# PSYCHOLOGICAL STRATEGIES, LLP
## APPLICATION FOR SERVICES

Referred By: _____ Date: _____

Patient Name: _____ Age: _____ Gender: Male Female

Date of Birth: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip Code _____

OK to send mail to this home address: _____ (initial)

If no, where may we send mail _____

E-mail: _____ OK to send e-mail appointment confirmations? _____ (initial)

Home Phone: _____ OK to leave a message: _____ (initial)

Work Phone: _____ OK to leave a message: _____ (initial)

Cell Phone: _____ OK to leave a message : _____ (initial)

Other Phone: _____ OK to leave a message: _____ (initial)

Occupation: _____ Place of employment: _____

Current Marital Status: (circle) Single Married Living as married Separated Widowed

Emergency Contact: Name: _____ Relation to you: _____

Address: _____ Phone: _____

If Child:
Mother's Name: _____ Mother's D.O.B.: _____

Father's Name: _____ Father's D.O.B.: _____

Parents are: (circle) Married Separated Divorced Widowed Never Married

Primary Physician: _____ Phone: _____

Address: _____ City _____ State: _____Zip: _____

Previous mental health contact for self or family members: _____

Current medications: Prescribed By:

_____ _____

_____ _____

_____ _____

There is a possibility my case will involve court proceedings: Yes _____ No _____

I authorize Psychological Strategies, L.L.P. to send informational mailings to my home address:

Signature: _____ Date: _____

I hereby apply for and consent to psychological therapy, consultation and/or testing. I understand that it is my responsibility to cooperate with treatment. My signature here certifies my consent that my therapist may use/share my Protected Health Information as described in the HIPAA PRIVACY NOTICE I have received.

Signature: _____ Date: _____

Signature: _____ Date: _____
(SECOND PARENT)

I authorize payment of medical benefits to _____ for services rendered. If a problem occurs with the insurance company regarding payment of medical benefits, the patient is responsible for payment of the medical benefits for services rendered in our office. All follow-ups with the insurance company will be the responsibility of the patient.

Signature: _____ Date: _____

Signature: _____ Date: _____
(SECOND PARENT)

Charges for services are due and payable at the time services are rendered, unless prior arrangements have been made with the therapist. If you have health insurance, it should be understood that this is an agreement between you and your insurance company to pay you certain amounts for medical care. Your therapist's bill is an agreement between you and your therapist. You are responsible for payment of your bill, regardless of the status of your insurance claim. Insurance companies have a schedule of fees which they will pay. Your therapist's fees may be more or less than this actual schedule. If you fail to meet your financial responsibilities, your account may be turned over to a collection agency or the appropriate court. I hereby give my consent to release necessary information for taking such action. The patient is responsible for any fees or expenses incurred because of collection or court actions.

Signature: _____ Date: _____

Signature: _____ Date: _____
(SECOND PARENT)

I hereby assume financial responsibility for all charges that may be incurred for treatment rendered to myself and/or my family member(s). I understand the financial policy described above. I have also read and understand the Patient Rights and Responsibilities and the HIPAA Notice of Privacy Practices. I have received a copy of both forms to retain for my records.

Signature: _____ Date: _____

Signature: _____ Date: _____
(SECOND PARENT)

Witness: _____ Date: _____

# NO SHOW/CANCELLATION POLICY

Psychological Strategies, LLP has a **very strict no show/late cancellation policy**. Because the appointment time is reserved for you, it is necessary to charge the patient for appointments which are not canceled ***48*** hours in advance. Initial: _____ _____

Failure to provide this advance notice generally means that we are unable to use this appointment time. Insurance companies can not be billed for these lost appointment times and, therefore, it will be the patient's responsibility to pay to designated office fee of **$75**.

I have read the above materials and agree to the terms.

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Therapist's Signature Date

**Patient Name: _____** **Patient ID:_____**

# PSYCHOLGICAL STRATEGIES, LLP

## Authorization to Disclose Information to Primary Care Physician

***Note: Complete top section to allow release of information; bottom section to deny consent***

**I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire in twelve (12) months from the date signed.**

I, _____ hereby authorize _____
*(Please Print Patient's Name)* *(Please Print Treating Clinician's Name)*

To release the following information to my Primary Care Physician: (Please initial each item if consent is given):

____ Dates of Service, symptoms, diagnosis
____ Treatment Progress
____ Psychotherapy Notes
___ Treatment Plan
___ Test Results
___ Other_____

_____ _____
*(Signature of Patient or Patient's Guardian)* *(Date)*

_____ _____
*(Please print the name signed above)* *(Witness)*

**Primary Care Physician's Name, Address & Phone**

_____

_____

_____

_____

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I, _____ hereby refuse consent for the release of my records to my primary care physician.

