will return your call within 12 hours. If calls have been transferred to a staff member's home telephone, your call may be answered in the name of that staff member rather than the office.

If you do not attend a scheduled appointment and do not call to cancel the appointment at least 24 hours before it was scheduled, you will be charged $64.50. This fee cannot be billed to an insurance carrier or government program and must be paid before another appointment will be scheduled. **Patients who miss a second appointment will no longer be seen at this office and will be referred to another service provider in the area.** **Patients who behave in a threatening or intimidating manner at this office will be asked to leave the office immediately and will not be scheduled for future appointments.**

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**Confidentiality of Information**

Generally, the information you disclose during assessment, counseling, and therapy interviews is confidential. We may not release information from your treatment file to other persons or agencies unless you sign a written consent (called a "release of information form") that allows us to disclose information to specific parties. If you provide consent to release information from your (or your dependent's) file, you have the right to revoke your consent within a reasonable time period. If you decide to revoke an information release you have signed here, you may do so by signing the "revocation" section on your copy of the form and returning it to our office. A blank copy of our authorization form is included in this packet.

However, under Indiana law, there are certain circumstances under which information you disclose cannot be treated in complete confidence and there are certain types of information that must be reported to the appropriate authorities. Circumstances under which information may not be treated as confidential include the following:

*1. situations in which a client discloses information that, in the therapist's professional*

*judgment, indicates s/he or someone else is physically neglecting, or physically or*

*sexually abusing, a minor child or vulnerable adult;*

*2. situations in which a client discloses information that, in the therapist's professional*

*judgment, indicates that the client intends to harm self or another person;*

*3. situations in which a client's records are summoned by a court of law as evidence in the*

*adjudication of the state's case against a client;*

*4. situations in which information is summoned by a court of law in order to settle the will*

*of a deceased client;*

*5. situations in which a client has sued a psychologist for malpractice; and*

*6. situations in which the client has signed a written consent with a federal, state, or local*

*agency that requires us to disclose information about a client to that agency; or has*

*signed a written consent with any other party requiring us to disclose information to*

*that party.*

**Please understand that we must report information that leads to knowledge or suspicion that a child or vulnerable adult is being physically abused, sexually abused, or neglected. We must report information that leads us to believe that a patient may attempt suicide or harm another person. We do not have a choice in this matter.**

If, at any time, you have questions as to the confidentiality of information you may wish to disclose, please discuss those questions with your clinician.

**Fees and Insurance Matters**

Fees for the various services provided by our staff are described on the last page of this information packet.

Many private and employer-provided health insurance programs will reimburse you for a portion of our fees. If you are able to provide our office with information about your insurance, we will submit claims for you. If you want us to submit claims to your carrier, please keep the following in mind.

1. We are not always aware whether or not we participate in your insurance plan. We often are unable to obtain this information on your behalf. **It is your responsibility to learn from your insurance representative whether or not we are fully participating, partially participating, or nonparticipating providers in your plan.**

2. We often do not know, and cannot determine, if you are required to have prior insurance or managed care authorization for your services. **You are responsible for determining if preauthorization is 6required and, if so, whether your doctor obtained this preauthorization. Preauthorization does**

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**not mean that your insurance carrier will pay for your services.** You may have a deductible that must be met, or payment for the services may be denied for other reasons. **You are responsible for all charges we file that are not paid by your insurance carrier.**

3. If you have more than one insurance carrier to which we must file claims, we must have a copy of all insurance cards/information at your first appointment. If we bill the insurance plan/s you provided us at the first session and they deny the claim, you may present other plans to which we should file claims. **However, you will be asked to pay all charges in full , and we will reimburse you if the additional plans you presented pay all or part of those charges.** If your insurance changes during your treatment here, we will gladly bill the new carrier *if* you notified us immediately when your insurances changed and provided us with current claim filing information.

4. We are not connected with your insurance/managed care company. If your claim is denied or the amount of coverage reduced for reasons with which you disagree, it is your responsibility to contact your insurance company to discuss their decision. **In the meantime, you will be expected to pay the amount of your charges that we filed and that the insurance carrier did not pay. We will refile your claim only one time if there is a dispute between you and your carrier about coverage amounts.**

5. Please understand that, if your account is more than 30 days outstanding, we will turn your account over to our attorney for collection. If your account must be taken to small claims court, your identity as a patient here will be no longer be protected information (although your clinical file will remain confidential). Additional charges, including substantial interest and attorney's fees, will be added. Patients whose accounts are taken to collections are no longer eligible to receive services at this office**. Please do not ignore our periodic billing statements, as we are quite willing to arrange payment plans**.

6. If you are concerned about the quality of our services, please feel free to discuss your dissatisfaction with Dr. Robison or Beth Robison. Please understand, however, that dissatisfaction with our services does not relieve you of your obligation to pay for your appointments.

7. Our payment policies are described in the form, Agreement to Pay Charges, which is enclosed in this information packet. Please read it carefully before signing it. We will be happy to answer any questions you may have about it.

**Participants in Managed Care Programs**

If you are enrolled in a managed care program (such as a Health Maintenance Organization or a Preferred Provider Network), you should be aware that, in order to receive the maximum benefits for services, your provider may be required to be a member of the organization's approved provider group. Approved providers are generally selected on the basis of geographic location and types of services provided in the service area. Check with your health plan representative to learn whether or not our office is a participating provider.

If your plan requires services to be provided by an approved provider in order for your services to be covered and Dr. Robison currently is not approved to provide such services for your carrier, you may still choose to receive your services here. However, you will be asked to pay the full charges at the conclusion of each appointment, unless installment payments are arranged.

