Adult New Patient Information

Patient Name: _____ Birth date: _____

Spouse/Partner Name: _____ Birth date:_____

Mailing Address: _____
City:_____ State:_____ Zip Code: _____
Contact Numbers: Hm: _____ cell: _____ work: _____
Preferred Contact Number: _____

Work Name/Address
(Patient): _____
Work Name/Address
(Spouse/Partner):_____

Is it okay to reach you at the numbers above? □Yes □ No
If not, where should we reach you? _____

Is it okay to leave a message at the numbers above? □Yes □No
Please leave any other information you would like us to know regarding maintaining your confidentiality:
_____
_____
_____

HIPAA Compliance

I acknowledge that I have received the HIPAA Notice Form.
***Signature*:** _____ ***Date*:** _____

Service Agreement

I acknowledge that I have received a Service Agreement Form, reviewed this information with my clinician, and agreed to the conditions specified.
***Signature*:** _____ ***Date*:** _____

Payment Agreement:

I, (please print name) _____understand that I am responsible for full payment at the time of each visit unless other arrangements have been made through my therapist. One guarantor must be designated and is responsible for all fees, regardless of insurance coverage. My insurance policy may not reimburse for some (CPT) procedures and/or diagnostic codes in which case I understand that I am responsible for the balance.

Signature: _____Date: _____

FEE SCHEDULE

Revised 1/1/2020

Description / Procedure	Code	Fee
Diagnostic Interview	**90791**	**$240.00**
Brief Psychotherapy (30 min)	90832	$93.00
Standard Psychotherapy (45-50 min)	**90834**	**$185.00**
Expanded Psychotherapy (60 min)	**90837**	**$198.00**
Family Therapy	90847	$198.00
Group Psychotherapy	90853	$157.00
Psychological Testing / Psychologist	96101	$350.00
Broken Appointment / Late Cancellation	99037	$45.00

Authorization to Bill and Payment Policy

Tax ID: 92-0161193

Patient Name:_____ Birth Date:_____

Primary Insurance Information

Subscribers Name:_____ Subscribers Birth Date:_____

Relation to Subscriber:_____ Subscribers Soc. Sec. #:_____

Primary Insurance Company: _____

Insurance Address:_____

Insurance Phone Number:_____

ID#_____ Group #_____

Secondary Insurance Information

Subscribers Name:_____ Subscribers Birth Date:_____

Relation to Subscriber:_____ Subscribers Soc. Sec. #:_____

Secondary Insurance Company:_____

Insurance Address:_____

Insurance Phone Number:_____

ID#_____ Group #_____

_____

As a courtesy, we will bill your insurance company for the services provided. Per your insurance, this is not a guarantee of payment. All claims are subject to review according to your plan provisions and limitations. Please review your policy for specific details on your plan coverage, co-pays and deductibles. We will not be responsible for monitoring your dollar or visit maximums on your plan, as this is the patient's responsibility. While Psychology Resources will submit claims on your behalf, it is your responsibility to manage and resolve any payment issues with your insurance company. Full payment is expected for any unresolved issues or non-payments with your insurance within 60 days of the date of service. Psychology Resources will not be held

responsible for any additional non-covered or over the usual and customary charges that is determined by the insurance company.

Your signature below indicates you read and understand the payment policy and authorize Psychology Resources to submit claims to your insurance company(s).

Signature_____ Date_____

PSYCHOLOGY RESOURCES

CLINICIAN - PATIENT SERVICES AGREEMENT

WELCOME TO OUR PRACTICE

This document contains important information about our professional services and business policies. It accompanies the information you were given about the Health Insurance Portability and Accountability Act (HIPAA). It is important that you read them carefully and understand them. We can discuss any questions you have. When you sign this document, it will represent an Agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on Psychology Resources unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the clinician and patient, and the particular problems you are experiencing. There are many different methods we may use to address and treat the challenges that bring you to us. Psychotherapy is not like a visit to a medical doctor. Instead, it calls for a very active effort on your part. In order for mental health intervention to be most successful, you will have to work on things we talk about during sessions.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant or challenging aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, or helplessness. On the other hand, psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. There are however no guarantees of what you will experience.

Intake and Evaluation Phase: We normally conduct an intake evaluation that will last from two to four sessions. Those first few sessions will involve an evaluation phase to better determine your behavioral health needs. By the end of the evaluation phase, we will be able to offer some typical treatment options for your needs, discuss the pros/cons of those various options, and provide an opportunity for you to make an informed decision regarding your treatment choice(s).

