CLINICAL PSYCHOLOGISTS, PC

Client Information Form

Date: _____

I. BASIC INFORMATION:

Client's Name: _____ Social's Security #: _____
Age: _____ Date of Birth: _____ Driver's License #:_____
Sex: Male _____ Female _____

Phone Numbers: **OK to leave a message?**
Cell Phone: _____ Yes _____ No _____
Home Phone: _____ Yes _____ No _____
Work Phone: _____ Yes _____ No _____
Email Address: _____ Yes _____ No _____

(Only the first name of the secretary or therapist and our phone number will be given.)

Present Address:
_____
_____
_____

Permanent Home Address: (if different from above)
_____ Phone: _____
_____
_____

Place of Employment: _____ Occupation: _____

II. ARE YOU SEEKING SERVICES FOR:

____ Yourself
____ Your Child (give age _____; **also Complete Section IV below**)
____ You and your spouse/partner/family; **also complete V below**)
____ Other: _____

Reason for Requesting Services:
_____

If coming in for an evaluation, have you received a copy of our "Customary Fee Guidelines" for children/adolescents and/or adults? _____ Yes, _____No Initials_____

Referred by: _____
Previous Mental Health Care: Yes _____ No _____
(If yes) Provider(s): _____ Date: _____
Provider(s): _____ Date: _____
Name of your Physician: _____ Phone: _____

III. PERSONS TO CONTACT IN AN EMERGENCY:

Name: _____ Relation to Patient: _____ Phone: _____
Name: _____ Relation to Patient: _____ Phone: _____

IV. INFORMATION NEEDED IF YOU ARE SEEKING SERVICES FOR YOUR CHILD

School: _____ Grade: _____ Phone: _____
Principal: _____ Special Class Placement: _____
Teachers: _____

Custodial Guardian(s): _____ Relationship to Child: _____

Contact Information for Parents or Primary Guardians:
Name: _____ Age: _____ D.O.B. _____

Home Address: _____ Phone: _____
_____

Business Address: _____ Phone: _____
_____ Occupation: _____

Additional Parent/Guardian Information Relationship to Child**:** _____
Name: _____ Age: _____ D.O.B. _____

Home Address: _____ Phone: _____
_____

Business Address: _____ Phone: _____
_____

Names of Parents if different from above: Mother _____ Father _____

Marital Status of Parents: Married ____ Divorced _____ Other (explain)_____

Stepmother's Name: _____ Stepfather's Name: _____
Sibling's Name: _____ Age: _____ Check if Half/Step?:_____
Sibling's Name: _____ Age: _____ Check if Half/Step?:_____
Sibling's Name: _____ Age: _____ Check if Half/Step?:_____
Sibling's Name: _____ Age: _____ Check if Half/Step?:_____

V. INFORMATION NEEDED IF YOU ARE SEEKING COUPLES THERAPY

Additional Client Name: _____ Social Security #: _____
Age: _____ Birth date: _____ Driver's License #:_____
Sex: Male _____ Female _____

Present Address (only if different from above): Ok to leave message?
_____ Phone: _____(cell) Yes _____ No _____
_____ Phone: _____(home) Yes _____ No _____
_____ Phone: _____(work) Yes _____ No _____

Place of Employment: _____ Occupation: _____

Previous Mental Health Treatment: Yes ____ No _____ Date(s): _____
Treatment Provider: _____

Emergency Contact: _____ Phone #: _____

Client Name: _____

VI. PAYMENT & INSURANCE INFORMATION

1. Name of person responsible for payment of services: _____

Send Bill to: _____ **Phone**: _____
Address: _____
_____

2. Any special billing instructions:
_____
_____
_____

3. We must have the following information if you want us to file your insurance:

Primary Insurance Information

_____
Name of Primary Insurance

_____
Policyholder's Full Name

_____
Relation to Patient

_____
Policyholders Date of Birth

_____
Social Security Number

_____
Policyholder's Employer

_____
Policy/ID Number

_____
Group Number

_____
Insurance Telephone Number

_____
Driver's License # / State

Secondary Insurance Information

_____
Name of Secondary Insurance

_____
Policyholder's Full Name

_____
Relation to Patient

_____
Policyholders Date of Birth

_____
Social Security Number

_____
Policyholder's Employer

_____
Policy/ID Number

_____
Group Number

_____
Insurance Telephone Number

_____
Driver's License # / State

VII. FEE AGREEMENT

Billing will occur at the end of each month for psychological services at the rate of $130.00 per 45 to 50 minute session. [Other charges: $140.00 per hour for initial intake appointments; $135.00 per hour for assessment (including test scoring and interpretation, report preparation, and consultation); $10.00 - $30.00 for records to be mailed/released. Charges for legal consultation, testimony, and telephone consultation should be discussed with your psychologist.]

I UNDERSTAND THAT MISSED APPOINTMENTS THAT ARE NOT CANCELLED 48 HOURS IN ADVANCE WILL BE CHARGED. THESE MISSED APPOINTMENTS CANNOT BE FILED WITH MY INSURANCE CARRIER AND I WILL BE HELD FINANCIALLY RESPONSIBLE.

