



NEW PATIENT INTAKE FORM

PERSONAL INFORMATION		
Name:		Date of Birth:
Address:		
Home Phone:	Cell Phone:	Email:

INSURANCE INFORMATION (if applicable):	
Company Name:	Insured Name: (if different from patient)
Identification/Member ID#:	Group Number:

FEE POLICY
<p>Unless other arrangements are made, payment or if applicable co-payment is expected upon receipt of services. When other services are rendered such as record review, collateral contact with other professionals, research and preparation of written report and testimony and services rendered outside the office that are not covered by your insurance plan you will be billed at \$120 per hour (prorated).</p> <p>There is a \$30 charge for each fifteen (15) minutes of a telephone consultation lasting longer than 5 minutes. Matters requiring lengthy email responses are billed at the same rate. Insurance companies will not pay this fee. For issues or questions requiring more than a brief phone conversation or email exchange you are encouraged to schedule an in-office visit to avoid this fee.</p> <p>Please be advised that insurance plans do not cover cancelled or missed sessions. Therefore in the event of missed or cancelled session, regardless of the reason for cancellation, without 24 hour advanced notice, you will be billed and are responsible for the full fee for the session(s) offered.</p> <p>By signing below I attest that I understand and agree to the fee policy and I am aware that I am ultimately responsible for any charges incurred for services rendered. I also understand that my Visa/Master Card account will be billed for any fees uncollected after 30 days.</p> <p>Should you have any questions or concerns regarding the financial policies above, please contact East End Psychological Associate, LLC at 502-426-1234.</p>

Signature of Patient(s) or Responsible Party: _____ Date: _____
Visa/MC Account: _____
Expiration Date: _____ Three Digit Security Code (listed on back of the card): _____
Name on Account: _____
Full Billing Address: _____



INFORMED CONSENT FOR TREATMENT

I _____ (print name of patient) agree and consent to participate in mental health services offered and provided by _____, a mental health provider at East End Psychological Services, LLC. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: 1) the scope of the provider's license, certification and training; or 2) the scope of license, certification and training of this mental health provider directly supervising the services received by the patient.

I understand and agree that all communication between this office and the patient is held in strictest confidence unless the patient authorizes release of information with a signature, or the provider is ordered by a court to release the information; threats to harm self/others are made by the patient; and/or abuse or neglect is suspected. In the latter two cases, the provider is required by law to inform legal authorities and/or potential victims.

If the patient is under the age of eighteen, I attest that I have legal custody of this child and am therefore allowed to initiate and consent for treatment.

Signature: _____ Date: _____

Relationship to Patient: _____



NOTICE OF PRIVACY PRACTICES

Patient Confidentiality is respected and information is only released about you in accordance with state and federal laws.

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

This notice describes policies related to the use of the records of your care at this private practice facility. I am required to give you this Notice about (1) the use and disclosure of your health information, (2) my legal responsibilities, and (3) your rights concerning your health information and to abide by the terms of this notice.

You may request a copy of this Notice at anytime by emailing to eastendpsychology@mc.com and requesting the Notice of Privacy Practices. For more information about privacy practices please contact the above email address or make your request in writing at the above address.

1. Use and disclosure of health information

The minimum necessary health information is disclosed about you for your treatment, for payment of your services and for health care operations.

- a. For Treatment: Health information for the purposes of referral to another health care professional for concurrent or transfer of treatment will be provided only when the patient has completed a signed authorization for release of information.
- b. For Payment: Information may need to be disclosed to obtain payment of services. For example, insurance companies or other agencies may be provided with the minimum necessary information in order for them to pay for your treatment. Should your insurance company require information other than identifying information, dates of service, diagnosis, CPT Codes and provider information, you will be asked to sign an authorization for release of information. Identifying information and balance due may also be disclosed to collection agencies in accordance with fair practices laws for small businesses.

2. Information disclosed without your consent

Under Kentucky and Federal law, information about you may be disclosed without your consent in the following circumstances.

- a. Emergencies. Sufficient information may be shared to address an immediate emergency you are facing.
- b. Judicial and Administrative Proceedings. Your personal health information may be disclosed in the course of a judicial or administrative proceeding in response to a valid court order or other lawful process, including if you were to make a claim for worker's compensation.
- c. Public Health Activities. If it was concluded that you were an immediate danger to yourself or others, health information may be disclosed about you to authorities, as well as to alert any other person who may be in danger.
- d. Child/Elder Abuse. Information may be disclosed about you in relation to the suspicion of child and/or elder abuse or neglect.
- e. Criminal Activity or Danger to Others. Information may be disclosed about you if a crime is committed on the premises or against staff or clinicians, or if it is believed someone else is in danger.
- f. National Security, Intelligence Activities, and Protective Services to the President or others. Health information may be released about you to authorized federal officials as authorized by law in order to protect the President or other national or international figures, or in cases of national security.
- g. Health Oversight Activities. Information may be disclosed about you to a health oversight agency for activities authorized by law. These activities might include audits or inspections and are necessary for the government to monitor the health care system and assure compliance with civil rights laws. Regulatory and accrediting agencies may review your case record to ensure compliance with their requirements. The minimum necessary information will be provided in these instances.
- h. Business Associates. The minimum necessary health information may be provided to our business associates that perform functions on my behalf or that provide this office with services if the information is necessary to perform such functions. All of my business associates sign agreements to protect the privacy of your information and are not allowed



to use or disclose any of the information other than specified for the purposes of their contracted activity, such as financial auditing.

