

BARROW AND ASSOCIATES
CLIENT PERSONAL/INSURANCE INTAKE DATA FOR BILLING OFFICE

Personal Information:

Date of First Visit: _____
Client's name Adult/Child: Last _____ First _____ MI _____
Address: _____ City _____ Zip _____
Home Phone: () _____ Work Phone: () _____
Date of Birth: Month _____ Day _____ Year _____ Age: _____ Gender: M F
Social Security Number Adult/Child: _____ Occupation: _____
Marital Status: Never Married _____ Married _____ Separated _____ Divorced _____
Referred by: _____ Family Physician: _____
 Yes No I grant permission for you to send a letter of thanks to the referral source.

Billing Information: (If different from above)

Responsible Party's Name: Last _____ First _____ MI _____
Address: _____ City _____ Zip _____
Home Phone: () _____ Work Phone: () _____

Insurance Information: If you have insurance, we will be glad to file for your benefits. PLEASE NOTE WE DO NOT FILE SECONDARY INSURANCE: We would be glad to give you a receipt with all the information you need to file yourself, please let us know. PLEASE CHECK ALL THAT APPLY:

Yes, BA can contact me at home or leave a message regarding insurance information.
 No, BA cannot contact me at home or leave a message regarding insurance information.
 Yes, I want you to file my insurance for me. No, I will file my own insurance.

IF YES . . . YOU MUST FILL OUT ALL OF THE INFORMATION BELOW. YOUR CLAIM WILL NOT BE FILED IF THIS IS NOT FILLED OUT.

Name Insurance Company: _____
Insurance I.D. Number: _____
Insurance Company phone number to verify benefits (800) _____
Primary Insured Party's Name: Last: _____ First: _____ MI: _____
Insured Party's Address: _____
Insured Party's Date of Birth: Month: _____ Day _____ Year _____ Social Security #: _____
Employed by: _____ Group#: _____

INSURANCE AUTHORIZATION NUMBER: _____

FOR OFFICE USE ONLY:

DSM IV-R Axis I: _____ Therapist: _____
DSM IV-R Axis II: _____

I attest the above information to be true and complete. I give my permission to release information to my insurance in order to file my claims.

Signature Date

Barrow and Associates
494 South Emerson, Suite B
Greenwood, IN 46143

PATIENT RIGHTS & RESPONSIBILITIES

- Patients have the right to be treated with personal dignity and respect.
- Patients have the right to care that is considerate and respects member's personal values and belief system.
- Patients have the right to personal privacy and confidentiality of information.
- Patients have the right to receive information about managed care company's services, practitioners, clinical guidelines, and patient rights and responsibilities.
- Patients have the right to reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.
- Patients have the right to participate in an informed way in the decision making process regarding their treatment planning.
- Patients have the right to discuss with their providers the medically necessary treatment options for their condition regardless of cost or benefit coverage.
- Patients have the right of members, families to participate in treatment planning as well as the right of members over 12 years old to participate in such planning within the limits of confidentiality.
- Patients have the right to individualized treatment, including:
 - Adequate and humane services regardless of the source(s) of financial support.
 - Provision of services within the least restrictive environment possible.
 - An individualized treatment or program plan.
 - Periodic review of the treatment or program plan.
 - Adequate number of competent, qualified, and experienced professional clinical staff to supervise and carry out the treatment or program plan.
- Patients and their families have the right to be informed of their rights in a language they understand.
- Patients have the right to voice complaints or appeals about managed care company or the care provider.
- Patients have the responsibility to give their provider and managed care company information needed in order to receive care.
- Patients have the responsibility to follow their agreed upon treatment plan and instructions for care.
- Patients have the responsibility to participate, to the degree possible, in understanding their behavioral health problems and developing with their provider mutually agreed upon treatment goals.