_____ (Initials)

AGREEMENT TO PAY: I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and/or court costs, if necessary in the event that I do not pay the full fee owed for services rendered. I also agree, in order to service my account or to collect monies I may owe to Clinical Psychologists, PC, that its agents may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers (which could result in charges to me).

I/We have read this disclosure and agree that Clinical Psychologists, PC, its employees and/or agents may contact me/us as described as above.

_____ _____

Responsible Party Signature Date

At your request, we will bill your insurance carrier directly. We cannot guarantee if or what your insurance will pay. It is the patient's responsibility to know what their outpatient mental health benefits are. The patient's share of the fee, including deductible, is due at the time of service. Payment in full, for the initial session is due at that time. Whoever is specified as responsible for the bill must pay for all fees in the event of nonpayment or reduced payment by your insurance company. Parents of college students will be billed only after they have signed a fee agreement. Should your account become delinquent, your name and other information relevant to collections may be turned over to a collection agency. You will be responsible for all collection expenses, attorney fees, and court costs expanded in the resolution of the account.

LEGAL / FORENSIC CHARGES

Depending on the forensic issue, your psychologist may not be willing to become involved in legal proceeding and may decline to do so. In the event that legal involvement concerning you does occur, charges for legal consultation and/or testimony will be billed at $180.00 to $250.00 per hour, to be agreed in advance in consultation with your psychologist. Insurance will not pay for these expenses and will not be filed under these circumstances. In the event that you become involved in litigation, you agree to pay at the forensic rate for all time spent by your psychologist on court related matters, including but not limited to:

1. Responding to subpoenas by attorneys for either party
2. Preparation for the case
3. Phone calls
4. Record copying and mailing
5. Time traveling to and from court
6. Time testifying in court
7. Time spent in a courthouse waiting to be called for testimony
8. Any other legal expenses incurred by the psychologist to respond to your legal case

I HAVE BEEN ORIENTED AS TO MY RESPONSIBILITES REGARDING MY FEE AND UNDERSTAND AND AGREE THAT I WILL BE RESPONSIBLE FOR PAYMENT OF THE BILL IN FULL.

Patient Signature: _____ Date: _____

Person Responsible for Payment Signature: _____ Date: _____

VIII. TO ALLOW INSURANCE TO PAY OUR OFFICE

As a courtesy, Clinical Psychologist, PC will file insurance at the end of the month after all necessary information is supplied to this office. However, we cannot guarantee payment by the insurance company. It is the patient's responsibility to keep abreast of, and notify this office of, any changes regarding insurance coverage, i.e., deductibles, percentage paid, yearly maximums, etc. If you offer health insurance as complete or partial payment of your fees, we ask that you assign the insurance payments to Clinical Psychologist, PC.

****We release only the Basic Minimum Information to your Insurance carrier in order to file your claim.**

I HEREBY ASSIGN ALL MENTAL HEALTH BENEFITS PAID BY MY INSURNACE COMPANY TO CLINICAL PSYCHOLOGISTS, PC THIS ASSIGNMENT WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL. I HEREBY AUTHORIZE CLINICAL PSYCHOLOGISTS, PC TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT.

Patient Signature: _____ Date: _____

Person Responsible for Payment Signature: _____ Date: _____

IX. IF YOU DO NOT WANT YOUR INSURANCE FILED, PLEASE INDICATE THIS BELOW.

I do not want my benefits assigned or my insurance filed. Therefore, I am fully aware that I am responsible for all charges incurred.

_____
Signature

_____
Date

CLINICAL PSYCHOLOGISTS, P.C. OFFICE POLICIES

Welcome to our practice! In order to save time and minimize confusion, we have prepared the following explanation of some of our policies. Please read the policies and sign below to indicate that you have read and do understand them. If you have any questions, discuss them with your psychologist.

Psychotherapy sessions are 45 to 50 minutes in length. Unlike many physicians and other professionals, we do not overbook. Your appointment time is reserved for you alone. Therefore, patients will ordinarily be charged for missed appointments and for appointments canceled less than 48 hours in advance. Since insurance companies will not pay for missed appointments, you will be billed directly.

Telephone consultation is not an effective substitute for a regular therapy session and should be limited to emergencies. If you are calling with an emergency, please indicate this in your message. Your call will be returned as soon as possible. Telephone consultation will be billed at the regular rate.

If you have an emergency outside office hours, the on-call psychologist can generally be reached through the answering service by dialing (334) 821-3350. If the psychologist is not available and you are concerned about your safety or that of the client, we would advise you to contact your physician, the local Crisis Line (334-821-8600), or the Emergency Department of the local hospital, whichever you deem appropriate.

Payment is due at the time services are provided. Billing for initial sessions is at the rate of $140.00 per 45 to 50 minute interval. All subsequent sessions are charged at the rate of $130.00 per session. Psychological testing, evaluation of test results and other accumulated data, and report preparation are billed at the rate of $135.00 per hour. Written reports are prepared when specifically requested.

