KNOWLES-DUNCAN & ASSOCIATES, LLC

PATIENT NAME: _____

Responsible Party Name: _____

Do you prefer to be called a different name? If so, what: _____

DATE OF BIRTH: _____/_____/_____ AGE: _____ SSN: _____-_____-_____

SEX: MALE / FEMALE

ADDRESS: _____

CITY_____ STATE_____ ZIP CODE_____

CELL PHONE: _____

EMAIL ADDRESS: _____

PRIMARY CARE PHYSICIAN: _____ PHONE #: ( )_____

ADDRESS: _____

_____

PERSON TO CONTACT IN CASE OF EMERGENCY:

NAME: _____ RELATIONSHIP: _____

PHONE: _____

Psychiatric Services Informed Consent

I do voluntarily consent to care and treatment by : Dr. Judi Knowles, Amanda Roberts, PMHNP-BC, Doris May, PMHNP-BC; and/or Cathy Appleton, LCSW.

- Be treated with respect and recognition of my dignity and right to privacy
- Receive care that is considerate and respects my personal values and belief system
- Personal privacy and confidentiality of information
- Receive information about my managed care company's services, practitioners, clinical guidelines, quality improvement program and patient rights and responsibilities
- Reasonable access to care, regardless of my race, religion, gender, sexual orientation, ethnicity, age or disability
- Participate in an informed way in the decision making process regarding my treatment planning
- Discuss with my treating professionals appropriate or medically necessary treatment options for my condition regardless of cost or benefit coverage
- Have family members participate in treatment planning and if I am over the age of 12 to participate in such planning
- 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
- An adequate number of competent, qualified and experienced professional clinical staff to supervise and carry out the treatment or program plan
- Participate in the consideration of ethical issues that arise in the provision of care and services, including
- Resolving conflict
- Withholding resuscitative services
- Forgoing or withdrawing life-sustaining treatment
- Participating in investigational studies or clinical trials
- Designate a surrogate decision maker if I am incapable of understanding a proposed treatment or procedure or am unable to communicate my wishes regarding care
- Be informed, along with my family, of my rights in a language I/we understand
- Voice complaints or appeals about my managed care company, provider of care or privacy practices
- Make recommendations regarding my managed care company's rights and responsibilities policies
- Be informed of rules and regulations concerning my own conduct
- Be informed of the reason for any utilization management adverse determination including the specific utilization review criteria or benefits provision used in the determination
- Have utilization management decisions based on appropriateness of care
- Request access to my Protected Health Information (PHI) or other records that are in the possession of my managed care company
- Request to inspect and obtain a copy of my PHI, to amend my PHI or to restrict the use of my PHI, and to receive an accounting of disclosures of PHI

I understand that I am responsible for:

- Providing (to the extent possible) my treating clinician and managed care company with information needed in order to receive appropriate care
- Following plans and instructions for care that I have agreed on with my treating clinician
- Understanding my health problems and participating, to the degree possible, in developing, with my treating clinician, mutually agreed upon treatment goals
- Attendance at scheduled appointments and cancellations within 48 hours of scheduled appointments are necessary to meet and maintain treatment goals.

Knowles-Duncan & Associates, LLC is not a crisis office. In the event that you feel you are in crisis DIAL 911 or go directly to the nearest emergency room. **We do not accept walk-ins.**

MEDICATION REFILLS - Medication refills should be addressed at the time of your appointment and will be provided until your next scheduled appointment. If due to unforeseen circumstances you will run out before your next scheduled appointment you must contact the office by calling 317-776-3310.

Controlled substances must be taken as prescribed. Under no circumstances will controlled medications be refilled early.

MEDICATION QUESTIONS, LAB RESULTS, AND OTHER MEDICAL CONCERNS SHOULD BE HANDLED DURING APPOINTMENTS.

SCHEDULE/CANCEL APPOINTMENTS – You can schedule or cancel an appointment by calling our office at 317-776-3310. Please remember that we require a **48-Hour** advance notice for all cancellations.

