EAST LOUISVILLE PSYCHOLOGY GROUP, PLLC
1230 South Hurstbourne Parkway, Suite 245
Louisville, KY 40222

New Patient Information Form

Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

D.O.B: _____ Sex: M _____ F_____ Social Security No.: _____-_____-_____

Referral Source: Self _____ Other, please list: _____

Patient Status: Single: _____ Married: _____ Divorced: _____ Widowed: _____ Other: _____

Employed: _____ Student: _____ Retired: _____ Disabled: _____

Responsible Party: _____

Briefly describe your reason for seeking psychological services: _____

_____

_____

Insurance Information

Primary Insurance: _____

Name of primary insurance policy holder: _____ I.D. number:_____

D.O.B.: _____ Employer: _____

Your insurance I.D. number if different: _____

Authorization required before first appointment: Yes _____ No _____

Co-payment: Yes _____ Amount: _____ No _____

Secondary/supplemental insurance: _____

Name of secondary/supplemental policy holder: _____

D.O.B.: _____ Employer: _____

Your secondary/supplemental insurance I.D. number if different: _____

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Information Regarding Psychological Services at East Louisville Psychology Group

We are committed to being of help to you, and seek your assistance in making that possible. Let us know of anything that is interfering with your satisfaction with our services. Ask any questions that concern you, and work actively with us to make the services that you receive effective in meeting your needs. We work for you…

Confidentiality

All client disclosures within a professional relationship with a licensed psychologist are protected as "privileged communication," with certain exceptions as defined by law. Those exceptions include: (1) a duty to warn all known parties of any intended physical harm that is disclosed by a client, (2) a responsibility to inform the proper state social service agency of any disclosed or suspected child abuse or neglect, spouse abuse or elder abuse, and (3) court-ordered release of clinical information, as part of judicial proceedings.

Cancellations

Due to the importance of being able to schedule appointments efficiently, we must require a minimum of 24 hours advance cancellation of scheduled appointments. All missed, forgotten or late-cancelled appointments will be charged at our usual and customary rate and insurance companies will not reimburse you for those charges.

In the event that you cancel or do not attend a session and do not reschedule an appointment, the psychologist will attempt to contact you to determine what problems exist. If there is no contact made, your case will be officially closed, and you will receive a letter to that effect. At that point any client/therapist relationship will be terminated, and there will no longer be any legal obligation on the part of the treating psychologist toward you, other than to maintain the confidentiality of your services here.

Fees

Our professional relationship is with you, and we must hold you responsible for all fees. We will gladly assist you in filing insurance forms or accepting assignment of benefits seeking insurance reimbursement as defined by your policy. You will be responsible for determining whether or not your policy covers the services, which you receive, the benefit limitations which may apply, and obtaining prior authorization if this is required by your policy. You must inform us immediately of any changes in your insurance coverage. If your insurance denies benefits, you will be charged at the usual and customary rate, rather than the discounted rate required by your insurance company.

In order to minimize the cost of bookkeeping and accounting services, we must expect payment at the time of service. We will accept payment by check or cash. We will charge the bank's processing fee for all checks returned by the bank. If these arrangements are not possible for you, please ask us to discuss a contractual agreement regarding the timing of your payment. Many insurance policies require a co-payment by you; please be prepared at the time of service to provide the co-pay and any deductible required before your benefits take effect. Should it become necessary to turn your account over to a collection agency, you will be charged the collection agency fee.

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Informed Consent Regarding Clinical Services Permission to Provide Treatment

I have been provided a copy of *Information Regarding Psychological Services at East Louisville Psychology Group* that outlines confidentiality, cancellation and missed appointment policy, the termination of services policy, and the fee policy. I have been given an opportunity to ask questions and discuss these policies, and I understand them to my satisfaction.

I, _____, accept my responsibilities as specified by the policies and agree to notify the office of any changes in residence, insurance coverage, or participation in clinical services. I understand that failure on my part to provide updated information regarding my insurance etc. that results in ineligibility for East Louisville Psychology Group, PLLC to bill my insurance carrier will make me responsible for the full fee amount allowed by my insurance carrier for the session, including any co-pay, deductible, and/or co-insurance. I give consent for my psychologist to provide mental health treatment.

_____ _____
Signature Print Name

_____
Date

(A parent or legal guardian must sign this form for patients under 18 (eighteen) years of age.)

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Informed Consent Regarding Medical Insurance and Managed Care

I, _____, have read and understand *Understanding Medical Insurance and Managed Care.*

_____ I elect to seek authorization for use of my insurance benefits in partial payment for my services. By my signature below, I hereby authorize my provider to communicate all necessary information to my insurance company or its designate in seeking benefits authorization on my behalf; this permission will remain in effect for the duration of my services, or until I rescind permission in writing.

_____ I elect not to seek authorization of my insurance benefits, and accept full financial responsibility for my participation in psychological services.

