#

* Ahwatukee Location has weekend hours!
* Ask about the House of Validation: Relationship Recovery Workshops Available (1-3 Day Retreat)
* Teen Group in Ahwatukee on Saturdays
* Codependency Group in Ahwatukee starting in October
* Low-Conflict Mediation Available

# EXTINGUISHING FEAR & TRAUMATIC STRESS COACHING, COUNSELING and MEDIATION SERVICES

**Visit my website for updates:** https://scottsdalecoachingandcounseling.com

**Office Locations: Circle the one you prefer:**

* **Regus Offices**: 6991 E. Camelback Rd Suite D-300, Scottsdale, AZ 85251 (Wednesdays)
* **Office Evolution** 2nd Floor: 4435 E. Chandler Boulevard, Phoenix, AZ 85044 (Flexible Schedule)

**It is critical that you find out from your insurance company what you “behavioral health benefits are.” Your behavioral health benefits are different from regular medical coverage.**

**Sign here that you have contacted your insurance company about your MH coverage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Phone Number: 203.609.1714 **(texting only) or email**

E-mail: dejayebotkin@gmail.com

**Intake Form**

How did you hear about me?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the Identified Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For Couples and Mediation – Each person needs their own packet.

Phone/Text #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(I give permission to text/email Not HIPAA compliant):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact/Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guarantor of Payment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Therapist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand **HIPAA** (Health Insurance Portability and Accountability Act of 1996) is a United States legislation that provides data privacy and security provisions for safeguarding medical information. I understand I can get more information about HIPAA by visiting: <https://searchhealthit.techtarget.com/definition/HIPAA>. I understand if I don’t understand, Dejaye will explain to me. I have read and agree to this statement:

Please sign and date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical/Mental Health History:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Person Provider or Facility** | **Phone Number** | **Diagnosis (Date received diagnosis)**  | **Medications Currently Taking**  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**List 3 Goals for this Treatment:**

1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Permission to Release** Consulting Records or consult with other providers/family members: **I give permission for Dejaye to speak to the following person(s):**

Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Credit Card Authorization Form**

**This is mandatory for phone sessions, copays, and no-show charges**

**24 Hour Cancelation Required to Avoid Charge**

**Also accepting Venmo@De-Jaye Or Zelle**

**Also accepting Zelle**

Name on card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Permission to Charge: In the event that I am not present to sign or my card is not available for swiping, I authorize Dejaye Botkin to charge my card the rate negotiated above. Credit cards have a $3.00 service charge.***

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Service Provider: AMEX VISA MASTERCARD DISCOVER

NO HSA Cards

Credit Card Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3 or 4 Digit Security Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code of Card Billing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Venmo ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zelle ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE BILLING INFORMATION**

1. **Please provide screen shot or a copy of your insurance card – both sides**
2. **Please bring a current letter or on-line print out from your insurance company outlining your Mental Health benefit coverage details.**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insurance is Under:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Insurance Holder if different from patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number if different from patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer of Insurance Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthday of Insurance Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Different - Birthday of Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Provider Type: (For example CHOICE PLUS/PPO/HMO)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID number on ID Card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group number on ID Card:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Claims Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Deductible Amount:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Copay Amount:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I agree to provide accurate information about my deductible and copay and I will let Dejaye know if my insurance changes or is canceled. I agree to pay any ‘pre-negotiated’ fees that my out of network insurance is unwilling to pay or deny.**

**Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pricing Subject to Change with Notice for Cost of Living Adjustments**

**Fee Schedule**

Reference for **In-Network Provider** Reimbursement Rates:

|  |  |  |
| --- | --- | --- |
| **Procedure Code** | **Description** | **Rate of Reimbursement**  |
| 90791 | Intake Session (1st Appointment) | $115.50 |
| 90832 | 30 minute session | 54.65 |
| 90834 | 45 minute session | 73.06 |
| 90837 | 60 minute session | 91.33 |
| 90847 | Family/Couple Therapy | 91.77 |

**Fees for Out of Network**

|  |  |  |
| --- | --- | --- |
| **Procedure Code** | **Description** | **Rate of Reimbursement**  |
| 90791 | Intake Session | $150.00 |
| 90832 | 30 minute session | 75.00 |
| 90834 | 45 minute session | 125.00 |
| 90837 | 60 minute session | 150.00 |
| 90847 | Family/Couple Therapy | 190.00 |
| No Code | Mediation 60 minutes | $200 |

**Other Fees**

|  |  |
| --- | --- |
| Less than 24 Hour cancellation fee | Price of Session  |
| Public Speaking Workshop | $300/hour |
| Mediation Services 60 minutes  | $200  |
| Group Session | $30 per session cash only  |

|  |  |  |
| --- | --- | --- |
| **Question** | **Answer** | **NA**  |
| Are you in relationship? With whom?  |  |  |
| Do you have co-dependent tendencies?  |  |  |
| Are you interested in attending group therapy as well?  |  |  |
| Have you ever thought about or attempted suicide? How? What happened? |  |  |
| Do you have mental health related physical symptoms? (Called somatic symptoms)  |  |  |
| Do you struggle with drugs/alcohol? |  |  |
| Do you or have you self-harmed? Hair-pulled, nail-biting? Eating Disorder, etc.?  |  |  |
| Do you struggle with sensory issues (light, sound, etc.)  |  |  |
| How many times have you been married/divorced?  |  |  |
| If applicable – what school do you attend? Grade? |  |  |
| Employer? Work Schedule? |  |  |
| Problems with Legal?  |  |  |
| What traumatic events have you survived?  |  |  |
| Have you had infidelity in your relationships?  |  |  |
| Family History of Mental Health or Substance Abuse?  |  |  |

**In the space below, please describe current symptoms, challenges, and the reason you made this appointment.**

**I have read and agree with all of the above and consider this a binding contract:**

**Signature of Patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* Please follow me on Instagram:  @extinguishfearandtrauma and thehouseofvalidation
* Please follow me on LinkedIn: <https://www.linkedin.com/in/dejaye-botkin-41330935>