Client Information

Name:_____**DOB:**_____**Sex:** ____**Male**____**Female**

Street:_____**Marital Status:**_____

City:_____**State:**_____**Zip:**_____**SS#:**_____

Home Phone:_____**May we call you at home?**_____**At work?**_____

Work Phone:_____**Employer:**_____

Cell Phone:_____**Email:**_____

Medical Information

Physician's Name:_____**Date of last physical exam:**_____

Are you on any regularly prescribed medications?_____ **If so, please list them:**

By whom were you referred to this practice?_____

Spouse/Parent Information

Name:_____**DOB:**_____**Sex:** ____**Male**____**Female**

Street:_____**Marital Status:**_____

City:_____**State:**_____**Zip:**_____**SS#:**_____

Home Phone:_____**May we call you at home?**_____**At work?**_____

Work Phone:_____**Employer:**_____

Cell Phone:_____**Email:**_____

***Others living in your household*:** _____**DOB:**_____

_____**DOB:**_____

To whom shall we mail your monthly statement? *Please note that we will bill charges to your insurance carrier if you desire. However, a statement will be mailed to you each month as well. You are responsible for payment of all charges until your insurance company pays.*

Responsible Party:_____**Relationship to Client:**_____

Street:_____**City:**_____**State:**_____**Zip:**_____

Home Phone:_____**Work Phone:**_____**SS#:**_____

Employer:_____

***In case of an emergency, please contact*:**

Name:_____**Phone:**_____

Relationship to Client:_____

Please read the following information and ask your therapist about any questions you might have. Please sign acknowledging that you understand this information and give voluntary consent to participate in treatment.

***COUNSELING AND PSYCHOTHERAPY*:** Counseling and psychotherapy attempt to help you develop alternative ways of coping with problems in living. The practice of counseling and psychotherapy is not an exact science and no guarantee exists that you will automatically feel better. Although most people do feel better, some people initially feel worse.

***CONFIDENTIALITY*:** Information which you provide to your therapist is confidential and cannot be released without your written authorization; however, some limitations to confidentially exist. Under the following circumstances, information may be released without your permission to the appropriate authorities: 1) To prevent serious, foreseeable and imminent harm to you or another identifiable person; 2) If you report an incident or any suspicion of child abuse or neglect to your therapist; or 3) If you make your mental status a court issue or a judge orders release of your records.

In the event your therapist is unavailable, your therapist may give necessary information to another therapist who is on call for his or her clients' needs. This information is to facilitate your treatment in your therapist's absence. **Your signature below authorizes such a release of information.**

***REGARDING HANDICAP ACCESS*:** Attempts are made to serve all clients regardless of and disability which may exist. Handicap-access offices are available for wheelchair patients. Unfortunately, restroom facilities that accommodate wheelchairs are not available. Because of the limitations of the facility, we are happy to make alternate arrangements in order to meet your therapy needs. Please discuss these needs with your therapist.

EMERGENCY SERVICE: In case of an emergency after office hours, an answering service will answer your call. Simply telephone 273-7292 and the answering service will notify your therapist or another therapist who is on call. If you are unable to reach your therapist, you may also call any of the following emergency numbers for assistance:

Stormont Vail West:	1-785-270-4600
Stormont Vail Emergency Services:	1-785-354-6100
St. Francis Hospital Emergency Department:	1-785-295-8090
Shawnee Community Mental Health Center:	1-785-233-1730

I have read, understand and agree to the above information:

Date:_____Client:_____

Date:_____Client:_____

Acknowledged by:_____Date:_____
Therapist

IF YOU WISH TO HAVE COPIES OF THE FORMS YOU HAVE COMPLETED, PLEASE INFORM YOUR THERAPIST AND COPIES WILL BE PROVIDED TO YOU.

IF YOU ELECT TO HAVE YOUR VISITS SUBMITTED TO YOUR INSURANCE COMPANY, PLEASE PROVIDE THE FOLLOWING INFORMATION:

Name of Primary Insurance Company:_____
(Please provide a copy of your insurance ID card)

ID #_____ Group #_____

Authorization # (if available)_____

Name of Insured:_____Date of Birth:_____

Other family members covered on this policy:

Name:_____DOB:_____Rel to Insured:_____

Name:_____DOB:_____Rel to Insured:_____

Name:_____DOB:_____Rel to Insured:_____

Does your policy require preauthorization for services? Yes_____ No_____

Did you contact your insurance company prior to today's visit? Yes_____ No _____

Do you have other insurance coverage? Yes_____ No _____
(If "yes", please provide a copy of your secondary insurance card.)

