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Missed appointment policy –

If you miss 3 appointments without calling/cancelling you will be terminated from our office. Your signature below acknowledges that you are aware of this office policy

_____ _____

Patient or guardian signature Date

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Due to a policy required by insurance companies our office must keep a **release or denial** for your current medical doctor in your file. Please sign the attached release if you like us to be able to speak to or send a summary to your medical doctor. If you choose not to sign it please "X" across the sheet, write decline and sign the bottom left side and date.

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RECORD RELEASE

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO INCLUDE SUPER CONFIDENTIAL PHI

I, _____, (Name of Patient making Request), hereby request an copy of my health records and authorize **Grinstead, Pierce and Associates**, (hereafter collectively referred to as "this Healthcare Facility") to use and disclose a copy of my health records to

_____

I prefer my records be sent in the following format, but understand that by law, the records can be sent in any electronic format similar if the format I desire is not available. I know this Healthcare Facility will supply these records within **30 days** of this request and will contact me should there be any reason they need to extend this time frame. I understand, by law this Healthcare Facility can request an extension for more time but, can only request an extension, once for an additional 30 days. The format which I prefer to have my electronic records sent is.

☐ Email a word document to (email address): _____
☐ Fax a copy to (fax number): _____
☐ Send a hard copy to (address: _____
☐ I will pick up a copy on or after (date): _____
☐ Phone calls
☐ Appointments (verify or make) ☐ Payments (call and check balance and pay)

I specifically authorize this Healthcare Facility to use and disclose verbally, by mail, fax or unencrypted email, the following types of ***super-confidential information*** as stated in the NOPP (initial where appropriate):

☐HIV records (including HIV test results) and sexually transmissible diseases
☐ Alcohol and substance abuse diagnosis and treatment records
☐ Psychotherapy records summary

The undersigned does hereby release, hold harmless and agree to indemnify this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given an opportunity to ask questions; that I have received a copy of the signed authorization; that I may inspect a copy of my protected health information to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original.

By Patient: _____ Date: _____
Print Name

_____
Sign Name

or

Patient's Representative: _____ Date: _____
Print Name

_____

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GP Associates

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Demographics Yearly Update

Please complete the following information

Client Name _____ Birthdate _____

Address _____

City _____ State _____ Zip _____

Billing Address (if different from above): _____

Phone - Home _____ Work _____ Cell _____

Emergency Contact_____

Name Relationship Phone number

Is there any concerns about our office contacting you by phone or mail? YES NO

Please explain _____

Policy Holder Name _____ Birthdate _____

Address (if different from client) _____

Medical Insurance Co _____ Employer _____

EAP/ Mental Health Company (if different from above) _____

Insurance ID Number (SSN if private pay or EAP) _____

Is there secondary insurance? _____

Relationship to client _____

PLEASE COMPLETE IF CLIENT IS A MINOR

Father's name _____ SSN _____

Father's Address _____ Phone Number _____

Employer _____ Date of Birth _____ Work Phone _____

Mother's name _____ SSN _____

Mother's Address _____ Phone Number _____

Employer _____ Date of Birth _____Work Phone _____

BY SIGNING BELOW, I AUTHORIZE THE RELEASE OF INFORMATION NECESSARY TO PROCESS MY INSURANCE/ EAP/ MANAGED CARE/ DDS CLAIM AND I ACKNOWELDGE FINANCIAL RESPONSIBILITY FOR THIS ACCOUNT

Client Signature _____ Date _____

Authorized Signature for a Minor _____ Date _____

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APPOINTMENTS

The therapy session will be 45-55-minute session (one appointment hour). **Once an appointment hour is scheduled, you will be expected to pay for a late cancellation unless you provide 24 hours advance notice of cancellation [unless we both agree that you were unable to attend due to circumstances beyond your control].* It is important to note that insurance companies do not provide reimbursement for cancelled sessions***

You will be responsible for $50 for the first missed appointment and $105 for any subsequent missed appointments. If this is a continuing pattern, your care may be discontinued in our clinic and we would provide you with referrals to other mental health clinics.

If patient is a Medicaid patient by state law we cannot charge for missed appointments. If a Medicaid patient no shows for an appointment they will be eligible to be discharged from therapy services and a referral will be provided to other mental health professionals.

We make every effort to make reminder calls, texts, or email if you give us permission and provide the valid information. However, reminder calls are a **courtesy**. We are not responsible in the event that you do not receive your reminder call, text, or email for any reason. Not receiving a reminder call regarding an appointment **does not** absolve your responsibility in terms of our missed appointment / no show policy.

The patient is responsible for contacting the office with any changes in phone numbers, addresses, insurance information, and legal issues pertaining to minor children.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE RECEIVED THIS AGREEMENT AND READ THIS AGREEMENT AND ARE CONSENTING TO TREATMENT WITH GRINSTEAD, PIERCE AND ASSOCIATES. IT ALSO INDICATES THAT YOU AGREE TO THE TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

We require any one 14 and older to sign this agreement. For all minors, 18 and younger, a parent/guardian must also sign.

_____ _____

Signature of Patient Date

_____ _____

If Minor Signature of Parent/Guardian Date

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INFORMED CONSENT/WAIVER FOR NON-COVERED, NON-THERAPY, OR UNUSUAL SERVICES

We would like you to know that not all services we provide are covered by insurance, and we would like you to be aware of our policies regarding these services. We will do our best to remind you if we receive a request to provide any services of this nature. We will not release any information without proper signed releases of information from all parties involved in therapy. We may also request that you sign a separate consent for certain specific services.

