Flatiron Psych Group

Kimberly Evans, Ph.D.
Miguel Humara, Ph.D.

PATIENT INFORMATION SHEET

Name: _____

Address: _____ Apartment: _____

City: _____ State: _____ Zip code: _____

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

E-mail address: _____ Date of Birth: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced Gender: ☐ Female ☐ Male

Emergency Contact: _____ Phone Number: _____

Employer: _____

Employer address: _____

Referring physician: _____

Physician Phone Number: _____ Physician Fax Number: _____

PARTY RESPONSIBLE FOR CHARGES (if other than patient)

Name: _____

Address: _____ Apartment: _____

City: _____ State: _____ Zip code: _____

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

E-mail address: _____

Relationship to patient: _____

INSURANCE INFORMATION

Primary Insurance: _____ Phone: _____

Group #: _____ Member Id. #: _____ Co-Pay: _____

Subscriber's name: _____ DOB: _____

----------FOR OFFICE USE ONLY----------

DX: _____ TX: _____

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CONSENT TO TREATMENT

Patient Name: _____ Date of Birth: _____

I, _____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above. Further, I consent to have treatment provided by a psychologist in collaboration with his/her supervisor. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. Flatiron Psych Group encourages that this decision be discussed with the treating therapist. This will help facilitate a more appropriate plan for discharge.

Psychological Services: Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods psychologists may use to deal with the problems that you hope to address. Psychotherapy calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience and there is a risk that therapy may not work out well for you.

Your first session will involve an evaluation of your needs. By the end of the evaluation, the psychologist will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. If you have questions about the procedures, discuss them whenever they arise. If for some reason treatment is not going well or not working for you, we will discuss with you options for how we might address this including if necessary assisting you with finding another qualified therapist. Following the evaluation, we will usually meet for 45 minute sessions scheduled at both the psychologist's and your convenience.

Based upon what is learned about your problems, the psychologist may recommend a medical exam or medication evaluation. If this occurs, your psychologist will fully discuss the reasons with you so that you can decide what is best. If you are treated by another professional, services will be coordinated with them and with your own medical doctor as you consent to this.

The clinical staff of Flatiron Psych Group are licensed psychologists in the State of California. This means that they are authorized by the state under their psychologist license to practice independently. They are subject to adhere to relevant federal and state guidelines. They adhere to the American Psychological Association's ethics code for psychologists.

If you need to contact your psychologist, they cannot promise that they will be available at all times and do not take phone calls when they are with patients. You can always leave a message on their confidential voicemail and they will return your call as soon as possible. Generally, they will return messages daily except during designated time-off periods.

If you have an emergency or crisis for which you need immediate attention, please contact 911. Since your psychologist is not often able to answer phone calls as they come into the office or respond to messages immediately, it is of the utmost importance that you contact 911 if you are in crisis and do not wait for them to call back. Other options may be to call the local community mental health center and ask to see someone immediately as you are in crisis or go to your local hospital emergency room.

If the client is 18 years of age and under there must a legal representative that can consent to treatment for them.

Finally, you have the right to terminate services at any point in time. Please discuss concerns you have as soon as possible with your provider. If you still choose to terminate services, please know that there can also be risks and benefits associated with that and that your decision to terminate may in agreement with your service provider or may be considered by your service provider to be against therapeutic advice.

HIPAA Privacy Notice: I certify that I have received a HIPAA privacy notice pamphlet and certify that I have read and understand its contents. I understand that as a recipient of services, I may get more information regarding my HIPAA rights from my service provider.

Recipient's Rights: I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information regarding my rights from my service provider.

Non-Voluntary Discharge from Treatment: A client may be terminated from treatment non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with his/her service provider or request to re-apply for services at a later date.

Client Notice of Confidentiality: The confidentiality of patient records maintained by Flatiron Psych Group's clinical and administrative staff is protected by Federal and/or State law and regulations. Generally, Flatiron Psych Group's clinical and administrative staff may not say to any person that a patient is in treatment or disclose any information identifying the patient unless: 1) the patient consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation, or 4) in accordance with state and federal regulations. Please refer to the Notice of Privacy rights provided to you.

