PATIENT DEMOGRAPHICS Today’s Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please Print Only. You are required to present your medication information, medical records (labs, x-ray reports, etc.), all forms to be placed in your chart or in need of completion by the physician, insurance card(s) and a valid picture ID to the front desk at the time of your visit.

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Age: \_\_\_\_\_\_\_ Gender: M or F Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is patient a minor/student: Yes or No

Guardian/Parent Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Contact Preference:(Check all that apply): Home Cell Work Email

Ethnicity: Caucasian African-American Asian Hispanic Other\_\_\_\_\_\_\_\_\_

How did you first find out about our services?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IN CASE OF EMERGENCY

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INSURANCE INFORMATION

Insurance#1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance#2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Main Insured Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Non-Insured/Financially Responsible Party (if different from patient):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY PYSICIAN INFORMATION

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we contact your primary care physician to discuss medical or medication issues and/or coordinate your care? No Yes If yes, please complete/sign “Release Consent” form in attached paperwork.

PHARMACY INFORMATION

Pharmacy Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICAL CONCERNS/PHYSICAL STATUS

List **ALL MEDICATION/FOOD ALLERGIES**, reaction and an estimated date of when each occurred below: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provide a brief description of the major/minor concerns that led you to seek treatment/therapy at this time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any existing medical conditions or current physical symptoms of concern to you? If so, please describe:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any hospitalization or treatment for medical, psychiatric or substance abuse problems within the last 5 years?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any history of suicide attempts or history of assault? Yes No

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? Yes No If yes, \_\_\_\_\_\_ per day

Do you drink alcohol? Yes No If yes, \_\_\_\_\_\_ per day/week

Do you engage in any other substance/drug use? Yes No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise? Regularly Occasionally Rarely Never

How is your general food diet?

Very healthy Questionably healthy Not very healthy Other

How is your general health? Excellent Good Fair Poor

PREVIOUS PSYCHIATRIST/THERAPIST

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What was your experience with therapy: PositiveNeutralLimitedNegative

Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Background Have any family members had any moderate to severe psychological or medical problems? If so, please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe your family relationships: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social/Occupational/Family

Your social network? No close friends One close friend Few friends Many friends

How often do you make contact with friends? Regularly Occasionally Infrequently Never

Are you currently in a romantic relationship? Yes No

How is the relationship? Generally positive Neutral Problematic

Are you able to talk to others about the concerns that bring you into therapy? Yes No

What is your living situation? Live alone Live with others, with whom?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you feel about work/school? Pleased Mostly satisfied Mixed

Mostly dissatisfied Unhappy
Any major dissatisfaction with: Work/School/Other Yes No

If so, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe any hobbies or recreational activities:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contractual Terms

Professional Fees and Payments**:** I understand that the cost of this service is my responsibility. Payment is expected at the time services are rendered. **NO EXCEPTIONS** unless prior arrangements have been made. I understand that if I am insured, my copay is my responsibility and is payable prior to services being rendered. I also understand that my provider has a fee schedule for services that are rendered and the fees are as follows and are subject to change at any given time:

Psychiatric Fees (effective October 1, 2016)

Initial diagnostic interview (50 min) $350

25-minute therapy w/medication management $250

15-minute phone consult /session $150

Returned check charge $35

Counseling Fees (effective October 1, 2016)

Initial diagnostic interview (90 min) $250

60-minute therapy $160

30-minute therapy $75

15-minute phone consult /session $35

Returned check charge $35

Psychological Service Fees (effective October 1, 2016)

Initial diagnostic interview (90 min) $375

50-minute therapy $250

25-minute therapy $150

15-minute phone consult /session $75

Returned check charge $35

Medication Refills/Lost Scripts:I understand that I must walk with my medications to each visit. I understand that requests for refills must be done prior to my visit or during my visit. I understand that once my request for refills is made, I must allow my provider two business days for my request to be processed. I also understand that if a prescription is given and is lost, it is my responsibility to pay for the replacement script(s) thereafter in the amount of $5.00 each.

Administrative Charges:I understandthat charges will be applied when a request is made for information that is sent or reviewed. I understand that any requests for copies of medical records will incur a charge after 10 pages in the amount of $\_\_\_\_\_\_\_\_\_.

