NAME (LAST/FIRST/MI) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First Middle

***Preferred name/nickname*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AGE \_\_\_\_\_\_

GENDER \_\_\_\_\_\_\_ ETHNICITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MARITAL STATUS \_\_\_\_\_\_\_\_\_\_

EMPLOYER/SCHOOL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HIGHEST EDUCATION LEVEL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE \_\_\_\_\_\_ ZIP \_\_\_\_\_\_\_

PHONE (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work # and Ext\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE CIRCLE RELATION TO POLICY HOLDER -- SELF -- SPOUSE -- CHILD -- STEP-CHILD -- OTHER

MEDICATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PERSONAL/FAMILY PHYSICIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRESENTING PROBLEM \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT Name & Phone#** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIOR MENTAL HEALTH TREATMENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE IF APPLICABLE AND POLICY HOLDER INFORMATION**:

Insurance Co. name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**ID/Policy#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_

Policy holder Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to insured\_\_\_\_\_\_\_\_\_

**POLICY HOLDER**  (LAST)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(FIRST)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(MI)\_\_\_\_\_\_\_

DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GENDER \_\_\_\_\_\_ SS# **(only If EAP or Military**) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MARITAL STATUS \_\_\_\_\_\_\_\_

HOME ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE \_\_\_\_\_\_ ZIP \_\_\_\_\_\_\_

PHONE (Home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work # and Ext\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_I**NSURANCE CO.**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**ID/Policy#**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FINANCIAL AGREEMENT AND INSURANCE ASSIGNMENT**

**THE FEE FOR SERVICE IS YOUR RESPONSIBILITY. CO-PAYMENTS ARE DUE AT THE TIME OF VISIT. WE WILL BILL YOUR INSURANCE.**

**A CHARGE OF $75 WILL BE ASSESSED FOR MISSED APPOINTMENTS UNLESS A 24 HOUR NOTICE IS GIVEN. If a client has two late cancelations or missed appointments within a 6 month period we reserve the right not to schedule future appointments. THERE WILL BE A CHARGE OF $25 FOR RETURNED CHECKS.**

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT FOR TREATMENT AND RELEASE OF MEDICAL INSURANCE INFORMATION**

I AUTHORIZE THE RELEASE TO THE ABOVE NAMED INSURANCE COMPANY ANY INFORMATION NECESSARY TO PROCESS THE INSURANCE CLAIMS AND FOR THE INSURANCE COMPANY TO SEND PAYMENT DIRECTLY TO THE DOCTOR.

SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Informed Consent, Authorization of Services and**

**HIPAA Privacy Notice**

This notice provides you with information about your rights as a patient, the therapeutic process, confidentiality, and the therapeutic relationship.

**HIPPA:** The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal law that requires all medical records and other protected health information (PHI) to be kept confidential. As such, patients have the right to understand and control how your health information is used. Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Confidentiality and Therapist/Patient Privilege:** Communication between a patient and therapist is protected by law. That is, the communication is privileged and only the patient can waive the privilege. A patient can waive the privilege by signing a Release of Information (ROI). Even after a ROI has been signed, a patient can later revoke the authorization in writing. The only other, rare, exceptions to confidentiality /privileged communication can occur when the client expresses a specific, serious, and/or imminent threat to harm him/herself, someone else, or reports child or elder abuse. Additionally, if therapists are court ordered by a judge to testify, the privilege is waived. Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Electronic Record Storage and Transfer of PHI for Billing Purposes:** Your treatment notes and insurance information, if applicable, is considered part of a clinical record of treatment and is part of your PHI. Your PHI will be stored electronically with Therapy Notes, a secure storage software with whom we have a signed HIPAA Business Associate Agreement (BAA). The BAA ensures that this company will maintain the confidentiality of your PHI in a HIPAA compatible secure format using point-to-point, federally approved encryption. Additionally, if your insurance company is billed, you should receive an Explanation of Benefits (EOB) from them. We also use a credit card company to process your credit card information. Please be aware that if you choose to use a credit card, the transaction will appear on your credit card bill as Psychological Associates of Woodstock.

 Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email/Text:** Email and text are not secure forms of communication and may compromise your confidentiality. We cannot guarantee that information you send us through email or text will remain confidential and any such information will be entered into your electronic record. We realize that electronic communication is preferred by many because it is an easier way to communicate especially when your therapist is not available by phone. We strongly recommend that you restrict your email/text communication. Your therapist will read your communication and will make every effort to keep your information secure. Your therapist will only respond briefly, unless she is using encrypted email/text, or will contact you by phone to discuss the matter further. By initialing below, you are indicating that you are aware of the limits to and the assume responsibility for unintentional and inadvertent breaks in confidentiality inherent in using this type of communication. **If you are in crisis, please do not use this type of communication, but follow the procedures listed in the “Emergencies” section of this document.**

Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consultation:** In order to provide the best care, we occasionally will consult with other mental health or medical professionals. During the consultation process, we do not reveal any identifying information about our patients. Additionally, we have administrative staff who will schedule your appointments, bill your insurance companies and/or collect other forms of payment from you on a regular basis. You acknowledge that you are aware that the administrative assistants will have access to some of your information, including diagnosis (but not the notes from your sessions) and will keep this information confidential. Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal Issues:** If you are involved in a legal issues that requires our assistance, please request a copy of our separate agreement that covers our policies on assisting with legal matters for your review and signature.

 Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance:** If you choose to use your insurance to cover part or all of the cost of your psychological services, your insurance company will require release of diagnostic information. At times, insurance companies will also conduct audits of our records and we will be asked to provide additional clinical information including summaries of your clinical record. We will always inform you and ask you to complete a ROI prior to completing such a request and we will provide the minimum amount of information necessary to comply with the request.

Please also be aware that using insurance to cover mental health services carries a small degree of risk to confidentiality, privacy, and future ability to obtain insurance since the insurance companies enter health information into their computers and report this information to the Medical Information Bureau, a national data base. Insurance (life, health, disability) providers can draw on this information to make future decisions about an individual’s insurability. Additionally psychiatric conditions may affect an individual’s admission to the military.

 Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Fees:** Fee for service therapy sessions are billed at $150 per session (50-55 minutes). Phone consultations lasting longer than 10 minutes will be prorated on the $150 per session fee schedule. Non-legal letters, developing a clinical summary, and other paperwork are billed at $75 per hour or a minimum of $25. As stated above, any services related to legal matters are covered under a separate agreement. Psychological evaluations are also covered by a separate agreement and will be explained to you by your psychologist. Periodically, there may be an increase in fees. We will provide at minimum of one month notice to all existing patients prior to increasing out of pocket fees. Cash, checks or certain credit cards are acceptable forms of payment. There is a $30 fee for returned checks which will be due on or before your next appointment. In certain cases, a sliding scale may be available. These cases will be handled on a case-by-case basis.

 Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Missed Appointments:** When you schedule an appointment, the psychologist/therapist is setting aside an entire hour to devote to your care. If you need to cancel an appointment for any reason, we require **24 hours’ notice** prior to your scheduled appointment. If you cancel your appointment with less than 24 hours’ notice or fail to attend your session, you will be charged $75. You will be required to pay your late cancellation fee prior to scheduling another appointment. Please note that insurance companies do not reimburse for missed appointments. Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**First Appointment:** At your first appointment, your therapist will conduct an intake assessment that includes a variety of questions about your presenting concerns and your background. This is also a time for you to ask any questions you may have about how your therapist conducts therapy, what the therapeutic process is about, what you should expect, office policies and procedures, and any information that is unclear to you in this document. At the end of the appointment, your therapist will make recommendations regarding how to move forward to achieve a good outcome for you/your child.

 Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Therapy:** Therapy is unlike seeing a medical doctor. Good results from therapy are typically achieved when the therapist is skilled, the patient is an active participant in the therapeutic process, and there is a good fit or a strong therapeutic relationship between the therapist and the patient. Please be aware that during therapy, strong feelings may arise and there is a risk of discomfort or distress while working through difficult issues. Your therapist will help prepare you and support you during these experiences and the expectation is that this discomfort is temporary and your emotional and psychological well-being will improve throughout the therapeutic process.

 Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Termination of Services:** Our goal is for termination of services to be a mutually agreed upon decision between the client and the therapist. There are times when either the client or the therapist choses to end therapy prior to all treatment goals being achieved. Common reasons for therapy to be terminated early include: financial constraints, need for additional services not offered at APS, and/or lack of progress. It is our policy that if a client has had a gap of 60 days in treatment or there have been at least two unsuccessful attempts to contact the client, the client’s chart will be closed.

 Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent to Treatment:** By signing below, you agree that you have read and agree to the aforementioned policies, the informed consent, and the HIPAA form. You are also agreeing to pay all fees for services rendered. If the client is a minor or an adult deemed unable to make his/her own legal and medical decisions, you are also indicating that you are the legal guardian of the client named below and have the authority to make mental health treatment decisions.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ Responsible Party’s Signature Patient’s Signature Date**

**As a courtesy** confirmation of appointments may be attempted to the phone number(s) you provide.

***# \_\_\_\_\_\_\_\_\_\_\_\_ # \_\_\_\_\_\_ # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

 *Please mark numbers with H(home), W(work) or C(cell) and indicate if messages can be left at the number(s) you provide.*

**REFERRED BY:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**