Fees: All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments; however, the patient is responsible for ALL fees, regardless of insurance coverage. Payment is due when services are rendered, unless other arrangements have been made in advance. Co-pays are due at the time of service. I authorize payment of medical benefits to Flatiron Psych Group and its clinical staff. I also authorize the release of any medical or financial information necessary to obtain payment on my behalf. Any cancellations made with less than 24 hours' notice will be charged at the full session fee. **When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not clinical information.**

My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original.

I consent to treatment and agree to abide by the above stated policies and agreements with Flatiron Psych Group and its clinical staff.

By typing my name in the field below (Signature of Client/Legal Guardian), I agree it is equivalent to my signature on this document and I consent to conduct the transaction to which this document is applicable by electronic means.

Signature of Client/Legal Guardian	Date

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

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ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the card you wish to use for all services rendered through this practice. Charges for services rendered will be deducted from the card designated below at the time services are rendered. We accept: Visa, MC & Discover.

Client Information:

Client Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Number: _____ Mobile Number: _____

Email: _____

Billing Information:

Please indicate the information associated with the debit card you wish to use. ☐ I prefer to use a credit card.

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____

I authorize all service fees to be deducted from the card ending in _____ (last four digits of the card)

Please enter the CVV code _____ (last three digits on back of card)

I authorize the use of this card for all services and fees at the time they are rendered for the following parties:

Full Name(s): _____

I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service. *By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the card holder and my signature below authorizes each individual charge for all dates of service. By typing my name in the field below (Cardholder Signature), I agree it is equivalent to my signature on this document and I consent to conduct the transaction to which this document is applicable by electronic means.

_____ _____

Cardholder Signature Date

Payments are processed by Therapy Partner.
Therapy Partner is a registered ISO/MSP of Fifth Third Bank, Cincinnati, OH and HSBC Bank USA National Association, Buffalo, NY.

Debit Card Information: ☐ I prefer to use a credit card.

Please provide your payment information below. The card information you provide on this form will be destroyed once your information has been securely encrypted and stored.

Card (circle one): ☐ Visa ☐ Master Card ☐ Discover

Card Number: _____ Expiration Date: _____

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HIPPAA Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

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 with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record 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, 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, and 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 and 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:

- **Child Abuse**: If, in my professional capacity, a child comes before me which I have reasonable cause to suspect is an abused or maltreated child, or I have reasonable cause to suspect a child is abused or maltreated where the parent, guardian, custodian or other person legally responsible for such child comes before me in my professional or official capacity and states from personal knowledge facts, conditions or circumstances which, if correct, would render the child an abused or maltreated child, I must report such abuse or maltreatment to the statewide central register of child abuse and maltreatment, or the local child protective services agency.
- **Health Oversight**: If there is an inquiry or complaint about my professional conduct to the California State Board for Psychology, I must furnish to the California State Board, your confidential mental health records relevant to this inquiry.
- **Judicial or Administrative Proceedings**: If you are involved in a court proceeding and a request is made for information about the professional services that I have provided you and/or the records thereof, such information is privileged under state law, and I must not release this information without

your written authorization, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. I must inform you in advance if this is the case.
- **Serious Threat to Health or Safety**: I may disclose your confidential information to protect you or others from a serious threat of harm by you.
- **Worker's Compensation**: If you file a worker's compensation claim, and I am treating you for the issues involved with that complaint, then I must furnish to the chairman of the Worker's Compensation Board records which contain information regarding your psychological condition and treatment.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. 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 that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes 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.
- *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 for which you have neither provided consent nor authorization (as described in Section III of this Notice). 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 the notice electronically.

Psychologist's Duties:

- 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.
- 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.
- If I revise my policies and procedures, I will mail the revised Notice to you, as well as making it available in my office.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Miguel Humara, Ph.D. at 917-476-0670. or Kimberly Evans, Ph.D., at 917-721-0757.

If you believe that your privacy rights have been violated, or you disagree with a decision I made about access to your records, you may speak to me directly at the phone number listed above.

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

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on January 1, 2009.

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. I will provide you with a revised notice by either distributing it to you in the office or mailing it to your home address.