Patient Information

Provider/Doctor: _____

Date: ____/____/_____

Please Print, ***Bold** sections are **required** information*

Full Name (first, middle initial, last): _____

Preferred Name: _____ Marital Status: Single Married Divorced Widowed Other

Date of Birth: ____/____/_____ **Social Security Number:** _____-____-_____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

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

Cell Service Carrier (for text message appointment reminders): _____

Email: _____ **Is client a dependent child? Yes No**

Gender: Male Female Other Gender Preference: _____

Responsible Party (if different from client): _____

Relation to client: _____ Legal Guardian: Yes No

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

Insurance Information

In order to use your Insurance, please complete this section in its entirety. Please provide your insurance card so we can copy the front and back for filing of claims or inquire about the Self Pay rate.

1. Primary Insurance Company: _____

Policy/Member/ID Number: _____ **Group:** _____

Primary Insurance Holder Name: _____ **Relation to client:** _____

Primary Insurance Holder DOB: ____/____/_____**Phone:** _____

Primary Insurance Holder Social Security Number: _____-____-_____

Employer (if policy through work): _____

OR, **if not using insurance, discussed Self Pay Rate: $_____/session (or until policy deductible met)**

2. Secondary Insurance Company (if applicable): _____

Policy/Member/ID Number: _____ Group: _____

Primary Insurance Holder Name: _____ Relation to client: _____

Primary Insurance Holder DOB: ____/____/_____Phone: _____

Primary Insurance Holder Social Security Number: _____-____-_____

Employer (if policy through work): _____

Other Pertinent Information (For example, Who would you prefer we call for appointment reminders or special circumstances of who not to release information to in the case of changing family dynamics):

_____

_____

Patient Financial Contract

I, _____, am responsible for obtaining prior authorization from my insurance carrier. We will bill your insurance if your provider is on your insurance panel. You are responsible for copayment amounts and deductibles as set by your insurance plan. These payments are due and payable at each appointment. If your insurance changes, you will immediately inform the front office staff. At any time during your treatment, if you become ineligible for insurance coverage, please notify your provider or the office staff. If you are not covered by any insurance plan, or your practitioner is not on your insurance provider panel, you agree to pay for the services in full or at the agreed-upon Self Pay rate at each appointment. If you have insurance that you would like to file yourself, the office staff will provide you with all the information necessary to file your own claims. We check insurance benefits as a courtesy but cannot guarantee coverage.

Initial: _____

Fees for Late Cancellations and/or Missed Appointments: Scheduled appointment times are reserved especially for you. If an appointment is missed or cancelled with less than 24 hours' notice, you may be billed in full for the missed or cancelled appointments. Your insurance company cannot be billed for fees associated with missed or cancelled appointments. We call and/or text clients to remind them of appointments as a courtesy and provide reminder cards for your convenience. If you come in on a cancellation call basis, your original appointment or other previously scheduled appointments will not be cancelled unless you explicitly request such.

Initial: _____

Fees for Additional Non-Covered Services or Assessment: Your provider is responsible for informing you of the assessment costs when you are beyond or outside your benefits. For special modalities of treatment not covered by your benefit plan (for example, psychological testing or family therapy), the agreement should outline your understanding that it is not a covered benefit and state the fees you will be responsible for. There will be a *$30.00* charge for checks returned by your bank for non-payment. When paying in cash, we ask that you have correct change, as we do not keep change in the office. We accept all major credit cards for your convenience, unless otherwise stated by your provider. **Initial:** _____

Release of Information to Obtain Payment for Services: I agree to pay all expenses not covered by insurance or as indicated below. I authorize the release of information to any insurance company for all claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the parties who accept assignment. By signing **I,** _____, agree to all terms and conditions of payment and collections, and in case of default agree to pay all costs of collection or attempts to collect, including but not limited to reasonable attorney fees and court costs. The provider reserves the right to retain a Collection Agent, to notify the Credit Bureau and to initiate proceedings in Small Claims Court. This Agreement is governed by the laws of Alabama. **Initial:** _____

_____ ___/___/_____

Signature **Date**

_____

Printed Name

_____ ___/___/_____

Witness **Date**

I have received a copy of the notice of policies and procedures to protect the privacy of your Personal Health Information _____**(Client)** given a copy of the Health Care Information.
Sign here _____(Client) if client declines to receive a copy, but is aware of and familiar with HIPAA policies and procedures.

Longwood Psychological Center
Adult Patient Questionnaire

Patient Name: _____ **Date:** _____

Please read the following questions and answer to the best of your ability by placing a checkmark in the appropriate boxes or fill in the blank as directed. Your cooperation is appreciated.

Referred by: _____

Please state in your own words why you have come to this office today:

_____
_____
_____
_____
_____
_____
_____

Please check ALL of the following symptoms or thoughts that apply to you **AT THIS TIME or during the past six months:**

___ Depressed mood
___ Diminished interests or pleasure
___ Sleep disturbance
___ Fatigue
___ Change in appetite
___ Hopelessness
___ Pleasure in few activities
___ Weight change
___ Agitation
___ Excessive worry
___ I feel like I am losing control.
___ Irritability
___ Poor Concentration
___ Tension
___ Feelings of panic
___ Socially withdrawn
___ Use of alcohol
___ Use of other drugs
___ Use of tobacco
___ Anxiety in social settings
___ Makes careless mistakes
___ Does not complete tasks
___ Difficulty organizing
___ Forgetful
___ Confusion
___ Disorientation
___ Aggression/Anger
___ Emptiness
___ Failure
___ Compulsive checking / counting
___ Indecisiveness
___ People talk about me.
___ Some people want to hurt me.
___ I feel emotionally distant from others.
___ I hear voices or sounds others do not hear.
___ I see things others do not see.
___ I smell things others do not smell.
___ Racing thoughts
___ I do risky or dangerous things.
___ Little interest in sexual activity
___ Sexual problems
___ Gender concerns
___ I don't like my body.
___ Binge eating/weight problems
___ Self-induced vomiting
___ Laxative abuse
___ Excessive fasting
___ Intense fear of weight gain
___ Impulsive
___ I think about hurting myself.
___ I have tried to hurt myself.
___ Sometimes I wish I were dead.
___ I think about hurting someone else.
___ Exposed to a significant traumatic event
___ Recurrent distressing dreams
___ Suspiciousness
___ Codependency
___ Mood Swings
___ Legal Matters