_____ _____
*(Signature of Patient or Patient's Guardian)* *(Date)*

_____ _____
*(Please print the name signed above)* *(Witness)*

**Patient Name: _____** **Patient ID: _____**

# PSYCHOLOGICAL STRATEGIES, LLP

## Authorization to Release Information

This form, when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize my therapist, _____ to release the following (Please initial each item if consent is given)

_____ Dates of service, symptoms, diagnosis
_____ Treatment Progress
_____ Psychotherapy Notes
_____ Other (describe in specific detail) _____
_____ Treatment Plan
_____ Test Results

This information should only be released to (List name and address of person to whom the information is to be released)

_____
_____
_____

I am requesting my therapist to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

_____
_____
_____

This authorization shall remain in effect until (fill in expiration date or an event that relates to the individual or the purpose of the use or disclosure).

_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage, and the insurer has a legal right to contest a claim.

I understand that my therapist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient Date

_____ _____
Signature of Witness Date

If authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

**Patient Name: _____** **Patient ID _____**

# NOTICE OF PRIVACY PRACTICES
THIS NOTICE EFFECTIVE 4/13/03


## PSYCHOLOGICAL STRATEGIES, LLP
7500 N.W. 5th Street, Suite 111, Plantation, FL 33317
(954) 584-6478 Fax (954) 797-4911
www.psychologicalstrategies.com


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.

## PURPOSE OF THIS NOTICE

Psychological Strategies, LLP is required by law to maintain the privacy of certain confidential health care information, known as Protected Health Information (PHI), and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. This Notice describes your legal rights, advises you of our privacy practices, and lets you know how Psychological Strategies, LLP, is permitted to use and disclose PHI about you.

This Notice is covered under HIPAA (Health Insurance Portability & Accountability Act). Any state law that is more stringent than the HIPAA rules and regulation has priority.

We are required to follow the privacy practices described in this Notice, though we reserve the right to change our privacy practices and the terms of this Notice at any time. If we do so, we will post a new Notice in the office waiting area as well as on our website at www.psychologicalsrategies.com. You may request a copy of the new notice from Lauren K. Cohn, Ph.D., Privacy Officer by calling (954) 584-6478.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED MENTAL HEALTH INFORMATION: We use and disclose PHI for a variety of reasons. For most uses/disclosures, we must obtain your consent. However, the law provides that we are permitted to make some uses/disclosures without your consent. The following offers more description and examples of our potential uses/disclosures of your PHI.

**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 practice group such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of my practice group, such as releasing, transferring, or providing access to information about you to other parties.

**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 when 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.

**Uses and Disclosures with Neither Consent nor Authorization**

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

- **Suspected Child Abuse**
- **Suspected Adult and Domestic Abuse**
- **Health Oversight**
- **Judicial or Administrative Proceedings**
- **Serious Threat to Health or Safety**
- **Worker's Compensation**

Your therapist can provide you with more details about these types of uses and disclosures and when they might occur.

**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 in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request 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 regarding you. 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 the 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.

**HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES**

If you believe that your privacy rights have been violated or if you are dissatisfied with our privacy policies or procedures, you may file a complaint either with us or with the federal government. We will not take any action against you or change our treatment of you in any way if you file a complaint. You may file a written complaint with the Office for Civil Rights (OCR), U.S. Department of Health and Human Services, Atlanta Federal Center, Suite 3B70, 61 Forsyth Street SW, Atlanta, GA 30303-8909.

**CONTACT PERSON FOR INFORMATION OR TO SUBMIT A COMPLAINT**

If you have questions about this Notice or any complaints about our privacy practices, please contact Lauren K. Cohn, Ph.D., Privacy Officer, Psychological Strategies, LLP, 7500 N.W. 5th Street, Suite 111, Plantation, FL 33317, (954) 584-6478, www.psychologicalstrategies.com.

# PSYCHOLGICAL STRATEGIES, LLP

www.psychologicalstrategies.com

## PATIENT'S RIGHTS AND RESPONSIBILITIES

**Welcome! At Psychological Strategies, LLP it is important to us that you know about your rights and responsibilities, as well as our obligations to you. Please read this information carefully. Your therapist will be happy to discuss any questions you have.**

**As licensed therapists, we are dedicated to providing quality therapy, testing and consulting services. You may be assured that each patient receives competent, considerate, prompt and respectful services, regardless of race, ethnic background, religion, gender, age, sexual preference or disability. When necessary, we will consult with other specialists, and we may refer you to additional resources.**

**Administrative policies are set up to allow us to work smoothly and efficiently. Your feedback is welcome; we will be glad to discuss your concerns. It is customary to acknowledge a referral made by another professional with a brief note. If you object to this, please advise your therapist.**

## YOUR RIGHTS:

When you become a patient you have the right to:

1. Confidentiality: It is our policy to respect your privacy and to protect the confidentiality of your relationship with your therapist. It is also our policy to inform you of the limits we have in protecting this right to confidential care. Some limitations are imposed by state statutes and others come from the ethical principles for mental health professionals. They are:

a. Ethical standards encourage therapists to confer with other professional when helpful and appropriate. Therapists at Psychological Strategies, LLP share information to facilitate patient care. All therapists in our office will maintain the privacy of this information.