Whenever possible, we will, at your request, bill your insurance carrier directly. In this case, the patient's share of the fee, including deductible, is due at the time of service. **We cannot guarantee if or what your insurance company will pay**. The first session must be paid in full regardless of insurance coverage. Discuss this with your psychologist if it is a concern for you. Parents of college students will be billed only after they sign a fee agreement. We will not bill divorced or separated non-custodial parents for services rendered to their children. You are responsible for all fees in the event of nonpayment or reduced payment by your insurance company. There is a returned check fee of $20.00. Should collection action become necessary, your name and other information relevant to collections may be released to a collection agency. You will be responsible for all collection expenses, attorney fees, and court costs expended in the resolution of the account.

Termination is a very important part of the therapy process. When you are considering ending your therapy, you need to give adequate notice so that the therapy relationship can be ended responsibly and in a manner helpful to you. Adequate notice will depend on the length and frequency of the treatment period.

Confidentiality means that your records and other information regarding your treatment will be released only with your consent. Although the confidentiality of psychological treatment is recognized in Alabama law, there are limits to confidentiality, some of which are explained below.

a. Should your psychologist believe that you pose a threat to yourself or another, he/she will take actions necessary to prevent harm.
b. Psychologists, like other professionals, are required by law to report known or suspected child abuse and/or neglect to the proper authorities.
c. When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA-benefits, and national security and intelligence.
d. Some Alabama courts have decided that the court's need for information regarding parents supersedes the need for confidentiality in psychological treatment when custody and parental rights are at issue. In a few such cases, information regarding treatment has been ordered released without the consent of the client.
e. If you choose to use your health insurance to assist in payment for services, the insurance company has the right to review records of your assessment and treatment.
f. In order to develop a therapeutic relationship, children under the age of 14 need a sense of privacy regarding their conversations with their therapist. Therefore, when the client is a child, the psychologist will share information with parents regarding the progress of therapy without necessarily revealing specific details of the content of therapy sessions. In Alabama, an individual is considered an adult at the age of 14 years for the purpose of seeking medical/psychological treatment. Information regarding an adolescent (14 years or older) may be released or discussed with parents only with permission of the adolescent, which will ordinarily be encouraged by the psychologist.
g. If you initiate a lawsuit alleging emotional or mental distress, we may not be able to protect the confidentiality of your records.

Please ask any questions you might have. Your signature indicates that you have read and understand the policies described above and that you have received a copy of these policies.

_____ _____

Signature (Patient or responsible party) Date

CLINICAL PSYCHOLOGISTS,P.C.

I have received and reviewed a copy of:

_____YES _____ NO HIPAA Privacy Policy

_____YES _____NO Clinical Psychologists P.C. office policies regarding billing, insurance, missed appointments etc.

Signature_____

Date_____

- **We release only the basic minimum information to your insurance carrier in order to file your claim.**

- **IF YOU DO NOT WANT YOUR INSURANCE FILED PLEASE INDICATE THIS BELOW.**

  I do NOT want my benefits assigned or my insurance filed. Therefore I am fully aware that I am responsible for ALL charges incurred.

Signature_____

Date_____

Clinical Psychologists, P.C. HIPAA Privacy Policy

When you sign our fee agreement and assignment of benefits (on the Client Information Form), you are giving us permission to release your Personal Health Information (PHI) for the following three purposes:

1. Treatment: (for other psychologists in our office to provide crisis coverage or consultation regarding your case. More extensive case discussion within our practice or with outside health care providers requires your written permission).
2. Payment: We provide the basic minimum information to your insurance necessary for treatment approval, payment authorization, and billing according to your insurance policy. If we send a bill to anyone other than you, the only information it contains are dates and type of services provided.
3. Standard Office Practice: (such as scheduling appointments, record keeping, phone calls, required audits, administrative services, and treatment coordination).

Any other release of your PHI requires your written permission.

Exceptions: Your psychologist may release confidential information without your consent if related to:

- On going child abuse, adult and domestic abuse
- Serious threats to health or safety
- Court orders or subpoenas
- Workers compensation case
- Licensing board investigations

Patients' Rights: You have the right to:

- Put restrictions on disclosures
- Request that we send confidential information (such as billing) to alternate locations to protect your privacy
- Receive a listing of disclosures made
- Request and receive a full copy of the privacy policy
- Submit a request to inspect, copy or amend your records (in coordination with your psychologist, see below)
- Right to restrict disclosures when you have paid for your care out of pocket. (You have the right to restrict certain disclosures of PHI to a health plan when you pay out of pocket in full for services.
- Right to be notified if there is a breach of your unsecured PHI. You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPPA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) risk assessment fails to determine that there is a low probability that your PHI has been compromised.

Psychologists' Responsibilities. We are committed to maintaining the privacy of your PHI and will notify you of any changes in our privacy policies and practices. Please note that under HIPAA, your psychologist has the right to deny your request to inspect, copy, or amend your records, but will make every reasonable effort to discuss this with you.

Privacy Complaints: If you feel we have violated your privacy rights, please direct your concerns ATTN: HIPAA Compliance Officer at Clinical Psychologists, P.C.

Effective Date, Restrictions, and Changes: This statement is effective as of September 23rd, 2013. It is a restatement of our original contents. Any revisions will be made available to you at your first visit after these revisions.