Treatment Sessions: If it is decided together that your intake clinician is the best person to provide your behavioral health services, then treatment sessions will begin. If you begin treatment sessions, we will always strive to be a good guest in your life, which especially means that we will try our best not stay too long. Your therapist will usually schedule a number of weekly therapy sessions into the future, and he/she will periodically conduct treatment reviews with you to determine if the prescribed course of treatment is working, and if not, make adjustments. The exact number of sessions scheduled into the future will vary over the course of treatment and are dependent upon many different factors. Please know that if treatment is successfully

completed prior to the completion of future scheduled sessions, then those sessions will be cancelled without any payment commitment.

No Show and Cancellations: There may be a cancellation fee for the missed appointments unless you provide one working day's advance notice (24 hours) of cancellation (unless we both agree that you were unable to attend due to circumstances beyond your control). You are encouraged to discuss this further with your clinician. It is important to note that insurance companies **do not** provide reimbursement for cancellation fees**.**

PATIENT RIGHTS

HIPAA provides you with several rights with regard to your Clinical Record and disclosures of protected health information. These rights are outlined in detail in the HIPAA Privacy Notice we have provided to you. Please review that information and ask us any questions you have. We are happy to discuss any of these rights with you.

****IMPORTANT** It is the position of Psychology Resources that we will not communicate with our patients via text or email.** We will communicate only in person and on the phone using the designated phone number that you have documented with us as secure. While the preferred communication style of the patient is important and valued, we have chosen to prioritize your privacy and exercise additional caution in our communication during these current times of expanding electronic media and data breaches. While improving, the possibility of negative stigma towards consumers of behavioral health services may still be found in the general community so we feel its import to exercise caution. Therefore, while many other health care providers in the community have and are utilizing email and texting with their patients, we at Psychology Resources have not and will not. Consequently, if you are insistent that you are permitted to email and/or text your provider, then you will need to find a different provider than Psychology Resources. Additionally, if you begin a patient relationship with us knowing that we will not email or text you and then change your mind and insist upon text/email communication, then you will be required to immediately find a new provider.

Minors and Parents. Minors and their parents should be aware that the law generally allows parents to examine and obtain copies of their child's treatment records. However, while parental access and copies may be legally allowable, such access may be therapeutically contraindicated. Privacy in psychotherapy is often crucial to successful treatment progress, particularly with teenagers. It is intuitively obvious that if a child/teen knows that everything he/she says to the clinician will be repeated to the parents, then it is very likely that the child/teen will be very guarded and/or non-participatory in treatment. Therefore, it is our general practice to request an agreement from parents that they allow a degree of doctor-patient privacy between their child/teen and the clinician. The parent will be quickly notified if anything illegal or potentially dangerous is learned by the clinician during a session. Also, during the course of treatment, we will provide parents general information about the progress of their child's treatment and attendance at scheduled sessions. We will also provide parents with a summary of their child's treatment upon request. If a parent changes their mind and demands that the clinician disclose everything that their child has discussed with the clinician and/or provide a parental copy of the record, then the parental request will be honored, but the parent will also be required to immediately find a new therapist because the conditions for starting therapy were voided.

In the event of a divorce, Psychology Resources may require court documentation of sole legal custody. Regardless of which parent has sole legal custody, it is our standard of practice to seek the approval and involvement of both parents in their child's therapy. Also, we think it important to clarify that Psychology Resources provides clinical services, NOT forensic or custody evaluations. Those two roles are entirely different in scope and purpose and are not interchangeable. Consequently, we strongly recommend that your child's therapy be kept separate from any future litigation between divorcing/divorced parents. As such we will not willingly take part in any court proceedings, nor will we provide opinions related to custody issues. Such services are available elsewhere in the professional community and parents may be referred as appropriate.

When a minor child of divorced parents is seen, we will require one parent to be the guarantor for billing purposes. That person will be the responsible party for any outstanding balances. Psychology Resources will not begin treatment until parents are able to agree upon a guarantor.

UNATTENDED MINORS IN THE WAITING AREA

Your child's safety and security are extremely important to us, which means that we need to ensure your child is not left unattended in the waiting area as follows:

Parent Only Sessions: Parents are asked not to bring their children when it is an intake or parent only session. If parents bring their child or children to a parent only session, the session will unfortunately need to be rescheduled.

Adult Individual Sessions: Similarly, adults who are receiving individual therapy cannot bring their children with them to wait in the waiting area during the parent's session. There are circumstances when bringing an infant with you into sessions may be either just fine or clinically contraindicated, so please talk with your therapist to determine if that option is right for your parent only or individual therapy session.

