Licensed Psychologists
Robert F. Calhoun, Ph.D.
Michael D. Johnston, Ph.D.
Brett Thomas, Ph.D.
Jason D. Gage, Ph.D.

Mountain States
Counseling & Psychological Services

Date:_____

Patient name: _____
Last First M.I.
Preferred name (if different):_____
Date of Birth: _____ Age: _____
Sex assigned at birth: M/F Gender identity:_____
Social Security #: _____ Marital Status: _____

Address:_____
City: _____ State: _____ Zip: _____
Home Phone: _____Cell: _____Work Phone: _____
Employer: _____
Employer Address: _____

Responsible Party:

Parent/Guardian 1: _____ Date of Birth: _____
Social Security #: _____ Relationship to patient: _____
Address: _____
City: _____ State: _____ Zip: _____
Preferred Phone #: _____ Work #: _____

Parent/Guardian 2: _____Date of Birth: _____
Social Security #: _____ Relationship to patient: _____
Address: _____
City: _____ State: _____ Zip: _____
Preferred Phone #: _____ Work #: _____

PLEASE HAVE OFFICE STAFF COPY INSURANCE CARD(S) AND PICTURE ID

Insurance Information

Although we have made copies of your insurance card(s); please fill out the below information

Primary Insurance: _____
Card/Policy Holder Name: _____ Date of Birth: _____
Social Security #: _____ Employer: _____
Policy/Member ID #: _____ Group/Account #: _____

Secondary Insurance: _____
Card/Policy Holder Name: _____Date of Birth: _____
Social Security #: _____ Employer: _____
Policy/Member ID #: _____Group/Account #: _____

Primary Care Physician: _____ Phone #: _____Fax: _____
Referring Physician: _____ Phone #: _____ Fax: _____

If applicable

Do you have an attorney helping with your case? Yes / No
Attorney Name: _____ Phone #: _____ Fax: _____
Address: _____

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Client Information

Confidentiality: Information exchanged during therapy or testing is confidential and will not be revealed or disclosed without written consent except where law has required disclosure. As Mental Health Professionals, we are legally obligated to report any observed or suspected abuse, neglect or abandonment of another. Should a client present a serious danger to themselves or others, we must notify local authorities.

Worker's Compensation Claims: I understand that if I am a worker's compensation claimant, there is a high possibility that my treating psychologist will be interacting with my attending physician(s), as well as other treating team members/providers (i.e. physical therapist, occupational therapist, etc.)

Cancellation: I agree to notify the office ***at least 24 hours*** before my appointment time if I intend to cancel or reschedule for any reason. I understand that I will be obligated to pay ***half the cost*** of the missed session if I do not call ***24 hours*** in advance.

Acknowledgement: I understand that my insurance may not cover the entire cost of my visit and/or testing portion of my visit. I also acknowledge being informed of such and agree to pay for portions not recognized or paid for by my insurance.

I AUTHORIZE TREATMENT AND AGREE TO OFFICE POLICIES.

Print Name: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

3380 W. Americana Terrace, Ste. 320 Boise, Idaho 83706 Fax (208) 323-1850 Phone (208) 375-6402

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BILLING POLICIES

As a courtesy, Mountain States Counseling & Psychological Services (MSCPS) is happy to ***assist*** with billing your insurance. ** Please note that we may or may not participate in your insurance company's network. ** ***Please also note that it is the patient's responsibility for any charges on their account to be paid in full***. If you choose not to have us bill your insurance for your services, we will not in the future, reverse your payments and then bill insurance. In some cases, network companies may deny or reject charges for referred services. It is common for networks to inform their customers (our patients) that if they reject or deny a claim or any charges, that they do not have to pay. It is agreed, that by signing this authorization/acknowledgement, that you, the patient will agree to pay any charges that the insurance company denies, regardless of circumstances and/or if your insurance company denies payment stating your services were not medically necessary. If your insurance does not pay within 90 days, you will be fully responsible for the full balance of your account. MSCPS does use a collection agency after 90 days if your account remains unpaid.

MSCPS also wishes to inform you that we are a teaching center, and may or may not have service extenders practicing under the Supervision of qualified individuals. It is common in that case to see a Supervising Doctor listed on billings to/from your insurance company or account billing information.

MSCPS will not bill insurances for any services that are related to legal, and/or not medical necessity.

I have read and understand the information on this page.

Signature:_____ Date:_____
Patient or patient Guardian

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Counseling & Psychological Services

This document contains important information about our professional services and business policies. We will also provide summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. The Notice, along with our privacy policies will be given to you.

