JOHN T. STALLWORTH, J.D., Ph.D., Psychology

Questions to ask if you plan on using insurance:

Many people get unpleasant surprises about the coverage they *thought* they had (large deductibles, higher co-pays than expected, need to pre-authorize visits, etc.) when they try to get reimbursed from their insurance company. I strongly recommend that you call and ask your insurance company these questions before our first appointment.

Your insurance policy may have specific coverage rules which you must know in order to get payment.

Please call the number on the back of your insurance card and tell them you want to **"VERIFY OUTPATIENT MENTAL HEALTH BENEFITS."**

Then write down the following information:

1.) Number I call to verify outpatient mental health insurance benefits?_____

2.) Who am I speaking with? _____

3.) What are my in-network benefits? _____ Deductible? _____
Co-payment? _____
% Paid by Policy? _____

4.) What are my out-of-network benefits? _____ Deductible? _____
Co-payment? _____
% Paid by Policy? _____

5.) Is Dr. Stallworth (Tax ID # 74-2372059) currently a network provider for my plan? _____

6.) Does my policy cover (check all that apply):
___ 90837 - Psychotherapy - 1 hour
___ 90834 - Psychotherapy - 45 minutes
___ 90832 - Psychotherapy - 30 minutes
___ 90847 - Family Therapy, conjoint therapy with patient present
___ 90846 - Family Therapy, without patient present
___ 90853 - Group Therapy

7.) Does it require pre-certification and if so, may I do it now? _____

8.) Does it require pre-authorization and if so, may I do it now? _____

9.) What are my coverage limitations as to number of visits per year? _____
dollar amount per year? _____

10.) **What is the Mental Health Insurance Co. Claims Address?**

Insurance Company Name & Address _____

MUST HAVE – Please write it here. _____

_____

By doing this you will minimize your possibility of incurring unexpected expenses. Should the Insurance Co. refuse to pay claims for professional service, I must look to you for payment.

Insured's signature _____ Date _____

4131 SPICEWOOD SPRINGS RD., SUITE K-6, AUSTIN, TEXAS 78759 (512) 345-6781

JOHN T. STALLWORTH, J.D., Ph.D., Psychology

Office Use: Provisional Dx: _____

FORM MUST BE COMPLETE

PATIENT INFORMATION

Patient Name _____ Marital Status_____

Current Address _____ Gender _____ Date of Birth _____/____/_____

City, State, ZIP _____ Soc. Security No._____-_____-_____

Telephone (Home)_____ Telephone (Work) _____

Employers Name _____ Occupation_____

Employers Address _____ E-Mail Address: _____

Spouse's Name_____ Spouse's Date of Birth_____

Family Physician _____ Referred by_____

In case of emergency, notify_____

_____ _____
(Area Code & Telephone) (Relationship)

INSURANCE INFORMATION

If you are going to use insurance, we will need to make a copy of your insurance card.

YES or NO Do you have health insurance coverage with any other insurance company?

YES or NO Are you covered by Medicare or Medicaid?

Policy Holders Name_____ Policy Holders Soc. Sec. # _____-_____-_____

Policy Holders ID# _____ Policy Holders Group # _____

Policy Holders Date of Birth ____/_____/_____ Employer _____

Policy Holders Current Address if different than above _____

Insurance Company claim phone number (_____) _____-_____

Relationship to patient? _____

YES or NO I authorize the release of any clinical or other information necessary to process my insurance claim and I authorize payment of insurance benefits to the provider.

_____ _____
Insured's Signature Date

John Stallworth, J.D., Ph.D.

Psychologist

Office Guidelines

This sheet was prepared to explain our office procedures. If you have any questions about them, please let us know.

Fees: **My fee for the initial session is $175. My basic fee for therapy is $145 for a 45-50 minute session. Longer sessions are prorated from this basic fee. Fees for other services such as psychological testing, reports, talking with other professionals, extended telephone conversations, etc, will be discussed with you prior to their occurrence. These services are billed at an hourly rate of $150.**

Appointments: I schedule my appointments personally. If you must cancel our scheduled appointment, please leave me a message at least 24 hours in advance. Please remember that without a full 24 hours notice you will be responsible for paying the full fee for your missed session. A missed session cannot be billed to insurance, and short notice may prevent another client from being able to use that appointment time.

Payment & Billing Questions: Our office accepts MasterCard, Visa, American Express and Discover cards, as well as cash or checks. Your payment, or co-payment, is expected at each session. As payments become due they will be billed within the month.

We will file your insurance claims for you whether I am a Network Provider with your insurance company or not. This service does not extend to HMO plans. Please realize that any amounts left unpaid by your insurance company (such as annual deductibles) will be your responsibility to pay.

Emergencies: In the event of an emergency, please call one of the emergency numbers first and then call Dr. Stallworth at 345-6781.

24-Hour Help Hotline	**472-4357**	**St. David's Pavilion**	**867-5800**
Brackenridge E. R.	**476-6461**		
		Seton Emergency Room	**323-1010**
Shoal Creek Hospital	**452-0361**	**Psychiatric Emergency Services**	**454-3521**

I have read and understand the information on this sheet.

Signature_____ **Date**_____

4131 Spicewood Springs Road, Suite K-6, Austin, Texas 78759 (512) 345-6781 FAX (512) 345-8083

Summary Notice of Privacy Practices

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.

My commitment to your privacy

My practice is committed to maintaining the privacy of your personal health information. Confidentiality is essential in my profession.

I will only use the information that I get from you to provide you with treatment, to arrange payment for my services or for some other health care operations. If either you or I wish to share your information for any other purposes, I will discuss this with you and ask you to sign a release.

Please note: State and federal laws may require disclosure in legal situations such as:
1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. I will only share information with a person or organization who is able to help prevent or reduce the threat.

2. When a judge requires disclosure, such as in lawsuits and legal proceedings.

3. When a law enforcement official requires me to do so.

4. When necessary for Workers Compensation and similar benefit programs.

_____ _____

Signature Date

Credit Card Information

Please provide the required information about the credit card you will use to pay any fees for missed appointments or to make payments on your account.

Type of Credit Card: ❑ Visa ❑ Master Card ❑ American Express ❑ Discover

Credit Card Number: _____

3 Digit Security Code on Back of Card: _____ Expiration Date: _____

Name as printed on card: _____

Billing address for credit card: _____

_____

_____

By my signature below, I grant John Stallworth, Ph.D my permission to charge the account described above for missed session fees.

_____ _____
Signature Date

_____
Printed Name

(Optional – Line through if you do not wish to grant this permission)

By my signature below, I grant John Stallworth, Ph.D. my permission to charge the account described above for any outstanding balance on a monthly basis.

_____ _____
Signature Date

_____
Printed Name

PAYMENTS DUE: Your payment or co-payment is expected at the beginning of each session. Also, please realize that any amounts left unpaid by your insurance (such as annual deductibles) will be your responsibility to pay.

CANCELED APPOINTMENTS: Please remember that without a full 24-hours notice, your credit card will be billed for full payment of your missed session. A missed session cannot be billed to insurance. If you do have to cancel an appointment, you may leave a message 24 hours a day, seven days a week at 512-345-6781 x23.