MEDICAL RECORDS - All requests for medical records will be charged according to Indiana State Law Code 16-39-9-3. Payment is due prior to the processing of your request. There is no charge for records released to another healthcare professional for treatment purposes. A current written release of information is required for all requests.

COMPLETION OF FORMS - A fee of **$50** *per every 15 minutes of time* required to complete paperwork will be charged for all forms (including but not limited to return to work, disability, FMLA, life insurance, etc). Payment in full is required prior to the release of the completed paperwork.

BILLING AND INSURANCE – Please refer to Knowles-Duncan & Associates, LLC financial policy for details associated with billing and insurance. Acceptable methods of payment include cash, check, and credit/debit cards including VISA and MasterCard. If at any time you have a question on your account, please feel free to contact our billing department at 317-776-3310.

KNOWLES-DUNCAN & ASSOCIATES, LLC FINANCIAL POLICY
Updated 01/01/2024

All fees are due at the time of service. Acceptable forms of payment include cash, check, credit card (Visa/MC) and health savings accounts/flex spending accounts.

For therapy patients ONLY: Knowles-Duncan Associates, LLC (KDA) can file claims upon your behalf with your primary insurance company upon submission of proof of insurance; however, the patient is ultimately responsible for all charges incurred with KDA.

It is the patient responsibility to verify that any/all providers with whom they are scheduled participate in their provider network. Patients will be responsible for all charges incurred as a result of services rendered with an out-of-network provider. At the time of service if the patient is unable to provide proof of insurance, payment will be due in full. Patients will be unable to schedule future appointments with outstanding or past due balances. KDA will not provide services to any patient with accounts in violation of the financial policy. Patient is responsible for all charges deemed non-covered by your insurance company. i.e. forensic time, prescription refill charges, patient assistance, medical record charges, report/paperwork fees, telephone consultations, etc.In an effort to provide the best patient care and to maximize appointment time physicians and counselors will not discuss financial matters, all questions and inquiries must be directed to the office staff or Practice Administrator, they will be happy to help.

Fee schedule is as follows:

Dr. Knowles Fees

New Patient Evaluation $475
Medication Follow Up (60min)$450
Therapy/Extended Medication Follow Up (40min) $300
Medication Management Follow Up (20 min) $150

Counselor Fees:

New patient Evaluation $175 Therapy/Extended Therapy Session $125

Nurse Practitioner Fees
New Patient Evaluation $350
Medication Follow up $125 or $250 (20-30min or 40-60min)

New Patients: New patients for **Dr. Knowles** are required to pay a $200 deposit in advance. The deposit will be applied to the patient's account following your first appointment. All deductibles, co-pays/co-insurances are due at the time of service. We require a 48 hour (2 business days) notice for all cancellations. Failure to attend your initial appointment (or if you cancel for any reason without proper notice) will result in the patient being responsible for full amount due of scheduled appointment.

The deposit is usually paid by credit card unless otherwise arranged. By providing KDA with your credit card account information for your deposit grants KDA permission to charge this said account for any initial appointments that are missed or cancelled appointments without proper noticeAll checks returned to KDA for non-sufficient funds will result in a $35 processing fee. The original check amount plus the processing fee must be paid immediately.

Statements reflecting the “amount due” will be mailed on or around the 15th day of each month. Payment in full is due upon receipt of the statement.

KDA requires a 48-HOUR (2 business days) ADVANCE NOTICE FOR CANCELLATIONS. If a patient arrives late for their appointment they may need to reschedule as well as be responsible to pay for the entire appointment. In the situation when the patient misses an appointment without proper notice they will be responsible for full amount due for set appointment. If KDA is able to fill that appointment no charges will be assessed to the patient. If severe weather requires our office to close or if our office closes for any reason the patient will NOT be charged for a missed/late-cancelled appointment. Multiple late arrivals, missed or late-cancelled appointments will result in an inability to continue to provide services to you.