Appointment Confirmation: I understand that all appointments when made are confirmed two (2) days prior to give me the opportunity to cancel within 24hrs to avoid a penalty. If I do not respond to a call confirming my appointment, it is understood that my appointment will be given to the next person seeking same. I understand that once my appointment is confirmed any cancellations thereafter will result in a cancellation fee. (See Cancellation Policy Below) I understand that if I am late to my appointment more than 15 minutes, I will be automatically rescheduled as each patient’s time is valuable.

Return Calls/Messages: I understand that all calls/messages left will be returned at the provider’s earliest convenience. I also understand that if it is an emergency, I will go directly to the Schneider Regional Medical Center or dial 911 for assistance.

I have read the terms and agree to all of the above as stated.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PSYCHOTHERAPY/PSYCHIATRY CONSENT

This form provides patients with information that is additional to that detailed in the Notice of Privacy Practices. Please initial each paragraph in the space provided indicating that you have read and understood the content of that paragraph.

Confidentiality: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission, except where disclosure is required by law. Medical records will not be given to family members at no time. A new record release including the name of the provider must be signed each time your information is to be released. Most of the provisions explaining when the law requires disclosure is described to you in the Notice of Privacy Practices that you received with this packet. Initials\_\_\_\_\_\_\_\_

When disclosure Is required by law: Some of the circumstances where disclosure is required by law are: (a)when there is a reasonable suspicion of child, dependent or elder abuse or neglect and (b)and where a patient presents a danger to self and others, (C) or is gravely disabled. (see also Notice of Privacy Practice). Initials\_\_\_\_\_\_\_\_\_

When disclosure may be required: Disclosure may be required pursuant to a legal proceeding. Of you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony from your therapist. In couple and family therapy, or when different family members are seen individually, confidentiality and privileges do not apply between the couple or among family members. Your therapist will not release records to any outside party unless they are authorized to do so by all adult family members who were part of the treatment.

 Initials\_\_\_\_\_\_\_\_\_\_

Health Insurance & Confidentiality of records: Disclosure of confidential information maybe required by your health insurance carrier, HMO/PPO/MCO/EAP, or other third party payer in order to process the claims.

Only the minimum necessary information will be communicated to the carrier.

Unless authorized by you the psychotherapy notes will not be disclosed.

 Initials\_\_\_\_\_\_\_\_\_\_\_

Confidentiality of e-mail, cellphone, texts and fax communications:

It is very important to be aware that email, cell-phone and text communication can be compromised. Emails and text messages, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all information that goes thru them. Please be aware that EFFECTIVE IMMEDIATELY, TEXT MESSAGING WILL NO LONGER BE AVAILABLE. Faxes can easily be sent erroneously to the wrong address so please be sure that the correct information is given. Initials\_\_\_\_\_\_\_\_\_\_\_

Consultation: Your therapist may consult with other professionals regarding their patients; however, the patients name or other identifying information is never mentioned. The patient’s identity remains completely anonymous and confidentiality is fully maintained. This is done to provide you with the best care possible. Initials\_\_\_\_\_\_\_\_\_\_\_

The Process of Therapy: Participation in therapy can result in a number of benefits to you, including improving interpersonal relationships and resolution of the specific concerns that led you to seek therapy. Psychotherapy requires your very active involvement, honesty and openness in order to change. Your therapist will ask for your feedback and views on your sessions, its progress, and other aspects of the therapy and will expect you to respond openly and honestly. Attempting to resolve issues that brought you to therapy, such as personal or interpersonal relationships, may result in changes that were not originally intended. Psychotherapy may result in decisions about changing perceptions, beliefs, behaviors, employment, substance abuse, schooling, housing or relationships. Sometimes more than one approach can be helpful in dealing with a certain situation. These approaches may include, but are not limited to: cognitive-behavioral, psychodynamic, behavioral, existential, systems/family of origin, developmental (adult/children/family), biblio-therapy, psycho-educational and/or pharmacological. Initials\_\_\_\_\_\_\_\_\_\_\_

