SOUTHEAST PSYCHOLOGY

PATIENT DEMOGRAPHICS FORM

Today's Date: _____ Date of Birth: _____-_____-_____

Patient's Full Legal Name: _____

Patient's Preferred Name: _____

Patient's SSN (Some payers require SSN for benefit information): _____-_____-_____

Best Mailing Address: _____

_____

Best Contact Number (s): _____

Best Contact Email: _____

Preferred Method of Communication for appointment reminders (Circle all that apply):

Text **Phone Call** **Email** **All** **Do NOT send reminders**

Financially Responsible Party (Please circle one): Self Parent/Guardian/Other (List Below)

Full Legal Name: _____

Preferred Name: _____

Date of Birth: _____-_____-_____ SSN: _____-_____-_____

Primary Insurance Company Name: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____-_____-_____ Relationship to Patient: _____

Secondary Insurance Company Name: _____

Subscriber's Name: _____

Subscriber's Date of Birth: _____-_____-_____ Relationship to Patient: _____

Please provide your insurance card(s) and form of identification when you return completed form to office staff

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Briefly describe how you were referred to our office:

_____

SOUTHEAST PSYCHOLOGY

INFORMED CONSENT AND PATIENT RESPONSIBILITY

As a patient of Southeast Psychology, YOU are our main concern. During your first few sessions, we will work hard to establish a treatment outline. Additionally, we will work with your insurance company to get your services covered, but we cannot guarantee that they will mutually share the same treatment goals we establish. As a result, it is possible that your insurance company could restrict, limit or deny your visits in our office. While we personally believe that your major medical and mental health benefits should be equal, many employer groups/insurance plans do not share this same belief. If we are listed as an in-network provider of your insurance plan, we will file your claims on your behalf as a courtesy. If we are not in-network with your insurance plan, you will need to pay for your services at the time of your appointment and we will then provide you with documentation to file your own claim according to your out of network benefits and filing requirements. We will try and retrieve your specific benefits as they are updated, but cannot guarantee coverage of any service as plans change frequently. At Southeast Psychology, we are on YOUR team and want to see YOU succeed. Thank you for trusting and allowing us to serve you.

Please initial beside each statement as an acknowledgement of your agreement to our terms. Please let us know if you have any questions or concerns.

_____ I understand that copayments, deductibles, coinsurance or other patient responsible monies are due at the time services are rendered.

_____ I understand that Southeast Psychology will send monthly statements and I am financially responsible for the entire balance owed within thirty (30) days.

_____ I understand that if my insurance does not cover my visits for *any* reason that I am financially responsible for services rendered and that I should request specific information from my insurance plan.

_____ I understand that if I NO SHOW or cancel an appointment that I will be responsible for the full cost of my appointment. *(Cancellation policy: we request 48-hour notice of cancellation prior to appointment.)*

_____ I understand that Southeast Psychology is DBA under *Ligare, LLC* and that my insurance claims might reflect this information after each visit.

_____ I have received and reviewed the Notice of Privacy Practices.

Signature: _____ Date: _____

SOUTHEAST PSYCHOLOGY

CASH FEE AND SERVICE SCHEDULE

Description and CPT Code	**Cost**
New Patient Therapy Appointment (90791)	$ 150.00
Individual Therapy Session (90837= +/- 60 minutes)	$ 125.00
Individual Therapy Session (90834= +/- 45 minutes)	$ 90.00
Individual Therapy Session (90832= +/- 30 minutes)	$ 75.00
Family Therapy Session (90836/90837)	$ 125.00
Group Therapy Session (90853)	$ 50.00
One-Time Psychological Evaluation/Consultation (90791)	$ 150.00
Psychological Testing Intake Appointment (90791)	$ 175.00
Psychological Testing (96101= per hour/unit)	$ 150.00
Phone Consultation (15 minute increments)*	$ 30.00
Form/Letter/Paperwork Completion (1-2 pages)*	$ 50.00

**Not covered by insurance*

By signing below, I acknowledge a full understanding of the fees outlined above. I understand that if my insurance does not cover/authorize services, for any reason, I may be billed the above rates. I also understand that upon notice all fees are subject to change.