Although we do not routinely submit secondary claims, we do need to indicate that coverage on claims to your primary carrier. You will be responsible for submission of claims to secondary carriers.

If you are covered under Medicare, please note that your claims will be forwarded to your supplemental policy as well as to Medicare.

REGARDING MANAGED CARE AND YOUR PRIVACY: Many insurance companies use the services of managers to monitor use of mental health benefits for their insureds. In order for you to use your benefits it may be necessary for me to provide a **detailed disclosure of your record** to a case manager or other employee of a managed care or insurance company. I cannot be responsible for the use of clinical information about you by an insurance company, managed care company, firms contracting with those companies, or their employees.

You may see whomever you wish for as short or long a time as you wish. Your managed care company, however, may tell you that you cannot. That is not true. What is true is that they **MAY NOT PAY** for you to see anyone you want, and, so, you may have to pay out-of-pocket for such services. That may not be as bad as it sounds.

Some people are choosing to forego utilizing their mental health insurance altogether. Some of the advantages are:

- Privacy is maintained. There are no computer records of your confidential information which may be available to any person who has access, legitimate or otherwise, within the bureaucracy. There is no risk of any paperwork coming through the personnel office of your employer.
- You and I make decisions about your care. No one else second-guesses your decisions and limits your options.
- Your paperwork is reduced. My paperwork is reduced.

PLEASE READ AND SIGN ONLY ONE OF THE FOLLOWING STATEMENTS!!

In order to safeguard your privacy, you may elect to self-pay your mental health bills.
IF YOU DO NOT WANT YOUR CHARGES TO BE BILLED TO YOUR INSURANCE COMPANY, read and sign the following statement.

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

I understand that mental health services provided to me by _____ may or may not be covered by my health care insurer. I am choosing to have all services billed to me directly and ask that no claims be submitted to my insurance carrier. I agree that I am financially liable for all expenses incurred.

THEREFORE, I <u>DO NOT</u> WANT INSURANCE CLAIMS TO BE FILED:

*Date:*_____ *Signed:*_____

*Date:*_____ *Signed:*_____

IF YOU WISH FOR CLAIMS TO BE SUBMITTED TO YOUR INSURANCE COMPANY, read and sign the following statement:

RELEASE TO INSURANCE COMPANIES*: I request the payment of authorized benefits be made on my behalf to my therapist for any services furnished by my therapist. I authorize Stonestreet Professional Offices and my therapist to release to my insurance company and its agents via direct mail, telephone, fax or electronic submission, information about me and my treatment process in order to determine the benefits payable for related services. I recognize that insurance benefits are limited, that I am financially responsible for noncovered expenses and that a psychological diagnosis must accompany requests for payable benefits. I also understand that additional information is often requested by insurance companies as claims are processed. I have read "Regarding Managed Care and Your Privacy" and understand its contents.*

THEREFORE, I <u>DO</u> WANT INSURANCE CLAIMS TO BE FILED:

*Date:*_____ *Signed:*_____

*Date:*_____ *Signed:*_____

If you have concerns or questions regarding any of the preceding information, please be certain to discuss them with me!

PAYMENT POLICY

Thank you for choosing me as your health care provider. I am committed to working with you to make your treatment successful. Part of your commitment to that success is the prompt payment of your bill. Please read and sign the following statement thereby indicating your understanding of my payment policy.

Therapist:_____

REGARDING INSURANCE: Although I may accept assignment of insurance benefits, **the entire balance is your responsibility** until your insurance company pays. The office staff cannot bill your insurance company unless you provide insurance information and a signed release to your insurance company. Your insurance policy is a contract between you and your insurance company. Please be aware that some, and perhaps all, of the services provided may not be covered services under your insurance policy.

REGARDING BILLING: **Payment of your insurance copayment is required at the time of service.** If you have no insurance coverage available to you, payment in full will be required at the time of each session. My office will submit claims to your insurance carrier per the information you provide. You will receive a statement of all services and payments on a monthly basis. **Any financial difficulties that would prevent you from meeting this contract should be discussed with me.** Any credits which are created by insurance company reimbursement will be refunded to you.

REGARDING TELEPHONE CONSULTATION: You may be charged for telephone consultations with you, your attorney, or any other party regarding you. These charges are based on time and are equal to my normal fee for in person psychotherapy. Telephone consultation is not paid by insurance and will be billed in full to you.

REGARDING REPORT WRITING: You may be charged for preparation of reports or letters which may be required at any time during your psychotherapy process. These charges are based on time and are equal to my normal fee for in person psychotherapy and cannot be billed to your insurance company and will be billed in full to you.