Psychiatric History:

I have received treatment for: Substance abuse □ Mental health issues □ Both □

The treatment occurred at:

□ Private psychiatrist □ Private counselor/therapist □ Mental Health Center
□ Hospital □ Other facility Specify where: _____

Are you presently being treated? Yes □ No □ If yes, by whom? _____
_____

Medical History:

Your current weight _____ Height in inches _____

Name of your primary care doctor _____

Phone: _____ Date last seen: _____

Do you have a history of any medical problem? Yes □ No □ If so, what? _____
_____

Are you presently being treated for any medical problem? Yes □ No □ If so, what?
_____

_____

Past surgeries: _____
_____
_____
_____

Females only:

Are you currently pregnant? Yes No

History of prior pregnancies/childbirths: _____
_____

Are you post-menopausal? Yes No How long? _____

Are you currently experiencing any physical pain? Yes No

Please specify: _____

Have you ever received treatment for any of the following medical conditions?

___ Neurological impairment
___ Seizure disorder
___ Visual loss / impairment
___ Hearing loss / impairment
___ Dementia
___ GI disorder
___ Obesity
___ Significantly underweight
___ Cirrhosis
___ Hepatitis
___ Heart condition
___ Hypertension
___ Asthma
___ Emphysema
___ Chronic bronchitis
___ Tuberculosis / +PPD
___ Cancer
___ Thyroid disease
___ Diabetes
___ Pregnancy
___ Irregular menstrual periods
___ Musculoskeletal condition
___ HIV / AIDS / Related condition
___ Other

Please list any medications you are currently prescribed and by whom they were prescribed:

_____
_____
_____
_____
_____

We appreciate your cooperation in preparing this information prior to your arrival at the office, as it will serve to expedite the process for all involved. Your therapist will discuss these and other issues in greater detail and help you develop a treatment plan to effectively deal with your concerns.

Notice of Provider'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 THIS DOCUMENTATION CAREFULLY.

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

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

- "PHI" refers to information in your health record that could help identify you.
- "Treatment, Payment, and Health Care Operations"
  1. *Treatment* is when I provide, coordinate and/or manage your health care and other services related to your health care. An example of treatment would be when I consult with another healthcare provider, such as your Primary Care Physician or another Psychotherapist.
  2. *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 and/or insurance coverage.
  3. *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, case management, and care coordination.
- "Use" applies only to activities within my office [office, clinic, practice group, etc.,] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my [office, clinic, practice group, etc.], 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 for 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, and/or family counseling session, which I have kept separate from the rest of your clinical 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, law provides the insurer the right to contest the claim under the policy.

III. **Uses and Disclosures with Neither Consent not Authorization**

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

- *Child Abuse*: If I am treating a child and I know or suspect that child to be a victim of child abuse or neglect, to a duly constituted authority.
- *Adult and Domestic Abuse*: If I have reasonable cause to believe an adult, who is unable to take care of himself or herself, has been subject to physical abuse, neglect, or exploitation, sexual abuse, emotional abuse, I must report this belief to the appropriate authorities.
- *Health Oversight Activities*: If the Alabama Board of Examiners in Psychology, Social Work, Counseling, or Marriage/Family Therapy is conducting an investigation unto my practice, then I am required to disclose PHI upon receipt of a subpoena from the Board.
- *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 the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legally appointed representative or a court date. The privilege does not apply when you are being evaluated for a third party or here the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety*: I may disclose PHI to the appropriate individuals if I believe in good faith that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of you or another identifiable person(s).
- *Worker's Compensation*: I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to work's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. **Patient's Right and Psychotherapist's Duties**

Patient's Rights:

- *Right to Request Restrictions*: You have the right to request restrictions on certain uses and disclosures of PHI. However, I am not required to agree to a restriction you request.
- *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 you are seeing me. On your request, I will send your bills to another address.
- *Right to Inspect and Copy*: You have the right to inspect and/or obtain 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. You may inspect and copy Psychotherapy notes unless I make a clinical determination that access would be detrimental to your health. On your request, I will discuss with you the details of the

request and denial process.
- *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.
- *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.
- *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 notice electronically.

Psychotherapist's Duties:

- I am required by law to maintain the privacy of PHI regarding you and to provide you with notice of my legal duties and privacy policies and practices with respect to PHI.
- I reserve the right to the privacy policies and practices described in this notice.
- If I revise my policies and procedures, I will provide a notice to 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 our HIPAA Compliance Officer at 1-800-368-1019 for further information. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The contact number listed above can provide you with the appropriate address upon request.

VI. Text Message Reminders

Upon implementation of the new text message reminder service, please be advised that your phone service provider might have fees for or associated with sending and receiving SMS/text messages. Also, these reminders are a courtesy, along with reminder calls and reminder cards, and it is your responsibility to schedule and keep appointments, or to cancel with at least 24 hours' notice to avoid a possible late cancellation charge.

VII. Effective Date, Restrictions, and Changes to Privacy Policy

This notice has been in effect since April 14th, 2003, with revisions made February 7th, 2020. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. If I revise my policies and procedures, I will provide a notice to you by mail.