_____ I understand that my insurance benefits will not apply to these services, and elect to continue services and to assume full responsibility for the resulting fees.

_____ I decline to participate in services at this time.

_____
Signature

_____
Date

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Notice Form Acknowledgement

I have been provided a copy of the *Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information* form defining the policies and practices to protect the privacy of my health information, and have been given an opportunity to discuss this information to ensure my comprehension of this material.

_____ _____

Signature Date

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Emergency Contact Information

Patient Name: _____

Emergency Contact Name: _____

Emergency Contact Address: _____

_____

Emergency Contact Home #: _____

Emergency Contact Cell#: _____

Emergency Contact Work #: _____

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Consent to Use Electronic Communication

The use of email and/or cellular-text messaging communication can be helpful and convenient during treatment. Some patients email or use text messaging to arrange for initial consultation or receive intake forms, whereas others utilize it for scheduling purposes during or after treatment.

Email and text communications are NOT guaranteed to be secure OR confidential, and the receipt or sending of emails and text messages CANNOT be guaranteed.

The lists of accepted and prohibited use of email and text messaging is subject to change at any time. Any emails or text messaging received or sent to your provider should be perceived as and can be included in the patient record. If any changes to the treatment are agreed to via email or text messaging, these changes supersede any prior agreements made, verbal or written. Any potential, current, or former patient who misuses electronic communications may be prohibited from any and all future electronic communication.

If you would like to communicate with your provider via email or text message, please provide your information here:

Email:_____

Cell:_____

I consent to the use of email and/or cellular text communication during and after my treatment with my treatment provider. Furthermore, I understand that any emails or text messages sent or received are NOT guaranteed to be secure OR confidential, and the receipt or sending of emails or text messages by your provider CANNOT be guaranteed. My signature below constitutes an understanding of this document and an agreement to abide by the conditions of it. The signed document will become a part of my or my child's patient record, and a copy will be provided to me on request.

_____ _____

Signature of client/parent/legal guardian Date

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Understanding Medical Insurance and Managed Care

You may remember when you simply scheduled appointments with your doctor, who received reimbursement from your insurance company as part of the benefits for which you paid in insurance premiums. For most Americans, that simple process has changed in ways that you should understand in order to be a well-informed consumer of medical and psychological services.

* * * * *

Medical and psychological service-delivery is currently becoming "industrialized": corporate structures – from nationwide corporations to local group practices – are being established to deliver and finance health services, striving for uniformity, economy and efficiency in service-delivery. In response to the escalating and inflationary growth of health-care costs, one mechanism used to contain costs is "managed care," by which payers (insurance companies, Medicaid, etc.) or their agents control the utilization of benefits through determining whether or not health-care services are warranted and appropriate. Decisions about authorization of benefits are made by "care managers" based upon information from the health-care provider (physician, psychologist, hospital, etc.) about a person's diagnosis, level of functioning, treatment plan, use of alcohol and drugs, risk of harm to self or others, and so forth. The information sought by the managed care company is "privileged" (confidential), and can only be shared by the provider if the patient signs a Release of Information form to authorize divulging the information.

If the patient wants to access benefits to pay for services, he/she must agree for the provider to disclose this material to the managed care company, whose staff will then decide about the "medical necessity" of services, the appropriateness of the services proposed, and whether or not all patients' diagnosis is covered by the insurance policy. If benefits are authorized, the patient will generally have a "co-pay" portion of the fee for which he/she is responsible, and the provider will have to accept a discounted fee (generally 15%-45% lower than the standard fee). After the authorized services are completed (generally 3-10 sessions), the provider will have to submit another report to the managed care company if further services are needed, in order again to seek authorization of the patient's benefits.

* * * * *

Health-care delivery and management continue to change at a rapid rate, keeping consumers and providers scrambling to stay informed and compliant with new requirements. Many of these changes have been positive, leading to increased accountability and efficiency in service-delivery.

Some of the new developments, though, can interfere with the services provided to patients. It is essential that you understand these problems, in order to make well-informed decisions about your utilization of benefits and participation in treatment.

* * * * *

Loss of Confidentiality

In order to help you access your insurance benefits, the provider must give considerable clinical information to staff of the managed care company, who then determine whether or not to authorize further services; this case review process may occur a number of times over the course of treatment. The clinical information required usually involves: your diagnosis and symptoms, your use of intoxicating substances, your psychiatric status and level of psychological/behavioral functioning, your risk of suicide, your progress in treatment, etc. Once divulged, much of this information is entered into the managed care

company's computer, and subsequently neither you nor the provider has control over the security of sensitive information about you.

* * * * *

Control of Treatment

The best psychological treatment involves a partnership between you and your treatment-provider, working together to identify and respond to your clinical needs. Managed care adds a new player to that relationship: a case manager who determines the acceptability of the treatment plan, but who does not know you or your situation. This person, reporting to the company's clinical director, will determine what type and duration of services will be authorized for benefits-payment.