Patient Signature _____ **Date** _____ **Therapist** _____

BARROW AND ASSOCIATES OFFICE FINANCIAL POLICIES

Your personal problems took time to develop and, therefore, it will take a certain amount of time to work them through. A therapy session is 50 minutes in length. You are encouraged to call your therapist if you have any questions or concerns between sessions. There is no charge for phone calls. The following will give you some ideas as to treatment cost, as well as our payment and insurance policies.

OFFICE CALLS:

In an effort to keep costs down we ask that you pay for your office visit at the time of service. Basic fees are \$100.00 to \$115.00 per session. Payment may be made either by cash, check, money order, or credit card. There will be a service charge of \$20.00 for any personal check returned by your bank. The \$20.00 fee will be added to your account.

SPECIAL CHARGES:

Diagnostic Evaluations: To make a more complete evaluation, your therapist may ask you to take a personality evaluation after the first visit. There is a charge of \$100.00 per MMPI-2 evaluation.

FILING YOUR INSURANCE CLAIMS:

As a courtesy to our patients, we will file your insurance. However, you are responsible for the full fee at the time of your visit except when covered by managed care, which requires pre-certification and possibly a deductible and a co-paid amount. If you do not call your insurance company and they require a pre-certification, then you are responsible for the full fee of the sessions not covered. Insurance companies generally require three to six weeks to process a claim. If your insurance company does not follow through with payment, the balance will be your responsibility to pay.

MANAGED CARE:

If you have a Managed Care health insurance plan and your plan requires you to contact your primary care physician or receive pre-certification for sessions before being seen by us, please be sure that the required referral or pre-certification has been obtained. It is your responsibility to be sure that the required referral is available at the time of your first appointment or you will be responsible for payment of the full fee.

MEDICARE:

We are not a Medicare provider.

STATEMENTS:

Be sure to check over your statement to keep you current with regard to your charges and payments on your account. Statements are mailed monthly on all accounts showing any balance due. Balances over 90 days old will go to collections unless specific arrangements are made with the billing office. Accounts that are sent to collections will also be charged the cost of collections, court fees, and attorney fees.

If you have any questions regarding insurance or statements, please call our Billing and Accounts Office at 317-888-0581.

LATE CANCELLATIONS:

To avoid a cancellation charge, please cancel 24 hours in advance of your appointment. Our office will take your call 24 hours a day at 1-317-888-0581. If after hours leave a message. If you do not show for your appointment or call to cancel your appointment late fee will be charged.

I understand that I am responsible for the full fees for services rendered. I understand that should my insurance company not pay for services, I am responsible for the full fee of those services not covered. I understand that if I do not cancel my appointment 24 hours in advance or if I do not show my appointment I will be charged from \$45.00 to \$100.00 depending on the circumstances of the cancellation/no show.

Signature

Date

Therapist

Barrow and Associates
494 South Emerson, Suite B
Greenwood, IN 46143 (317-888-0581)

**BARROW AND ASSOCIATES
OFFICE POLICY**

INSURANCE INFORMATION CONFORMATION

I have checked with my insurance for out-patient mental health benefits and understand those benefits. Which are:

Deductible Per Year: _____ **Has The Deductible Been Met?** _____
Co-Pay Per Visit: _____

If I have not checked my insurance for out-patient mental health benefits. I understand that I am responsible for paying the full fee at the time of service.

Name

Date

Barrow and Associates
A STATEMENT OF CONFIDENTIALITY

The American Psychological Association's "Ethical Standard of Psychologists" states that the confidentiality of professional communication about individuals must be maintained. Only when a client being seen in therapy and other persons involved give their express permission is confidential professional communication shown to an individual requesting such information. Although confidentiality and privileged communication remain rights of all clients of psychologists according to state law, some courts have held that if an individual intends to take harmful or dangerous action against another human being, or against themselves, it is the psychologist's duty to warn the person or the family of the person who is likely to suffer the results of harmful behavior, or the family of the client who intends to harm himself, of such intention. All child sexual and physical abuse must by law be reported.