Accounts in violation of our financial policy are subject to placement with a third party collection agency. The patient will then be responsible for reasonable attorney and collection fees.

If you are detained or incarcerated we will not be able to provide services to you. We will attempt to help you locate an establishment who can provide services.

Forensic / Court / Legal - A $1000.00 retainer fee is required. Hourly individual provider fees may very however, these fees will have a minimum of two times the provider base rate. Payment in full is due at the time of scheduling. Fees are non-refundable unless cancelled 2 business days in advance.

BY MY SIGNATURE BELOW:

I HAVE READ AND UNDERSTAND THE PATIENT RIGHTS & RESPONSIBILITIES/FINANCIAL POLICIES AND INFORMED CONSENT OF KNOWLES-DUNCAN & ASSOCIATES

I AUTHORIZE MY PROVIDER TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIM TO MY INSURANCE COMPANY AND TO RECEIVE PAYMENT FROM MY INSURANCE COMPANY FOR SERVICES RENDERED BY KNOWLES-DUNCAN & ASSOCIATES, LLC.

I AGREE AND CONSENT TO PARTICIPATE IN THE MENTAL HEALTH SERVICES OFFERED AND PROVIDED BY KNOWLES-DUNCAN & ASSOCIATES, LLC., A MENTAL HEALTH PROVIDER AS DEFINED IN INDIANA LAW. I UNDERSTAND THAT I AM CONSENTING AND AGREEING ONLY TO THOSE SERVICES THAT THE ABOVE NAME PROVIDER IS QUALIFIED TO PROVIDE WITHIN: (1) THE SCOPE OF THE PROVIDER’S LICENSE, CERTIFICATION, AND TRAINING; OR (2) THE SCOPE OF THE LICENSE, CERTIFICATION, AND TRAINING OF THESE MENTAL HEALTH PROVIDERS DIRECTLY SUPERVISING THE SERVICES RECEIVED BY THE PATIENT.

I HAVE RECEIVED THE PRACTICE’S NOTICE OF PRIVACY PRACTICES AND UNDERSTAND THAT MY PROTECTED HEALTH INFORMATION MAY BE USED BY THE PRACTICE AS DESCRIBED IN THE NOTICE.

Patient Signature or Personal Representative _____

Date _____

Description of Personal Representative’s Authority_____

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH

INFORMATION TO PRIMARY CARE PHYSICIAN

PATIENT NAME: _____ D.O.B._____

ADDRESS: _____ PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

******PLEASE CHOOSE ONE OF THE FOLLOWING OPTIONS ******

[ ] I do NOT want any information released to my Primary Care Physician

[ ] I authorize Knowles-Duncan & Associates, LLC, Inc to release my protected health information to my PCP

PLEASE NOTE: Without complete information below will be unable to process your request. Dr: _____

Address: _____ City_____ State____ Zip_____

Phone: _____ Fax: _____

I understand that this request will be valid for one hundred eighty (180) days from the date written below. At that time the request will be void and no further information will be furnished pursuant to it.I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Knowles-Duncan & Associates, LLC. I understand that a revocation is not effective to the extent that Knowles-Duncan & Associates, LLC has relied on the use or disclosure of the protected health information.This release prohibits redisclosure except in accordance with 42 C.F.R., 21 et seq., which is a federal regulation governing release and use of patient record information pertaining to treatment for alcohol and drug abuse.

Knowles-Duncan & Associates, LLC. will not condition my treatment whether I provide authorization for the requested use or disclosure.

I agree to pay. KNOWLES-DUNCAN & ASSOCIATES, LLC an actual cost incurred in preparing and delivering the information requested herein. A copy of this authorization shall be as valid as the original.