Your provider is often contractually prohibited from billing you for services not authorized, which directly controls the services that you can receive, regardless of any agreement between you and your treater. This provision is designed to protect you from unnecessary expense, but also limits you and your therapist's freedom to collaborate in individualized treatment. In the pursuit of economy and benefits cost containment, brief treatment and the use of psychiatric medication is often encouraged by the managed care company, even if your psychologist decides that a different treatment approach is preferable.

* * * * *

Excluded Diagnoses

Often without your awareness, your insurance coverage may exclude certain diagnoses from benefits-utilization. Some of these exclusions are: attention-deficit disorders, behavioral problems, adjustment problems in response to stressor or losses, and interpersonal relationship problems (marital/partner, parent-child, work-related). Your medical insurance is designed to cover medical problems, and your treatment must be "medically necessary" in order to be authorized; this requires a significant level of impairment of your functioning, the presence of symptoms of a disorder, and the establishment of a diagnosis which is communicated to the managed care company.

* * * * *

Services Not Covered by Insurance

In addition to excluded diagnoses, there are a number of services people seek from a psychologist that are not covered by medical insurance. They include: marital/relationship therapy, consultation about personal or career decisions, enhancement of parenting skills, child custody evaluation, evaluation of learning problems in children, counseling/psychotherapy focused on issues not causing psychological symptoms.

After considering the advantages and disadvantages of using your insurance benefits in seeking psychological services, you must make that decision. Your psychologist will discuss with you any questions you may have, and will inform you if it appears unlikely that your services will be covered by insurance.

If you wish to access your benefits, you may have to contact the number on your insurance card to seek preauthorization for your first appointment; after that, we will do the rest, submitting claims and the clinical information necessary to seek subsequent benefits-authorization

If you choose not to access your benefits, or if your services are unlikely to qualify for insurance benefits, your psychologist will be glad to discuss with you ways to design your services and payment to be sensitive to your budget.

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Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes. To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health records that could identify you.
- *"Treatment, Payment, and Health Care Operations"*

  --*Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.

  --*Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

  --*Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations of PHI or psychotherapy notes at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

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

1. **Child Abuse:** If I have reasonable cause to believe that a child is dependent, neglected or abused, I must report this belief to the appropriate authorities, which may include the Kentucky Cabinet for Families and Children or its designated representative; the Commonwealth's Attorney or the County Attorney; or local law enforcement agency or the Kentucky State Police.

   "Dependent child" means any child, other than an abused or neglected child, who is under improper care, custody, control, or guardianship that is not due to an intentional act of the parent, guardian, or person exercising custodial control or supervision of the child.

2. **Adult and Domestic Abuse:** If I have reasonable cause to believe that an adult has suffered abuse, neglect, or exploitation, I must report this belief to the Kentucky Cabinet for Families and Children.

- **Health Oversight Activities:** The Kentucky Board of Examiners of Psychology may subpoena records from me relevant to it disciplinary proceedings and investigations.

- **Judicial and Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your personal or 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 you communicate to me an actual threat of physical violence against a clearly identified or reasonably identifiable victim or an actual threat of some specific violent act, I have a duty to notify the victim and law enforcement authorities.

- **Workers' Compensation:** If you file a claim for workers' compensation, you waive the psychotherapist-patient privilege and consent to disclosure of your health information reasonably related to your injury or disease to your employer, workers' compensation insurer, special fund, uninsured employers' fund or the administrative law judge.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

1. *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

2. *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a

family member to know that you are seeing me. On your request, I will send your bills to another address.)

3. *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

4. *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

5. *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

6. *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

1. I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

2. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

3. If I revise my policies and procedures, I will notify you by mail.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact your doctor.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person above can provide you with appropriate address information upon request.

VI. Effective Date

This notice will go into effect on 11/1/2011.

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The lists of accepted and prohibited use of email and text messaging is subject to change at any time. Any emails or text messaging received or sent to your provider should be perceived as and can be included in the patient record. If any changes to the treatment are agreed to via email or text messaging, these changes supersede any prior agreements made, verbal or written. Any potential, current, or former patient who misuses electronic communications may be prohibited from any and all future electronic communication.

If you would like to communicate with your provider via email or text message, please provide your information here:

Email:_____

Cell:_____

I consent to the use of email and/or cellular text communication during and after my treatment with my treatment provider. Furthermore, I understand that any emails or text messages sent or received are NOT guaranteed to be secure OR confidential, and the receipt or sending of emails or text messages by your provider CANNOT be guaranteed. My signature below constitutes an understanding of this document and an agreement to abide by the conditions of it. The signed document will become a part of my or my child's patient record, and a copy will be provided to me on request.

_____ _____
Signature of client/parent/legal guardian Date

_____ _____
Signature of client/parent/legal guardian Date