_____ _____

Print Patient Name | Print Responsible Party Name

_____ _____

Signature of Patient/Responsible Party | Date

SOUTHEAST PSYCHOLOGY

CREDIT/DEBIT CARD AUTHORIZATION FORM

I hereby authorize Southeast Psychology to securely store the following credit/debit card information in my electronic record. I also authorize Southeast Psychology to charge this credit/debit card for the following professional services. Payment(s) will only be made for:

- Appointment Fee (patient responsibility portions or non -covered services)
- Missed Appointments
- Late cancellation fees
- Phone Consultation fees
- Form/Letter/Paperwork Completion

The charge will be determined by the cash fee and service schedule provided. Your signed copy is available in your medical record.

Please circle the type of card: MasterCard Visa Discover AmEx

Card Number: _____-_____-_____-_____

Three digit security code: _____ Exp. Date: _____/_____

Billing Address: _____

_____

Card Holder's Name (print): _____

Card Holder's Signature: _____

Date: _____

SOUTHEAST PSYCHOLOGY

HIPPA Notices of Privacy Practices

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

HOW WE MAY USE AND DISCLOSE MEDICAL/MENTAL HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical/mental health information. For each category of uses or disclosures, we will elaborate on the meaning and provide specific examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Payment We** may use and disclose medical/mental health information about you so that the treatment and services you receive at the Practice may be billed to and payment may be collected from you, an insurance company or a third party.

- **For Treatment We** may use medical/mental health information about you to provide you with medical/mental health treatment or services. We may disclose medical/mental health information about you to doctors, nurses, , medical/mental health students, or other Practice personnel who are involved in taking care of you at the Practice. Different departments of the Practice also may share medical/mental health information about you in order to coordinate the different services you need, such as prescriptions and lab work. We also may disclose medical/mental health information about you to people outside the Practice with your written consent and in some cases without your consent if your mental health is significantly compromised and failure to involve others could result in harm to you or another.

- **For Health Care Operations We** may use and disclose medical/mental health information about you for Practice operations. We may also disclose information to doctors, nurses, medical/mental health students, and other Practice personnel for review and learning purposes. We may combine the medical/mental health information we have along with medical/mental health information from other practices to compare how we are doing and thus, evaluate where we can make improvements in the care and services we provide. We may remove information that identifies you from this set of medical/mental health information so that others may use it to study health care and health care delivery, without learning the identity of the patients.

WHO WILL FOLLOW THIS NOTICE

This notice describes our organization's practices and that of:

- Any health care professional authorized to enter information into your chart.
- All employees, staff and other Practice personnel.
- All of these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical/mental health information with each other for treatment, payment or Practice operations purposes described in this notice.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION

We understand that medical/mental health information pertaining to you and your health is personal. We are committed to protecting your medical/mental health information. We create a record of the care and services you receive at the Practice. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Practice, whether made by Practice personnel or by your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical/mental health information created in the doctor's office or clinic. This notice will inform you about the different ways in which we may use and disclose medical/mental health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical/mental health information.

The law requires us to:

- Make sure that medical/mental health information that identifies you is kept private;
- Acquire your authorization before any use or disclosure of any psychotherapy notes, PHI for marketing purposes, and sales of PHI;
- Give you this notice of our legal duties and privacy practices with respect to medical/mental health information about you; and
- Follow the terms of the notice that is currently in effect.

OTHER CATEGORIES OF INFORMATION THAT WE MAY USE OR DISCLOSE INCLUDE.

Appointment Reminders. We may use and disclose medical/mental health information to contact you as a reminder that you have an appointment for treatment or medical/mental health care at the Practice.

As Required By Law. We will disclose medical/mental health information about you when required to do so by federal, state or local law.

Health-Related Benefits and Services. We may use and disclose medical/mental health information to tell you about health-related benefits or services that may be of interests to you.

Individual Involved in Your Care or Payment for Your Care. We may release medical/mental health information about you to a friend or family member who is involved in your medical/mental health care.