- i. Marketing. No information will be disclosed to a third party for the purposes of telemarketing, direct mail marketing or marketing through electronic mail. This office does not keep a mailing list for marketing purposes.
- j. Scheduling appointments. Your phone number may be used to call you or to leave messages to schedule or remind you of appointments. Your address may be used to mail monthly statements or other billing information.

3. Your Rights Regarding Your Health Insurance

- a. Right to Inspect and Copy. You have the right to look at or get a copy of your record with limited exceptions. Your request must be in writing. If you request a copy of the information, a reasonable charge may be made for the costs incurred.
- b. Right to Amend. You have the right to request that your record be amended. Your request must be in writing and it must explain why the information should be amended. Your request may be denied under certain circumstances.
- c. Right to an Accounting of Disclosures. You have the right to receive an accounting of the disclosures made of your health information after April 14, 2003, for most purposes other than treatment, payment or health care operations. To request an accounting of disclosures, you must submit your request in writing. Accountings are available beginning April 14, 2003 and remain available for six (6) years after the last date of service.
- d. Right to Request Restrictions. You have the right to request a restriction or a limitation on health information disclosed about you. For example you could ask that no information shared with an insurance company in which you would be responsible to pay in full for services provided. While you are in treatment or after treatment has terminated, a written request should be mailed to 6520 Glenridge Park Place, Suite #1, Louisville, KY 40222. Your request may be denied under certain circumstances and after serious consideration or unless the information is needed in an emergency or by law.
- e. Right to Request Confidential Communication. You have the right to request that communications with you about health information be disclosed in a certain way or sent to a specified address. You must make this request in writing, and it must specify the alternate means through which you may be reached. Every attempt to accommodate reasonable requests will be made.
- f. Right to Obtain a Paper Copy of this Notice. You have the right to obtain a copy of this notice and can make such requests through email for an electronic copy or by sending your request in writing with a SASE to 6520 Glenridge Park Place, Suite #1, Louisville, KY 40222.

Any other uses or disclosures not set out in this Notice will be made only with your written authorization. You may revoke authorization for release of information at anytime by sending your revocation in writing. Revocations will become effective only after they have been received and filed and will only be for disclosures not already completed.

The right to change the Privacy Practices is reserved provided applicable law permits such changes. Before the effective date of a material change, changes to this Notice will be made and dispersed. The practice is required to abide by the terms of this Notice beginning April 2003.

Questions and Complaints: If you believe your privacy rights have been violated, you may file a complaint with the US Department of Health and Human Services.

This notice is effective 4-14-03

Signature of Patient(s) or Responsible Party: _____ **Date:** _____



EMAIL CONSENT FORM

Email communication offers an efficient way to communicate with the staff of East End Psychological Associates, LLC. From appointment reminders to providing updates and information, email allows the psychologist and the patient to avoid some of the frustrations of “phone tag,” finding appropriate times to make phone calls and voice mail communication that may not convey all of the necessary data. However, this medium is not without its risks.

1. RISKS OF USING EMAIL

Transmitting patient information by email has a number of risks that patients should consider before using email. These include, but are not limited to, the following risks:

- Email can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Backup copies of email may exist even after they are sent or the recipient has deleted his or her copy.
- Employers and on-line services have a right to inspect email transmitted through their systems.
- Email can be used to introduce viruses into computer systems.
- Emails may not be secure, and therefore it is possible that the confidentiality of such communications may be breached by a third party. Email can be intercepted, altered, forwarded, or used without authorization or detection.

2. GUIDELINES FOR USE OF EMAIL COMMUNICATION

East End Psychological Associates, LLC cannot guarantee, but will use reasonable means, to maintain security and confidentiality of email information sent and received. East End Psychological Associates, LLC will not be liable for improper disclosure of confidential information that is not caused by intentional misconduct. Patients must acknowledge and consent to the following conditions:

- Email is not appropriate for urgent matters or an emergency situation. Instead please call East End Psychological Associates, LLC. We cannot guarantee that any particular email will be read and responded to within any particular period of time.
- Email should be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via email.
- East End Psychological Associates will check email on a regular basis, however, there may be exceptions to this. In addition there can be server problems or line/connection problems. East End Psychological Associates, LLC will not check email when out of the office, on vacation or in training.
- Most email messages will be filed electronically in the patient record.
- East End Psychological Associates, LLC will not forward patient identifiable emails to others outside the practice without the patient’s prior written consent, except as authorized or required by law.
- East End Psychological Associates, LLC will never distribute a patient’s email address to a third party.
- East End Psychological Associates, LLC is not liable for breach of confidentiality caused by the patient or any third party.
- Use caution when using your employer’s computer.
- Inform provider of changes in your email address.
- Ordinarily there will be no charge for use of periodic, brief emails. Should a message require a lengthy response a regular correspondence rate will apply. The patient can then choose to discuss the matter during the scheduled session rather than paying a correspondence fee.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email communication with staff of East End Psychological Associates, LLC, and consent to the conditions and instructions outline.

Patient’s signature/Authorized Individual

Email address to be used

Date