MISSED APPOINTMENTS: Unless canceled **at least 24 hours in advance,** my policy is to charge for missed appointments. This charge cannot be billed to your insurance company. Please help me serve you by keeping scheduled appointments.

COLLECTIONS: If you fail to uphold your agreement to pay for your counseling services in a timely manner, your account may be forwarded for legal collection proceedings. At that time your name and other necessary information may be released to my agents for the purpose of collecting monies owed and additional cost of collection may be added to your balance due.

I have read the Payment Policy and I understand and agree to its contents:

_____ _____

Signature of Client or Parent if Client is a Minor *Date*

_____ _____

Signature of Co-Responsible Party *Date*

Revised: 8/29/01

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

I understand that mental health services provided to me by _____ may or may not be covered by my health care insurer. I am choosing to have all services billed to me directly and ask that no claims be submitted to my insurance carrier. I agree that I am financially liable for all expenses incurred.

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Witness Signature Date

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL & MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures
I may use or disclose your protected health information (PHI), for treatment, payment and health care operations purposes with your consent.
Treatment Your health information may be used or disclosed when I consult with another health care provider such as your family physician or another professional.
Payment Your health information may be used to determine eligibility and coverage and to seek payment from your health plan or other sources of coverage that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the condition being treated.
Health care operations Your health information may be used as necessary to support the day-to-day activities and management of my practice**.** For example, information on the services you received may be used to support quality assessment and improvement activities, business-related maters such as audits and administrative services and case management and care coordination.

Other uses and disclosures require your authorization
Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

***Child Abuse -** If I have reason to suspect that a child has been injured as a result of physical, mental or emotional abuse or neglect or sexual abuse, I must report the matter to the appropriate authorities as required by law.
***Adult & Domestic Abuse –** If I have reasonable cause to believe that an adult is being or has been abused, neglected or exploited or is in need of protective services, I must report this belief to the appropriate authorities as required by law.
***Health Oversight Activities –** I may disclosed PHI to the Kansas Behavioral Sciences Regulatory Board if necessary for a proceeding before the Board.
***Judicial & Administrative Proceedings –** If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

***Serious Threat to Health or Safety –** If I believe that there is a substantial likelihood that you have threatened an indentifiable person and that you are likely to act on that threat in the foreseeable future, I may disclose information in order to protect that individual. If I believe that you present an imminent risk of serious physical harm or death to yourself, I may disclose information in order to initiate hospitalization or to family members or others who might be able to protect you.
***Workers Compensation –** I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Individual Rights
You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Professional's Duties
I am required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. I am also required to abide by the privacy policies and practices that are outlined in this notice
.
Right to Revise Privacy Practices
As permitted by law, I reserve the right to amend or modify my privacy policies and practices. These changes in my policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, I will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that I maintain.

Requests to Inspect Protected Health Information
As permitted by federal regulation, I require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting me.

Complaints
If you would like to submit a comment or complaint about my privacy practices or if you believe that your privacy rights have been violated, you should call the matter to my attention by sending a letter describing the cause of your concern to:

Heather Barber, Office Manager
Stonestreet Professional Offices
5847 SW 29th Street
Topeka, KS 66614
785-273-7292

You will not be penalized or otherwise retaliated against for filing a complaint.

Effective Date
This Notice is effective on or after December 1, 2006.

We Care About Your Privacy

The privacy of your medical information is important to me. I understand that your medical information is personal and I am committed to protecting it. I create a record of the care and services you receive here. I need this record to provide you with quality care and to comply with certain legal requirements. The attached notice will tell you about the ways I may use and share medical information about you. The notice describes your rights and certain duties that I have regarding the use and disclosure of medical information.

Please sign below and return this form to me or my receptionist acknowledging that I have provided you with the attached "Notice of Privacy Practices". If you have questions about this notice, please discuss your concerns with me.

Your Therapist

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the "Notice of Privacy Practices" on _____
(Date)

_____ _____
Name of Patient (Print or Type) **Signature of Patient**

_____ _____
Signature of Patient Representative **Relationship to Patient**
(Required if patient is a minor or an adult who is unable to sign this form.)

For Office Use Only:

An attempt was made to obtain an acknowledgement of receipt of the Notice of Privacy Practices. The acknowledgement was not obtained because:

- ☐ **The patient declined to sign the acknowledgement**
- ☐ **Other** _____

_____ _____ _____
Name of Patient **Name of Staff Member** **Date**