Child Therapy Sessions: Regarding child-focused therapy sessions that are scheduled for your child, we do understand that your child's treatment may require the clinician to talk briefly with you alone, either before or after a session with your child. This time however will need to be kept brief (10-15 min). The administrative assistants will do their best to keep an eye on your child but please know they are also engaged in other duties. If you are uncomfortable with this please decline this option and call the clinician in advance with any information you would like to share. Children under the age of 5 cannot be left unattended by a parent at any time. Siblings also cannot be left in the lobby unless this has been approved by the clinician on a limited occurrence.

CONFIDENTIALITY

Information regarding your health care, including payment for health care, is protected by the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. parts 160 and 164. HIPAA requires that we provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. Confidentiality regulations and Psychology Resources' privacy practices are described in detail in the Notice of

Privacy Practices accompanying this agreement. Please refer to this document and let us know if you have any questions.

In addition to the Privacy Notice please be aware of the following: Your signature on this Agreement provides consent for those activities, as follows:

- Psychology Resources is a group practice and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes such as scheduling, billing and quality assurance. All staff members are bound by the same rules of confidentiality and have been given training in order to protect your privacy.
- We contract with a bookkeeping company. As required by HIPPA, we have a formal business associate contract with this business, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with the name of this organization.
- You should also be aware that your contract with your health insurance company requires that we provide them with information relevant to the services that are provided to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. Though all insurance companies claim to keep such information confidential, Psychology Resources has no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report submitted, if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier.

PROFESSIONAL FEES

A fee schedule is provided separate from this document, and it denotes the various professional services that we offer as well as the rate for those services. If you become involved in legal proceedings that require our participation, you will be expected to pay for all of our professional time, including communication with any involved attorney, court testimony and preparation, and transportation costs. We charge a higher hourly rate for time spent on legal matters due to the intricacy of this involvement.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep Protected Health Information about you in your Clinical Record. If you provide us with an appropriate written request, you [or your legal representative] have the right to examine and/or receive a copy of your records. Please note that clinical records can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in our presence, or have them forwarded to another mental health professional so you can discuss the contents. We reserve the right to charge a copying fee of $40.00 to cover related expenses if the majority of the file is being requested.

BILLING AND PAYMENTS

As a courtesy, we will bill most major insurance companies for services rendered. Psychology Resources is a preferred provider of United Health Care and Premera/Blue Cross Blue Shield. We do not bill Triwest, Tricare, Medicaid, Medicare, Tefra or Denali Kid Care, as they do not reimburse us. If you have a health insurance policy, it may or may not provide some coverage for mental health treatment. We recommend that you contact your carrier and verify your plan benefits. We will provide you with whatever assistance we can to help you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of Psychology Resources' fees. You will be expected to pay your portion of the cost for each session at the time of service unless we agree otherwise. At the end of each session you will be provided with a superbill itemizing the charges for that session.

As your insurance policy denotes a relationship between you and the insurance company, we ask that you watch your explanation of benefits (EOB) and contact your insurance company to resolve any payment and benefit coverage problems. We expect that all balances on your account be paid within 60 days unless we have reached a separate agreement with you.

CONTACTING US

Please contact the front office for all scheduling related matters to include cancellations at (907) 272-4407. Office hours are Monday through Saturday and office, hours vary during these days. Messages can also be left for the clinicians via the voicemail system. The front office can transfer you or their voicemail can be accessed via the automated directory. Clinicians monitor their voicemail and make every effort to return your call on the same day you make it when we are scheduled to be in the office. If you are unable to reach us and feel that the situation is an emergency, contact your family physician, psychiatrist, or go to the nearest emergency room. If we are unavailable for an extended time (for example on a trip) we will provide you with the name of a colleague to contact, if necessary.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE

_____ _____

Signature **Date**

Telemental Health Informed Consent

I, _____, hereby consent to participate in telemental health with, _____ , as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to telemental health:

1) I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

2) During telemental health sessions, I (participant or parent/guardian) agree to be in an area that is considered private from other individuals, to ensure my confidentiality. Parent/guardian agrees to provide their child an area to provide privacy and respect their privacy throughout telemental health sessions, unless their participation has been agreed upon by the therapist and child.

3) I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4) I understand that the privacy laws that protect the confidentiality of my protected health information also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

5) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.

6) I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, I or the therapist will attempt to end and restart the session. If we are unable to reconnect within 5 minutes, the therapist will call and the therapy session will continue over the telephone.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency. I understand that if I express an a desire to hurt myself or others and I disconnect from the session and cannot be reached, the therapist will call 911.

8) I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

I understand that I may benefit from telemedicine but that results can vary depending on the individual.

I have read and understand the information provided above. I have discussed it with my counselor and my questions have been answered to my satisfactions. My signature below indicates my informed and willful consent of treatment using this platform.

_____ _____

Client Signature Date

_____ _____

Clients Guardian's Signature Date

_____ _____

Provider's Name and Signature Date

Revised 1/2020