Thomas E. Mates, Ph.D.
Licensed Psychologist
7032 Wrightsville Avenue, Suite 103-B
Wilmington, NC 28403

National Register of
Health Service Providers
In Psychology

Bus. 910-256-6163
Fax 910-256-6748

Date _____ Home Phone _____

Patient _____
Last Name First Name Middle Initial

Street Address _____

City _____ State _____ Zip Code _____

If A Minor: Parent's/Guardian's names _____

School (if a minor): _____ Grade _____

Birthdate _____ Age _____ Sex: ____M____F, Marital Status _____

Patient or Parent employed by _____

Business Address _____

Business Phone _____ Home Phone _____

Spouse or other parent employed by _____

Business Phone _____ Home Phone _____

Who is responsible for payment of this account? _____

Patient SS# _____ Spouse SS# _____

Our office does not file insurance. If you wish to file your own insurance we will give you a receipt that will allow you to do so.

N. C. State insurance can not be filed for any services.

CONSENT TO RECEIVE TREATMENT

Please read carefully and sign.

1. **I understand that Dr. Mates is a sole practitioner not affiliated with any other Mental Health professionals.**
2. **I understand the business policies of Mates Mental Health Services, PLLC.**
3. **I consent to receive treatment and understand that I am financially responsible for services rendered. I also have the right to refuse treatment at any time.**
4. **I will pay the charges for appointments I do not cancel by 4:00 p.m. on the last day before an appointment.**
5. **In case of emergency, when Dr. Mates is not available, you will be referred to the Mobile Crisis Line or your nearest emergency room.**

Signed _____ Date _____
(Responsible Party)

Office Manager of Therapist _____

Parental Consent (Must be signed if client is child)

I, _____(your name) do hereby certify that I have legal custody of/am the legal guardian for medical consent purposes of _____ _____(child's name). I give my permission for him/her to receive mental health treatment or evaluation.

_____ _____
Parent/Guardian Witness

_____(Date) _____(Date)

APPOINTMENTS:

Initial Interview: 0 - 60 minutes session Psychotherapy: 38 - 55 minutes session

Couples/Family Therapy: 38 - 55 minutes session

According to CPT IV, the following procedures are billable contacts and treated as such: TELEPHONE CONSULTATIONS, COLLATERAL CONTACTS WITH RELEVANT AGENCIES, and WRITTEN REPORTS CONCERNING DIAGNOSIS AND TREATMENT OF A PATIENT. All of the above are billed according to time involved.

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Notice Receipt Acknowledgement

THIS FORM IS TO CONFIRM THAT YOU HAVE RECEIVED MY NOTICE OF PRIVACY PRACTICES.

Patient Name: _____ Date of Birth _____

Address: _____

Phone: _____ Social Security Number _____

I, _____, acknowledge that I have received Mates Mental Health Services, PLLC Notice of Privacy Practices. I have had full opportunity to read and consider the contents of this Notice of Privacy Practices.

Signature _____ Date _____

If this acknowledgement is signed by a personal representative on behalf of the individual, please complete the following:

Patient`s Name: _____

Personal Representative`s Name: _____

Relationship to Individual: _____

If you would like for us to leave personal health information regarding your care or appointments on an answering machine, please place a check in the space provided and complete the section below.

_____ Thomas E. Mates, Ph.D. or his staff may leave a message regarding my personal health information or an appointment on the answering machine at this number _____.

CLIENT CENTERED PLAN

Please complete the items noted by the asterisks (**).

**Patient/Child's Name: _____

**Parents Name: _____
(if applicable)

**Primary Problem: _____

_____

Measurable Goals/Outcome: _____
_____
_____
_____
_____

Service Intervention Strategies/
Responsible Party: _____
_____
_____
_____

Date of achievement for goals/outcome: _____

Type of Service(s) being provided: _____
_____

Date for Plan Review: _____ Comments on Plan Review:
_____
_____
_____
_____

**Patient/Parent
Signature: _____Date: _____

Therapist Signature: _____Date: _____

11-18-2011 per Medicaid workshop