Termination: You have the right to terminate therapy at any time. Ideally, this happens when the goals of therapy have been met. If at any point during psychotherapy, your therapist believes they are not effective in helping you reach the therapeutic goals, they are obliged to discuss it with you and, if appropriate, to terminate treatment. If at anytime you feel the need to consult with another therapist, your therapist will assist you in finding someone qualified to tend to your needs. Initials\_\_\_\_\_\_\_\_\_\_\_\_

Telephone & Emergency Procedures: If you need to contact your therapists between sessions, please utilize the office telephone **(340)244-9658** anytime during regular business hours. If it is between regular business hours, please leave a message and the front office will return your call in a timely manner. We do not return calls after hours or on weekends. In the event of an emergency or if there is immediate danger or potential for harm, please **dial 911** or proceed to the **Schneider Regional Medical Center.** Initials\_\_\_\_\_\_\_\_\_\_\_\_

Payments & Copays: Each patient is expected to pay for services prior to his/her appointment time. Payments are excepted in the form of cash, checks, credit card and/or money order. All fees will be charged at the same rate, unless indicated and agreed upon otherwise.

 Initials\_\_\_\_\_\_\_\_\_\_\_\_

Insurance: All insurance will be verified before service is rendered. If your insurance is not valid, patient is responsible for payment in full.

 Initials\_\_\_\_\_\_\_\_\_

I have read all of the above carefully and by initialing on each line, I understand and agree to comply with the rules as they are given to me. If there are any questions, I will ask prior to initialing or signing same.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Print Name Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Front Office Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Therapist Signature

CANCELLATION/PAYMENT POLICY

24 Hour Cancellation Notice: I understand that a 24-hour notice is needed to cancel a psychotherapy or psychiatry session. Since scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours (1 day) notice is required for re-scheduling or cancellation. I am aware that the cancellation fee of **$250.00 CANNOT** be charged to my insurance and that I am responsible for the full amount. I also understand that the fee of **$250.00 must be paid in full** prior to my making any additional appointments.

 Initials\_\_\_\_\_\_\_\_\_\_\_

Payment Information: I understand that my credit card information will be kept confidential and secure and will not be charged without my knowledge. I also understand that once my credit card has been charged, a receipt will be given and/or forwarded to my email if an email address is provided.

I, the undersigned, authorize and request Integrative Health and Behavioral Specialists, LLC to charge my card, using the information as indicated below, for any balances on my account, cancellation fees and copays deemed necessary by my insurance carrier. This authorization also relates to all payments not covered by my insurance company for the services provided to me by Integrative Health and Behavioral Specialists, LLC.

This authorization will remain in effect until I cancel. It is understood that in order to cancel, a 30-day notice must be given to Integrative Health and Behavioral Specialists, LLC in writing and my account must be in good standing.

 Initials\_\_\_\_\_\_\_\_\_\_\_

Credit Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exp. Date: \_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_

CV(3 digits back of card): \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Card Type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTICE OF PRIVACY PRACTICES

Effective January 1, 2016

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services is referred to as Protected Health Information (“PHI”). This Notice of Privacy

Practices describes how your provider may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

Under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), your provider is required to maintain the privacy of PHI and to provide you with notice of his or her legal duties and privacy practices with respect to PHI. Your provider is required to abide by the terms of this Notice of Privacy Practices. Your

provider reserves the right to change the terms of this Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that your provider maintains at that time. Your provider will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon

request or by providing one to you at your next appointment.

HOW YOUR PROVIDER MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment:Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your healthcare treatment and related services. This includes consultation with clinical supervisors or other treatment team members. Your provider may disclose PHI to any other consultant only with your authorization.

For Payment: Your provider may use and disclose PHI so that he or she can receive payment for the treatment services provided to you. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing

services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, only disclose the minimum amount of PHI necessary for purposes of collection will be disclosed.

For Health Care Operations: Your provider may use or disclose, as needed, your PHI in order to support his or business activities including, but not limited to, quality assessment activities, licensing and conducting or arranging other business activities. For example, your PHI may be shared with third parties that perform various business activities provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. Your PHI may be used to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

Required by Law: Under the law, your provider must make disclosures of your PHI to you upon your request. In addition, disclosures must be made to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining compliance with the requirements of the Privacy Rule.

Without Authorization: Applicable law and ethical standards permit your provider to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

• Required by Law, such as the mandatory reporting of child abuse or neglect or elder abuse, or mandatory government agency audits or investigations.