I understand that I have the right to:

● Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights)

● Refuse the sign this authorization

● Receive a copy of this authorization

Signature of Patient or Personal Representative_____

Description of Personal Representative's Authority_____

Date_____

WITNESS - Office Staff Signature & Date_____

INSURANCE FORM

Patient Name: _____ DOB: _____

PRIMARY:

Insurance Company: _____ Phone #_____

Insured Name: _____ DOB_____

ID#: _____ Group#: _____

Relationship to patient: _____ Insured SSN: _____

Employer: _____

SECONDARY:

Insurance: _____ Phone #_____

Insured Name: _____ DOB_____

ID#: _____ Group#: _____

Relationship to patient: _____ Insured SSN: _____

Employer: _____

Please be aware that mental health benefits may be separate from medical insurance benefits. If you are not familiar with your mental health benefits we would strongly suggest that you call your insurance company. You will be responsible for all charges that are not paid by your insurance.

It is your responsibility to:

1) Verify your coverage and benefit information

2) Verify that you are scheduled to see a provider in your network

3) Obtain authorization for services if required by your insurance

Our office will not contact your insurance company to verify, benefit information until after the provider has seen you.

Do you understand this disclaimer? [ ] YES [ ] NO

Patient Signature or Personal Representative _____ Date_____

PATIENT HISTORY QUESTIONNAIRE

Briefly describe the problems you are having and when they began:

_____

_____

_____

_____

MENTAL HEALTH HISTORY

Please list any psychiatrist, psychologist, or counselors you are currently in treatment with: [ ] NONE

_____

Please list any psychiatrist/counselors you have seen in the past and response to treatment? [ ] NONE

_____

_____

Please list any previous psychiatric hospitalizations or intensive outpatient programs: [ ] NONE

_____

_____

Please list all past psychiatric medications you have taken, dates, and response to each: [ ] NONE

_____

_____

_____

Please list any family history of mental health/substance abuse problems: [ ] NONE

_____

_____

Please list any other pertinent mental health information you would like us to know:

_____

_____

_____

_____

SYMPTOM CHECKLIST

Please check any symptoms you are experiencing

[ ] Addiction to _____
[ ] Anxiety
[ ] Appetite-Increase or Decrease
[ ] Avoidance of People
[ ] Body Pains
[ ] Change in Eating Habits
[ ] Compulsions
[ ] Concentration Problems
[ ] Dizziness
[ ] Fatigue
[ ] Fear of _____
[ ] Guilt
[ ] Hallucinations
[ ] Headaches
[ ] Hopelessness
[ ] Impulsivity
[ ] Indecisiveness
[ ] Irritability
[ ] Loneliness
[ ] Memory Problems
[ ] Mood Swings
[ ] Panic Attacks
[ ] Paranoid Feelings
[ ] Racing Thoughts
[ ] Restlessness
[ ] Sexual Difficulties
[ ] Sleeping Problems
[ ] Stomach Upset
[ ] Suicidal Thoughts
[ ] Tearfulness
[ ] Trembling
[ ] Weight Gain/Loss

SUBSTANCE USE HISTORY

Please describe your current and/or previous use of caffeine/alcohol/tobacco products/illegal drugs:

Type Used	*Current/ Previous*	*Amount Used*	*How often*	*Last Used*

GENERAL MEDICAL HISTORY

[ ] Head Injury	[ ]Heart Disease	[ ]Hepatitis	[ ]Hypoglycemia	[ ] High Fevers	[ ]Seizures
[ ] Lung Disease	[ ] Diabetes	[ ] Cancer	[ ] Thyroid problems	[ ] Liver Disease	[ ]HIV
[ ]Asthma	[ ] Hypertension	[ ] STD's	[ ] Memory problems	[ ] Kidney Disease	[ ] Arthritis
[ ] Chronic Pain	[ ] Headaches	[ ] Loss of Consciousness		[ ] Fibromyalgia	[ ] Meningitis

Other: _____

Please describe any checked items above, including age of onset:

_____

_____

_____

List all medications you are currently taking including the date started, dose, & the prescribing doctor:

_____

_____

_____

_____

_____

List the names and specialties of all the physicians who you are **currently** seeing:

_____

_____

_____

List any allergies or medication intolerance you have:

_____

List any hospitalizations/surgeries you have had in the past:

Date:_____ Hospital: _____ Reason: _____

Date:_____ Hospital: _____ Reason: _____

Date:_____ Hospital: _____ Reason: _____

Please list any family history of medical problems:

_____

_____

_ _____

Women Only

First day of your last menstrual period: _____ Number of days in cycle: _____

Age at first menstrual period: _____ Are your periods: Regular / Irregular

Total number of pregnancies_____ Children delivered: _____ Miscarriages/Abortions: ____

Do you currently use birth control: Yes No Method Used: _____

RELATIONSHIP HISTORY

Marital Status: never married married separated divorced remarried widowed

Please describe your current relationship, including any stressors:

_____

_____

If married, length of marriage: _____ Spouse's name _____

Number of previous marriages: _____ Number of previous long-term relationships: _____

Describe prior marriages/long-term relationships and the reason for the divorce or break up:

_____

_____

_____

List all people that are currently residing in your home and their relationship to you:

_____

_____

FAMILY - SOCIAL HISTORY

Where did you grow up? _____ Did your family move around? Yes / No

If yes, please describe: _____

_____

How many siblings do you have? ___ Half-Siblings? ___ Step-Siblings? _____

Which family member(s) are you close to? _____

Describe your childhood: _____

_____

_____

_____

Were you ever abused (physical, sexual, emotional) ?_____

_____

Has there been major losses, changes, or crisis in your life? Yes No

If yes, please describe: _____

_____

_____

_____

_____

EDUCATIONAL HISTORY

What is the highest grade you completed? _____
Did you receive any special education services? YES / NO
Did you have any discipline problems at school? YES / NO
How did you get along with your teachers and peers?
_____

MILITARY HISTORY

Have you ever served in the military? YES / NO If so, which branch? _____
Date of entry: _____Date of exit: _____ Highest rank achieved? _____
Were you stationed in a combat or other high risk zone? Yes or No
List any disciplinary action taken against you:_____
Type of discharge: _____

OCCUPATIONAL HISTORY

Are you currently employed? YES / NO If yes: FULL-TIME / PART-TIME
If yes, Where? _____

How long have you been there? _____ Current Position/Title:_____

Do you like your job? YES / NO Do you get along with your co-workers? YES / NO
Have you ever been laid off / fired? YES / NO
If yes, explain: _____
Longest job previously held - Where? _____How long? _____
Are you currently on disability? Yes/ No Are you currently applying for disability? Yes/No

RELIGIOUS/SPIRITUAL HISTORY

[ ] NONE [ ] CATHOLIC [ ] JEWISH [ ] PROTESTANT [ ] OTHER _____
I attend services: NEVER OCCASIONALLY MONTHLY WEEKLY MORE THAN ONCE A WEEK

LEGAL HISTORY

Have you ever been arrested for or convicted of a crime? YES / NO
If so, please list charges and results (probation, incarceration, fine, etc):
_____
_____
_____

KNOWLES-DUNCAN & ASSOCIATES, LLC

Notice of Privacy Practices for Protected Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or healthcare operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain both before and after the change. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment. You will be asked by your physician to sign this Notice of Privacy Practices. We will make a good faith effort to obtain a written acknowledgement that you received this Notice of Privacy Practices for Protected Health Information the first time we provide services to you after April 14, 2003 or as soon as reasonably practicable under the circumstances. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to obtain payment for your health care bills and to support the operation of the physician’s practice. Following are examples of the types of uses and disclosures of your protected health care information that the physician’s office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment. We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party that may need access to your protected health information. For example, we would disclose your protected health information, as necessary, to

Uses and Disclosures of Protected Health Information home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you.

For rexample, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.