Philip Oncley, Ph.D.

5212 Katella Ave., #104, Los Alamitos, CA 90720 ~ (714) 490-7069 Fax (562) 493-1684
901 Dove St., #150, Newport Beach, CA 90802 ~ (949) 271-9583

NEW CLIENT INFORMATION

To be completed by the client (parent or guardian if client is younger than 18 years).

PATIENT'S NAME: _____ **TODAY'S DATE:** _____

HOME ADDRESS: _____ **CITY / STATE / ZIP:** _____

HOME PHONE: (____) _____ **BUSINESS PHONE: (____)**_____

DATE OF BIRTH: _____ **AGE:** _____ **SEX:** _____ **MARITAL STATUS:** _____

CELL/PAGER/VOICE MAIL: _____ **E-Mail:**_____

STUDENT STATUS: □ **Non Student** □ **Full Time** □ **Part Time** □ **Unknown**

REFERRED BY: _____ **ADDRESS** :_____

CITY / STATE / ZIP: _____ **PHONE:** _____ **FAX:** _____

RELATIONSHIP TO REFERRAL SOURCE:

Person financially responsible for payment of services and / or subscriber of the primary insurance plan:

NAME: _____

HOME ADDRESS: _____**CITY / STATE / ZIP:** _____

HOME PHONE: (____) _____ **BUSINESS PHONE: (____)**_____

OCCUPATION / TITLE: _____ **EMPLOYED BY:** _____

EMPLOYER ADDRESS: _____**CITY / STATE / ZIP:** _____

PRIMARY INSURANCE: _____ **GROUP NAME OR NUMBER:**_____

INSURANCE ADDRESS: _____

CITY / STATE / ZIP: _____ **PHONE NUMBER:** _____

SECONDARY INSURANCE:_____ **ADDRESS:**_____

PLAN NAME/GROUP NUMBER: _____

PATIENT'S RELATIONSHIP TO SUBSCRIBER ON INSURANCE: □ **Self** □ **Parent** □ **Dependent** □ **Other**

SECONDARY INSURANCE: □ **No** □ **Yes**

DO YOU WISH TO PAY CO PAY OR FEE WITH CREDIT CARD: □ **YES** □ **NO** **If yes, please complete next line.**
Card Type: □MC □VISA Name: Number: Expiration:

Provider Code: _____Account Type: □ Contract □ Insurance □ Cash Contract / Insurance Name: _____

Procedure: _____ Full Fee: _____ Adjustments:_____ Co Payment: _____ Amount Charged: _____

Provider / Account Code: _____Diagnosis: Code: _____ Description: _____ □ DSM-4 Office: _____

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CONSENT FOR TREATMENT

CONFIDENTIALITY

All written or spoken material from any and all sessions, including psychological testing, will be considered confidential unless:

1. the patient authorizes release of information with his / her signature.
2. the patient presents a physical danger to self.
3. the patient presents a danger to others.
4. child / elder abuse / neglect are suspected.
5. witnessing of domestic violence by minors

In the latter two cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

In addition, it is understood that: 1. Cases are sometimes discussed among the professional staff for educational and /or research purposes. 2. While all telephonic, cell, e-mail, and fax communications are performed with the utmost concern for privacy/confidentiality, the patient acknowledges that no system of communication can be guaranteed 100% confidential.

CONSENT FOR TREATMENT

I authorize and request that my therapist carry out psychological examinations, treatments, and / or diagnostic procedures which now or during the course of my care as a patient are advisable.
I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I understand that psychotherapy is a collaborative process between my therapist and myself and that results may vary. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

RELEASE OF INFORMATION

I authorize the release of information for claims, certification / case management, and other purposes related to the benefits of my Health Plan.

I understand that all personal information is kept in compliance with HIPPA standards and that I can request a copy of these standards from my therapist.

I understand and agree to all of the above information.

_____
PRINTED Patient (or Parent / Guardian) Name

_____ _____
SIGNATURE Patient (or Parent / Guardian) Date

Philip Oncley, PhD.
Child and Adult Psychology

5212 Katella Ave., #104, Los Alamitos, CA 90720
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(714) 490-7069 (562) 430-7986 *(949) 271-9583* FAX (562) 493-1684

FEE SCHEDULE

PROFESSIONAL FEES:

Consultation or Intake (Initial Visit) $185.00
Individual Psychotherapy, Family Therapy or Marital Counseling $150.00
Psychological Testing/Evaluation (Time / Hour Testing + Scoring + Report Writing) $150.00
Organizational Consulting $150.00
School, or Home Visit (Time / Hour at Site + Travel) $150.00
Hospital Visit (Including Psychological Testing) $200.00
Neurofeedback $150.00
Group Psychotherapy $65.00

ADMINISTRATIVE FEES:

Returned Check $15.00
Disability and Workcomp forms (per page) $25.00
Reports (per hour) $150.00

All fees are to be paid at the time of service.

Certain health insurance plans have pre-arranged contracted fee arrangements that are different than the amounts quoted. Upon verification of your eligibility and benefits, your insurance carrier will be billed for you and your therapist will be paid directly by the carrier. **The patient will be responsible for any applicable deductibles and co-payments at the time of service.** If you are not eligible at the time services are rendered, you are responsible for payment of the quoted fees.

CANCELED / MISSED APPOINTMENTS

Sessions normally are scheduled for 45 minutes. Group sessions are scheduled for approximately 90 minutes. A scheduled appointment means that time is reserved only for you. If an appointment is missed or canceled with less than 24 hours notice, the patient will be billed according to the scheduled fee. This usually must be paid by the patient as insurance companies do not customarily pay for missed appointments.

DELINQUENT ACCOUNTS

If accounts become delinquent (past 30 days) our office will begin collection procedures. We will attempt to contact you directly, however if your account remains delinquent (past 90 days) an outside collection agency and / or small claims court action may be taken. In such cases non clinical information (as given on the New Client Information form) regarding this account will not be treated confidentially. Patient will be responsible for all court and legal fees incurred if above action is necessary.

If any of the above provisions are not satisfactory please make alternative arrangements prior to or during your first

therapy appointment. Please sign to indicate that you have carefully read and agree to the above conditions.

_____ _____

Client Signature and Date Therapist Signature and Date

Philip R. Oncley, Ph.D.
Child and Adult Psychology
5212 Katella Ave., #104, Los Alamitos, CA 90720~ 901 Dove St., #150, Newport Beach, CA 92660
Phone (714) 490-7069 ~ Fax (562) 493-1684

Request for Release/Exchange of Information

Date: _____

To: _____

_____

_____

Regarding: _____

Age: _____

Address: _____

_____

I request that, for the purpose of diagnosis and treatment my Medical/School/Psychological/Personal information be released to or exchanged with:

Philip Oncley, Ph.D.
5212 Katella Ave.,
Los Alamitos, CA 90720

901 Dove St., #150
Newport Beach, CA 92660

Exceptions:_____

I also agree to the exchange of relevent information for the duration of my treatment - but not more than one year from the date of signing.

Signature:

_____ _____
Client (Parent or guardian if minor) Date

_____
Relationship to client