Therapy records may be subpoenaed, for example, in certain criminal, child custody, and divorce cases. If your records are subpoenaed, your therapist will make every effort to work with your attorney, if necessary, to protect your confidentiality.

In addition to this, the psychologist may seek the services of a collection agency if a client's billed fees are not paid after sufficient warning. In the event of non-payment of fees, I waive my rights of confidentiality in order to facilitate the collection process.

It is assumed that the client has given his permission to release the information requested on insurance forms if they are provided to the psychologist or his staff to be completed.

The psychologist will, under no circumstances, inform such individuals without first sharing that intention with the client. Every effort will be made to resolve the issue before such a breach of confidentiality takes place.

I have read the above and understand the psychologist's social and economic responsibility to make such decisions where necessary.

DATE _____ BY _____

CONSENT FOR MENTAL HEALTH SERVICES

I, the undersigned, agree and consent to participate in the mental health services offered and provided by _____, a mental health provider or psychologist, as defined in Indiana law.

I understand that I am consenting and agreeing only to those mental health services that the above named provider is qualified to provide within:

(a) the scope of the provider's license, certification, and training; or (b) the scope of license, certification, and training of those mental health providers directly supervising the services received by the patient.

Name: _____ Date of Birth: _____

Witness: _____ Date: _____

BARROW AND ASSOCIATES

Notice of Psychologist's and Therapist'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 IT CAREFULLY.

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

We may use or disclose your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *written authorization*. 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 we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
 - *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we 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 our practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- “*Disclosure*” applies to activities outside of our practice, such as releasing, transferring, or providing access to information about you to other parties.
- “*Authorization*” is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when we are asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information.

We will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we 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) we 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 nor Authorization

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

- *Child Abuse* – If we believe that a child is a victim of child abuse or neglect, we must report this belief to the appropriate authorities.
- *Adult and Domestic Abuse* – If we believe or have reason to believe that an individual is an endangered adult, we must report this belief to the appropriate authorities.
- *Health Oversight Activities* – If the Indiana Attorney General's Office (who oversees complaints brought against psychologists instead of the Indiana State Psychology Board) is conducting an investigation into my practice, then we are required to disclose PHI upon receipt of a subpoena.
- *Judicial and Administrative Proceedings* – If the patient is involved in a court proceeding and a request is made for information about the professional services we provided you and/or the records thereof, such information is privileged under state law, and we will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- *Serious Threat to Health or Safety* – If you communicate to us an actual threat of violence to cause serious injury or death against a reasonably identifiable victim or victims or if you evidence conduct or make statements indicating an imminent danger that you will use physical violence or use other means to cause serious personal injury or death to others, we may take the appropriate steps to prevent that harm from occurring. If we have reason to believe that you present an imminent, serious risk of physical harm or death to yourself, we may need to disclose information in order to protect you. In both cases, we will only disclose what we feel is the minimum amount of information necessary.

- *Worker's Compensation* – We may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker'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 Rights and Psychologist's and Therapist'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. However, we are 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 us. On your request, we 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 our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we 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. We may deny your request. On your request, we 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, we 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 us upon request, even if you have agreed to receive the notice electronically.

Psychologist's and Therapist's Duties:

- We are 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.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

- If we revise our policies and procedures, we will provide you with a revised notice by mail.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact Alfred R. Barrow, Ph.D. HSSP, 494 South Emerson Ave., Suite B, Greenwood, Indiana 46143-1953.

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.

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

This notice will go into effect on April 14, 2003.

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. We will provide you with a revised notice by mail

YOUR SIGNATURE BELOW INDICATES YOUR CONSENT TO OUR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION ABOUT YOU FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. YOU HAVE THE RIGHT TO REVOKE THIS CONSENT, IN WRITING, EXCEPT WHERE WE HAVE ALREADY MADE DISCLOSURES IN RELIANCE ON YOUR PRIOR CONSENT.

Service Recipient Signature

Date