If you are unsure whether or not your plan requires services to be provided by an approved provider in order to receive full benefits, please contact your personnel director or consult your employee benefits manual.

We accept any standard insurance that covers mental health services provided by psychologists or Health Service Providers in Psychology. Please note that a few carriers will send payments only to their members. If you are covered by one of these plans, we will inform you of this and ask that full payment be made at the time of service, unless other arrangements are made with us. We will, however, submit claims for you.

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**Medicaid and County Assistance Recipients**

If you are a participant in the Medicaid program or anticipate that your fees will be paid through a county fund, we will defer your fees and bill Medicaid or the county on your behalf. We will accept the standard Medicaid payment for services provided to you. You will not be charged a co-payment

for those services. However, should you become ineligible to receive Medicaid, you will become responsible for all fees incurred after the date you become ineligible.

Please note that, in Indiana, there are different types of Medicaid programs. Some programs require you to contact your primary care physician for a formal referral to our office. **We must receive this referral before we can bill Medicaid for your services**.

Also, if a patient is covered by both Medicaid and a private insurance plan, the other plan automatically must consider claims before Medicaid will consider them. Please do not withhold relevant private insurance information from us, as Medicaid will not pay and we will be forced to bill you for services. If you disagree with a Medicaid decision that the patient has other insurance, it is your responsibility to work through the disagreement with your welfare case worker.

If fees for your services are to be reimbursed by a county or school fund, we usually will have received advance notice of this fact. If we have not been notified of your eligibility for county-funded services and you believe you are eligible, please discuss this matter with our office manager. We will contact the appropriate county official.

**Medicare Recipients**

Our office is a provider under Medicare Part B and we accept assignment of benefits. We will file your claims for you. If you have not met the Medicare B deductible, you will be responsible for the full fee until the deductible is met. After your deductible is met, you will be asked to pay the 50 percent co-payment at the conclusion of your appointments, unless monthly installments payments are arranged. If you also receive assistance under Medicaid or have other insurance, your fees will be deferred until all of your plans have been billed.

**Medicaid and Social Security Disability Evaluations**

If you were referred to this office for a psychological examination by the Medicaid Office or the Disability Determination Bureau (SSI, SSD), financial arrangements for your services have been arranged. You will not be asked to pay a fee for any services received as part of that evaluation.

**Disclosure of Therapist Credentials**

Your clinician will be Floyd F. Robison, Ph.D, HSPP; Elizabeth A. Robison, M.S., LMHC;

Troy A. Pederson, M.S., LMHC; or Lyn Hoyer, M.S.

***Floyd F. Robison*** has a Ph.D. in Counseling and Educational Psychology from Indiana University (1982). He is a Health Service Provider in Psychology and a Fellow of the Association for Specialists in Group Work. He is in general practice, with emphases in psychological evaluation, consultation on psychotropic medications and related issues, and mental health services for older adults in the community and health care facilities.

***Elizabeth A. Robison*** has an M.S. degree in Counseling and Counselor Education from Indiana University (1997). She is a Licensed Mental Health Counselor, Licensed Social Worker, and National Certified Counselor. She is in general practice, with emphases in gerontological assessment and counseling, and child and adolescent therapy.

***Troy A. Pederson*** has an M.S. degree in Counseling and Counselor Education from Indiana University (1993). He is a Licensed Mental Health Counselor. He is in general adult practice, as well as couples' therapy.

***June Lyndon Hoyer*** has an M.S. degree in Counseling and Counselor Education from Indiana University (2011). She is completing her Ed.S. degree with a concentration in Mental Health Counseling at Indiana University. She is in general adult practice, as well as family therapy.

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***Lyndsay R. Mack*** has an M.S. degree in Counseling and Counselor Education from Indiana University (2011). She is completing her Ed.S. degree with a concentration in Mental Health Counseling at Indiana University. She is in general adult practice, as well as family therapy.

**Fee Schedule (Effective March 1, 2011)**

**Standard Fees** (Please note that fees negotiated with your managed care organization may be lower than those fees shown below)

*Counseling and Therapy*

Initial Interview: $150.00

All subsequent interviews:

50 minutes $125.00

25 minutes $64.50

*Groups: Counseling and therapy (when available) :$40.00 per group meeting*

*Psychological Evaluations*

Our office performs the following types of psychological evaluations:

Attention deficit hyperactivity disorder

Autism spectrum disorders

Bariatric surgery qualification

Competency to manage financial and personal affairs

Dementia assessment

Disability

Employment/Fitness for duty

General evaluation of mental status/Differential diagnosis

Return to Work

Rehabilitation potential

School problems

Sex offender assessment

Substance abuse

*Special Evaluations*

Child Custody Evaluations: $1000.00 - $3000.00 (Availability of this service is limited)

*Testing*

General Testing: 150.00 per **hour**

Intelligence/Memory/Personality 150.00 per **test**

*Consultation With Fellow Professionals*

**In-Office**: 80.00 per hour

**Out-of-Office** (includes civil court appearances): 150.00 per hour plus travel and per diem expenses. Time in court is billed for all time at the courthouse and courtroom, and in travel to and from the court. Please advise your attorney of this fee if you plan to obtain an order for your clinician to testify. If your attorney needs to speak to your clinician in person, the consultation is billed according to the in-office consultation fee.

**Professional Supervision**: $100.00 per hour if not a former graduate student of Dr. Robison/No charge if the supervisee is one of his former graduate students or a professional colleague.

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**Statement of Understanding**

I have read the information in this packet. All of my questions have been answered to my satisfaction. I have received a copy of the packet. By my signature below, I accept the financial policies at this office and agree to receive treatment at this office.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient (or Legal Guardian) Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date