Research. Under certain circumstances, we may use and disclose medical/mental health information about you for research purposes. Before we use or disclose medical/mental health information for research, the project will have been approved through a research approval process and you would be offered the option to participate or decline in said research after receiving full information as to the scope of the Research being conducted.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical/mental health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Treatment Alternatives. We may use and disclose medical/mental health information to inform you about, recommend possible treatment options or alternatives that may be of interest to you.

LESS FREQUENT USES AND DISCLOSURES OF YOUR PERSONAL INFORMATION INVOLVING THOSE NOT DIRECTLY INVOLVED IN YOUR CARE COULD INCLUDE:

- **Coroners, Medical/mental health Examiners and Funeral Directors.** We may release medical/mental health information to a coroner in order to identify a deceased person or determine the cause of death. We may also release information about patients of the Practice to funeral directors as necessary to carry out their services.
- **Health Oversight Activities.** We may disclose medical/mental health information to a health oversight agency for activities authorized by law.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical/mental health information about you to the correctional institution or law enforcement official. This release would be necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **Law Enforcement.** We may release medical/mental health information if asked to do so by a law enforcement official:
    - In response to a court order, subpoena, warrant, summons or similar process;
    - To identify or locate a suspect, fugitive, material witness, or missing person;
    - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
    - About a death we believe may be the result of criminal conduct;
    - About criminal conduct at the Practice; and
    - In emergency circumstances to report a crime; the location of the crime or victims; or to identify, description or location of the person who committed the crime.

- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose medical/mental health information about you in response to a court or administrative order. We may also disclose medical/mental health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Military and Veterans.** If you are a member of the armed forces, we may release medical/mental health information about you as required by military command authorities.
- **National Security and Intelligence Activities.** We may release medical/mental health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- **Public Health Risks.** We may disclose medical/mental health information about you for public health activities. These activities generally include the following, but are not limited to:
    - Preventing or controlling disease, injury or disability;
    - Reporting births and deaths;
    - Reporting child abuse or neglect;
    - Reporting reactions to medications or problems with products;
    - Notifying people of recalls of products they may be using;
    - Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
    - Notifying the appropriate government authority if we believe a patient has been a victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- **Worker's Compensation.** We may release medical/mental health information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Uses and disclosures not described in this Notice of Privacy Practices will be made only with your authorization.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical/mental health information we maintain about you:

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical/mental health information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Practice Administrator.
- **Right to Amend.** If you feel that medical/mental health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Practice. To request an amendment, your request must be made in writing and submitted to the Practice's Administrator. In addition, you must provide a reason that supports your request.
    - We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:
    - Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
    - Is not part of the medical/mental health information kept by or for the Practice;
    - Is not part of information which you would be permitted to inspect and copy; or
    - Is accurate and complete.
- **Right to Inspect and Copy.** You have the right to inspect and copy medical/mental health information that may be used to make decisions about your care. You may access PHI maintained electronically in one or more designated record sets, whether or not the designated record set is an electronic health record. Usually, this includes medical/mental health and billing records, but does not include psychotherapy notes.
  To inspect and copy medical/mental health information that may be used to make decisions about you, you must submit your request in writing to the Office Manager. If you request a copy of the information, we are entitled to charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request, whether it is in paper or electronic form.
- **Right to a Paper Copy of this Notice.** You have the right to a paper copy of this notice.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical/mental health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Practice's Administrator. We will not ask you the reason for the request and will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to Restrict Disclosures to Health Plan**. You have the right to restrict disclosures of PHI to a health plan if the disclosure is for payment or health care operations and pertains to a health care item or service for which you have paid out of pocket in full.
- **Right to be Notified of Breach.** You have the right to or you will be notified following a breach of unsecured PHI if you are affected by the breach.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical/mental health information we use or disclose about you for treatment, payment or health care operations. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
  To request restrictions, you must make your request in writing to the Administrator. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical/mental health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the Practice. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you visit the Practice for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact the Practice Administrator. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF MEDICAL/MENTAL HEALTH INFORMATION

Other uses and disclosures of medical/mental health information not covered by this notice or the laws that apply to use will be made only with your written permission. If you provide us permission to use or disclose medical/mental health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical/mental health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provide to you.

If you have any questions about this notice, please contact the Practice Administrator.

Effective Date: January 15, 2018