Some specific examples of non-covered services include but *are not* limited to:

Preparation for any services requested in regard to litigation
Testimony in court and time spent waiting to testify or present requested information.
Deposition for any litigation
Reports in regard to any litigation
Any services in response or regard to litigation
Any fees associated with protecting your medical record including but not limited to:
Filing a motion to quash a subpoena
Letters (to attorney, school, law enforcement, DHS and others)
Reports (conciliation, school, etc.)
Meeting with attorneys and others
Associated travel for any non-covered services
School staffings, meetings with teachers and other school personnel, etc.
Conciliation
Specific phone consultations that do not include therapy
Requested medical records, summaries, reports, etc.
Time blocked out for anything on this list (even if it is cancelled within 24 hours)

SERVICES IN REGARD TO LITIGATION: WE REQIRE PREPAYMENT IN FULL FOR ANY SERVICES IN REGARD TO LITIGATION. FEES FOR THESE SERVICES ARE $200.00 PER HOUR. When possible, we will provide you with an estimate regarding costs for these services.

I understand that I will be billed for the therapist's time and I acknowledge responsibility for paying for these services in full.

_____ _____

Signature of client or guardian Date signed

Print client name:_____

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ADDENDUM TO CONSENT FOR COUPLES OR FAMILY OR GROUP THERAPY

When there is more than one person in the room with the healthcare professional there is a "limit of confidentiality." Anyone in the room could choose to speak about the session to outsiders. Although all parties should treat information shared as confidential, it is equally important that all parties involved know that confidentiality is limited.

Parents, by signing below, you are consenting to being quoted or discussed in your children's psychotherapy notes, intake or history.

Further, if any one of the parties requests copies of the chart it will require the signature of all parties that signed the original "informed consent" before any information will be released.

To maintain and protect the therapeutic process, I ask that you sign below. By signing you are also agreeing to *not* ask for records of these group/couple/family sessions to be released for any legal/litigation purposes.

_____

Print name

_____

Signature Date

_____

Print name

_____

Signature Date

_____

Print name

_____

Signature Date

_____

Print name

_____

Signature Date

_____declined to sign this addendum on this date: _____

_____ Therapist initials

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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ___ _____

Signature of Privacy Officer

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MINOR CHILD CHECKLIST DATE:_____

CHILD'S NAME:_____ APPT. DATE:_____

PARENT'S NAME(S):_____

□ If your child is adopted we will need adoption paperwork to verify custody

ARE YOU AND THE OTHER PARENT MARRIED SEPARATED DIVORCED

(IF MARRIED AND COMING TOGETHER, YOU CAN SKIP THE REST OF THIS CHECKLIST)

□ If divorced, we will need a copy of the decree at or before the 2nd session

□ What are the custody arrangements? JOINT CUSTODY PRIMARY CUSTODY

OTHER_____

□ Who will be attending the appointments? _____

□ We always encourage both parents to be involved in therapy for a child. Will you notify the other parent? YES NO _____

_____

□ Is there litigation pending at this time? YES NO

If yes understand that the therapist in not agreeing to be an expert witness or to testify at any deposition, court proceeding, or in any other way.

□ If there is joint custody or any type of shared custody, it is our understanding that each parent has the ability to give their consent for medical treatment of a child unless the court has specified in the order that the consent of both parents is required. Each parent can know about all appointments and treatment of the child. If either parent calls our office to inquire about appointments or treatment, we are obligated to release that information. We will always encourage both parents to be involved in the treatment of a child. We will not take sides or be involved in any pending litigation. The therapists are not inclined to abandon the patient by a quick and clinically unwarranted termination of treatment because one of the parents is upset.

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Name_____ Date of Birth _____

Childhood Developmental History

(Please complete if client is 18 years old or younger)

1). Please list any allergic reactions to things the client may have:

_____

2). List any significant injuries while growing up?

_____
_____
_____

3). List any ***past or present*** serious health diseases? (chicken pox, whooping cough, pneumonia, etc..)

_____
_____
_____

4). List any ***past or present*** chronic health problems (asthma, ear infections, etc.)

_____
_____
_____

5). List any hospitalizations and briefly explain the reason why?

_____
_____
_____

6). Were developmental milestones met appropriately? Yes☐ No☐ (If No then identify what delays occurred):

_____
_____

7). What type of social interaction does your child engage in?

☐Normal ☐Isolates self ☐Very Shy ☐Alienates Self ☐ Dominates others

☐Inappropriate Sex play ☐Associates with acting out peers ☐ Other _____

8). Does your child have any intellectual / academic disabilities?

☐Normal Intelligence ☐High Intelligence ☐Learning Problems ☐Underachieving ☐Authority conflicts ☐Attention conflicts ☐mild retardation ☐Moderate retardation

☐Severe Retardation ☐Other _____

9). Does or has your child exhibited any of the following emotional/behavioral problems? (Please check all that apply)

☐ None	☐ Repeats words of other	☐ distrustful
☐ Drug use	☐ Not trustworthy	☐ extreme worrier
☐ Alcohol abuse	☐ hostile/angry mood	☐ self-injurious acts
☐ Chronic Lying	☐ indecisive	☐ impulsive
☐ Stealing	☐ immature	☐ easily distracted
☐ Violent temper	☐ bizarre behavior	☐ poor concentration
☐ Fire-setting	☐ self-injurious threats	☐ often sad
☐ Hyperactive	☐ frequently tearful	☐ breaks things in anger
☐ Animal cruelty	☐ lack of attachment	☐ Assaults others
☐ Disobedient		

☐ Other_____