INFORMATION SHEET

PATIENT INFORMATION

DATE____________

Name:______________________________________

Address:______________________________________

____

Phone:______________________________________

Date of Birth:______________________________________

SSN: ______________________________________

Sex: ______________

Emergency Contact:______________________________________

Employer:______________________________________

School/Grade:______________________________________

Work Phone:______________________________________

Occupation:______________________________________

Relationship to Insured:______________________________________

Marital Status: Married Sep Divorced Widowed Single

Phone:______________________________________

Referred By: ______________________________________

How would you like to be reminded of your appointment? (please circle one) Text Email Home

PRIMARY INSURANCE INFORMATION

Name: ______________________________________
Last First M.I

□ SELF □ PARENT □ SPOUSE □ GUARDIAN

Address:______________________________________
(if different)

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Home Phone:______________________________________
(if different)

Birthdate: ______________________________________

SSN:______________________________________

Insured's Employer:______________________________________

Insurance Company:______________________________________

Plan Name:______________________________________

Insured's ID#: ______________________________________

Policy Group#:______________________________________

Do you have secondary or other insurance coverage? YES ____ NO ____

RESPONSIBLE PARTY

Name:______________________________________

Address:______________________________________

Home Phone:______________________________________

Date of Birth:______________________________________

SSN: ______________________________________

Release to Insurance Companies: I authorize the release of any medical or other information necessary to process insurance claims.

____
Signature Date

Authorization to Pay Benefits to Provider: I authorize payment of benefits directly to the therapist for the services provided. Where applicable, I also request payment of government benefits to the party who accepts assignment.

____
Signature Date

MEDICARE - ONE TIME AUTHORIZATION – Approved Form No: OMB No. 0938-0222

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to ______________________________ for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

______________________________ ______________________________

PATIENT'S SIGNATURE DATE SIGNED

TREATMENT INFORMATION

Previous Inpatient and Outpatient Alcohol and/or Mental Health:

______________________________ ______________

Name or Location Date(s)

______________________________ ______________

Name or Location Date(s)

REASON FOR TODAY'S VISIT/CURRENT ISSUES: ______________________________

____

____

____

Others Living in the Home:

Name: ______________________ DOB ___/___/___ School/Employer ______________________

Name: ______________________ DOB ___/___/___ School/Employer ______________________

Name: ______________________ DOB ___/___/___ School/Employer ______________________

Name: ______________________ DOB ___/___/___ School/Employer ______________________

MEDICAL INFORMATION

Primary Care Physician: ______________________ Date of Last Visit: ______________

Address: ______________________________

Physician's Phone: ______________ Medical Issues: ______________________

Allergies and/or Adverse Reaction to Medication

Current Medications (incld. Dosage & length of usage): ______________________

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INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

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

I understand that I am eligible to receive a range of services from my provider. The type and extent of services that I receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me.

I am aware that I must authorize my provider, in writing, to release information about my treatment, and I understand that once information is released to insurance companies or any other third party, that my provider cannot guarantee that it will remain confidential. When consent is provided for services, all information is kept confidential, except in the following circumstances:

- When there is risk of imminent danger to myself or to another person, my provider is legally bound to take necessary steps to prevent such danger.
- When there is suspicion that a child or elder is being sexually or physically abused, or is at risk of such abuse, my provider is legally required to inform the proper authorities.
- When a valid court order is issued for medical records, my provider is bound by law to comply with such requests.

While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read the Notice of Privacy Practices which was provided to you for more detailed explanations, and discuss with your provider any questions or concerns you may have. I have been offered a copy of the Notice of Privacy Practices.

By my signature below, I voluntarily request and consent to behavioral health assessment, care, treatment, or services, and authorize my provider to provide such care, treatment, or services as are considered necessary and advisable. I understand the practice of behavioral health treatment is not an exact science and acknowledge that no one has made guarantees or promises as to the results that I may receive. By signing this Informed Consent to Treatment Form, I acknowledge that I have both read and understood the terms and information contained herein, and that I have been offered a copy of the Notice of Privacy Practices.

Client Signature: ______________________________ Date: ______________

Parent/Guardian Signature (for minor): __________________ Date: ______________

PAYMENT AGREEMENT

Insurance: If you have authorized us to do so, we will submit claims on your behalf to the insurance company. However, you must pay all costs insurance does not cover including copayments, coinsurance, deductible and no-show fees. You are responsible for verifying your coverage by calling the number on your insurance card. Some companies REQUIRE YOU TO CALL to get an authorization number before your first session. If you do not make this call, you may end up with a bill that your insurance company will not reimburse.

Collections: If you fail to uphold your agreement to pay for your services, your therapist may forward your account to a collection agency. At that time, your name and other necessary information will be released to the collection agency for the purpose of collecting monies owed, and additional costs of collection may be added to your balance due.

Missed Appointments/Late Cancellations: A missed appointment is any appointment not cancelled within 24 hours. You may incur a charge by your therapist for a late cancellation or missed appointment. This charge cannot be billed to your insurance and will be billed to you in full.

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 the normal fee for an in-office appointment. Telephone consultations are not paid by insurance and will be billed to you in full.

Reports: 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 the normal fee for an in-office appointment. Reports are not paid by insurance and will be billed to you in full.

I have read the Payment Agreement and I understand and agree to its contents.

Client Signature: ______________________________ Date: ______________

Parent/Guardian Signature (for minor): ____________________ Date: ______________

NOTICE OF PRIVACY PRACTICES

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

Uses & 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 matters such as audits and administrative services, and case management and care coordination.

Other uses & disclosures requiring your authorization: Disclosure of your PHI 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.

Use & 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 disclose 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 identifiable 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.

Worker's 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 PHI.
- 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 PHI 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 nest office visit. The revised policies and practices will be applied to all protected health information that I maintain.

Requests to Inspect PHI: As permitted by federal regulation, I require that requests to inspect or copy PHI, 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 complaint about these 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 66617
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

Notice of Right to a "Good Faith Estimate"

This notice describes your right to receive a "Good Faith Estimate" (GFE) explaining how much your health care will cost. Please review it carefully.

Under the law, health care providers need to give patients who don't have certain types of health care coverage or who are not using certain types of health care coverage (i.e. self pay) an estimate of their bill for health care items and services before those items or services are provided.

- You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- If you schedule a health care item or service at least 3 business days in advance, make sure your healthcare provider or facility gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your healthcare provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.
- If you receive a bill that is at least $400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate and the bill.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

An electronic copy of this notice is available on my website and you may request a paper copy.

Acknowledgement of Receiving Notice of Right to a Good Faith Estimate

I ,______________________________, have read and understood the Notice of Right to a Good Faith Estimate. I have had the opportunity to have the notice explained to me in terms I understand. I understand that I have the right to request a copy of the Notice of Right to a Good Faith Estimate at any time.

____ ________________________ _________________

(signature of client or personal representative) (relationship if rep.) (date)

Version approved 1/15/22