• Required by Court Order

• Necessary to prevent or lessen a serious an imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission: Your provider may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI maintained about you. To exercise any of these rights, please submit your request in writing to your provider.

Right of Access to Inspect and Copy. In most cases, you have the right to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. Your provider

may charge a reasonable, cost-based fee for copies.

Right to Amend. If you feel that the PHI your provider has about you is incorrect or incomplete, you may ask for it to be amended, although your provider is not required to agree to the amendment.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures that your provider makes of your PHI. Your provider may charge you a reasonable fee if you request more than one accounting in any 12-month period.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or healthcare operations. Your provider is not required to agree to your request.

Right to Request Confidential Communication. You have the right to request that your provider communicate with you about medical matters in a certain way or at a certain location.

Right to a Copy of This Notice. You may ask your provider for a paper copy of this notice at any time.

COMPLAINTS

If you believe your privacy rights have been violated, you may submit a complaint with the Federal Government. Filing a complaint will not affect your right to further treatment or future treatment. To file a complaint with the Federal Government, contact:

Secretary of the U.S. Department of Health and Human Services

200 Independence Avenue, SW

Washington, DC 20201

(202) 619-0257

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receipt of the Notice of Privacy Practices, which explains my rights and the limits on ways my provider may use or disclose personal health information to provide service.

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If signed by other than client, indicate relationship:

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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. Typically, treatment is provided over the course of several weeks.

I understand that I have the right to ask questions throughout the course of treatment and may request an outside consultation. (I also understand that my provider may provide me with additional information about specific treatment

issues and treatment methods on an as-needed basis during the course of treatment and that I have the right to consent to or refuse such treatment). I understand that I can expect regular review of treatment to determine whether

treatment goals are being met. I agree to be actively involved in the treatment and in the review process. No promises have been made as to the results of this treatment or of any procedures utilized within it. I further understand that I may stop treatment at any time, but agree to discuss this decision first with my provider.

I am aware that I must authorize my provider, in writing, to release information about my treatment but that confidentiality can be broken under certain circumstances of danger to myself or others. 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 ethically 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 take steps to protect the child, and 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.

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. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONSENT TO OBTAIN INFORMATION

**Please PRINT (except signatures) and provide complete information in each section.**

Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, the undersigned, hereby authorize to release medical information concerning the above named patient to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Laurie McPearce M.D FAPA**

Name of Person and/or Institution Mailing Address:

 P.O Box 12387

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ St. Thomas VI, 00801

Complete Mailing Address/Street/P.O Box

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip Code

☐ **Information checked below is for phone release only. Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Check the information to be disclosed (include dates where indicated): ☐Minimum necessary or specify

☐Entire Record

☐Medication list ☐Allergy list ☐Immunization record

☐Most recent history and physical or specify date(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐Clinical notes related to visit(s), specify visits or date(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐Test results (i.e. lab, X-ray, EKG, etc.), specify type and date(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐Billing information, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐Other, specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As per my request, the reason for release of information is: ☐medical care ☐legal ☐insurance

☐Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that this authorization is voluntary and that I may cancel this consent to release information at any time by sending written notice to Laurie McPearce M.D FAPA, 1 Havensight Way St. Thomas 00802/ P.O Box 12387. I understand that any release which was made prior to my cancellation in compliance with this authorization shall not constitute a breach of my rights to confidentiality. Disclosure of this information carries with it the potential for unauthorized disclosure, and once information is disclosed it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information or ask questions by contacting Laurie McPearce at the above address.

I understand that Laurie McPearce may not require completion of this form as a condition of treatment. However, when the provision of services is solely for the purpose of creating a medical report (protected health information) for a third party, refusal to sign may result in a denial of those services.

I Understand that the information to be released may include information in the following categories unless I specifically deny the release (**initial** any category **not** to be released).

Substance Abuse\_\_\_\_\_ Mental Health\_\_\_\_\_\_\_ HIV-related information\_\_\_\_\_\_

This agreement will expire one year from the date of signature, unless previously revoked or otherwise indicated (specify number of days or months)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Guardian Date

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- |
| **MEDICATION ALLERGIES:**  |
| Medication Name: | Dose: | Instructions: | Physician: | Initials: |
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