MEETINGS

Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

PROFESSIONAL FEES

There is a session fee (45-50 minutes) for appointments. Other professional services will be billed by the hour or partial hour. Other services include report writing, telephone conversations, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require our participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party.

OFFICE HOURS

The office is usually open between 9 AM and 5 PM. If you leave a message we will make every effort to return your call on the same day you make it, with exception of weekends and holidays.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND HAVE BEEN GIVEN A DOCUMENT EXPLAINING OUR RECORD KEEPING POLICY.

Client (Parent/Guardian) Date

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HEALTH CARE INFORMATION POLICIES

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by the Health Insurance Portability and Accountability Act (HIPAA) and/or Idaho law. However, in the following situations, no authorization is required:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patient. We will note all consultations in your Clinical Record.
- You should be aware that we practice with other mental health professionals and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

There are some situations where we are permitted or required to disclose information without your Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services we provided, such information is protected by the psychologist-patient privilege law. We cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.
- If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.
- If a patient files a worker's compensation claim, we may be required, upon appropriate request, to provide all clinical information relevant to or bearing upon the injury for which the claim was filed.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a patient's treatment. These situations are unusual in our practice.

- If we have reason to believe that a child under the age of eighteen (18) years has been abused, abandoned or neglected or you have observed the child being subjected to conditions or circumstances which would reasonably result in abuse, abandonment or neglect, the law requires that we file a report with the appropriate government agency, usually Idaho Department of Health and Welfare. Once such a report is filed, we may be required to provide additional information.
- If a patient communicates an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such a threat, we may be required to take protective actions. These actions may include notifying the potential victim and contacting the police, and/or seeking hospitalization for the patient.
- If we believe that there is imminent risk that a patient will inflict serious physical harm or death on him/herself, we may be required to take protective actions. These actions may include attempting to hospitalize the patient, calling the police or contacting family members or others who can assist in protecting the patient.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit our disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not an attorney's office. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, we keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem affects your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance

carrier. Except in unusual circumstances where we believe that access would seriously endanger you or others or the record makes reference to another person (other than a health care provider) and we believe that access is reasonably likely to cause substantial harm to said other person or where information has been supplied to us confidentially by others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing.

We have a copying fee of $2.00 per page. The exceptions to this policy are explained below. If we refuse your request for access to your Clinical Records, you have a right of review (except for information supplied to me confidentially by others), which we will discuss with you upon request. In addition, we also keep a set of Psychotherapy Notes. These notes are for our own use and are designed to assist us in providing you with the best treatment. Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written and signed Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of Protected Health Information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of Protected Health Information that you have neither consented to nor authorized; determining the location to which Protected Information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes our policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, we will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. We will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless we feel that the child is in danger or is a danger to someone else, in which case we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

TELEHEALTH

Telehealth, which is the practice of delivering clinical health care services via technology-assisted media or other electronic means between a practitioner and a client who are located in two different locations, may be offered if your provider deems it appropriate to do so. If telehealth services are offered, only HIPAA-compliant platforms will be used. While all efforts will be made to offer a strong and secure connection, there are potential risks including the session being disrupted by technology failures, service interruption, breaches of confidentiality by unauthorized persons (you should ensure you are in a private location), and/or limited ability to respond to emergencies. There will be no recording of any of the online sessions by any party. All confidentiality and privacy laws associated with in-person services outlined above also pertain to telehealth.

NONDISCRIMINATION

Mountain States Counseling and Psychological Services does not discriminate against any person on the basis of race, color, national origin, disability, age, sex, or gender identity in admission, treatment, or participation in its programs or services.

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RELEASE/EXCHANGE OF INFORMATION

Patient Name: _____ **Date of Birth:**_____

This is to authorize the release/exchange of information regarding the above stated patient between the following parties:

_____ **To/From:**_____
Mountain States Counseling & Psych Services _____
3380 W. Americana Terrace, Ste 320 **Phone:**_____
Boise, Idaho 83706-2549 **Fax:** _____

Records of information to be sent from your current file or received from the party indicated:

_____ **Psychological Evaluation** _____**Neuropsychological Evaluation**
_____ **Therapy Notes** _____**ALL AVAILABLE RECORDS**
_____ **Telephone Consult** _____ **Other (specify)**
Dates to be included: From:_____ **To:**_____
Reason for request: _____

The undersigned hereby consents to the release of the above stated information.
Signature: _____

Date: _____ **Relationship to Patient:** _____

Witness: _____ **Date:** _____

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 psychologist 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 you information and no longer protected by the HIPAA Privacy Rule.

Federal regulations, 42 C.F.R.2.1 (1996) prohibits the release of "alcohol or substance abuse information" without the consent of the patient.