b. According to the Florida Psychological Services Act (490.0147, 1987) we are obligated by law to inform relevant parties when there is a clear and imminent danger to the patient, to other individuals or to society. In addition, Florida Statute (415.504, 1987) requires mandatory reporting of suspected child abuse or neglect, and statute (415.103) requires mandatory reporting of suspected abuse, neglect or exploitation of aged or disabled adults.

c. When the person licensed under the Florida Psychological Services Act (490.017, 1987) is a party defendant to a civil, criminal or disciplinary action arising from a complaint filed by the patient, in which case the waiver is limited to that action. In the event of receiving a subpoena, the patient will be contacted, and either a written waiver or objection is expected, or the patient will arrange for his/her attorney to file a protective order, should be there be an objection to honoring the subpoena. A copy of the motion and protective order will need to be forwarded to your therapist. A fee will be charged for copying records and for any time required by the legal process.

d. If you are asking this office to file insurance claims, you need to understand that we have no control over who at the insurance company will see the paperwork. Therefore, confidentiality may be limited in this regard. Many managed care companies require extensive treatment reports.

e. Parents (including non-custodial parents) do have the legal right to information concerning a minor child. From a therapeutic standpoint, however, it is important for the child or adolescent to develop a trusting relationship with the therapist. Therefore, we request that parent grant the child confidentiality subject to the above limitations. We will, of course, consult with parents regarding involvement in the treatment process.

Except in circumstances outlined in a, b, c, d, and e above, we will not release to others any information regarding you and your treatment unless you request and authorize its release with your signature. We encourage you to discuss any questions you may have about confidentiality or release of information with your therapist.

2. *Information re; the Cost of Services:* You have the right to be informed of the cost of professional services before receiving the services. Co-payments and/or deductibles are payable at the time of the service.

3. *Informed Consent:* You have a right to know the nature of the services you are receiving. In the early sessions we will discuss goals and develop a treatment plan to meet your specific needs. We encourage you to participate fully

in these discussions. We emphasize short-term, goal directed, cognitive-behavior therapy. The patient and therapist work as a team to achieve treatment goals.

4. *Risks:* The process of change can sometimes be upsetting. The exploration of one's own feelings and behaviors and relationships in therapy may carry a slight risk of psychological distress. In some situations, examination of relationships during the course of treatment may result in a decision to make changes in some of those relationships. If you ever experience any distress, please bring this to the attention of your therapist. **AS AN OUTPATIENT PRACTICE, THERE IS LIMITED ABILITY TO RESPOND TO EMERGENCIES.** University Pavilion Hospital (954-722-9933) offers 24 hour emergency evaluations if there is an immediate risk to yourself or others. The local 911 system may also be used in life-threatening emergencies. Calls regarding minor emergencies can be made to the on-call therapist at _____. Your therapist can give you additional information about our on-call system.

5. *Dual Relationships/Gifts:* Ethical guidelines prohibit any other relationship developing outside the patient-therapist relationship. In Florida, the patient-therapist relationship is a lifetime relationship. Gifts are prohibited by ethical guidelines.

6. *Length of Appointments:* Therapy sessions are 45 minutes.

7. *Other Therapists:* Lauren K. Cohn, Ph.D. and Lori D. Pink, L.C.S.W. are Co-Directors of Psychological Strategies, LLP. Other therapists are independent practitioners and are responsible for their own Standards of Care.

## YOUR RESPONSIBILITIES:

1. Unattended minors cannot be left in the waiting room unsupervised. Please make arrangements for child care during your appointment.

2. You are responsible for supplying accurate and complete information about yourself, your past illnesses, previous therapy, medication, family and work history. Please provide updates when appropriate.

3. You are responsible for honoring your financial agreement. Payment for psychological services is due at the time services are rendered. Fees for groups, workshops and organizational consultation are negotiated on a case by case basis. **Phone calls will be billed at the same rate as a therapy session; phone calls may not be covered by insurance.**

Psychological services are covered under many health insurance plans. Please check your insurance policy to confirm that you do, indeed, have mental health coverage. Insurance is a method of reimbursing you for fees paid to a doctor, not a substitute for payment.

4. You are responsible for keeping appointments. Missed appointments, except in emergencies or incapacitation, will be billed. Since some office work can be accomplished, no show appointments and cancellations less than _____ hours in advance are billed at $50. **Insurance cannot be billed for this charge. Patients are personally responsible for this fee.**

5. If we must be involved in litigation because of professional services provided to you: 1) Your therapist must be paid a forensic professional fee, which is different from regular in-office fees. 2) A retainer must be paid in advance based on an estimate of minimum time required for forensic services. 3) Out of the office services are charged on a portal to portal basis. The forensics fee will be applied to all services connected to the litigation, including but not limited to telephone conferences, depositions and court appearances.

6. You are responsible for following treatment recommendations, completing therapeutic assignments and communicating your treatment progress.