Castillo Psychological, LLC

1605 S. Main St.
Las Cruces, NM 88005
Email: services@castillopsychological.com

Phone: 575-527-0614
Fax: 575-541-4062

INTAKE INFORMATION

Name______________________________ Social Security #__________________________

Date of Birth______________ Age______ Guardian (if applicable) _________________

Address____

City ___________________________State___________ Zip Code______________________

Home Phone__________________________ Cell___________________________________

Work Phone__________________________ Email__________________________________

Employer____________________________ School_________________________________

Highest Level of Education: ____

Referral Source: ____

Emergency Contact (name & number) ____

Please check if a message can **NOT** be left at the following number:

Home phone___ Cell Phone___ Work phone___

Medical Information

Primary Physician ________________________ PCP Phone _______________________

Medication ____

Medical Concerns ____

FINANCIAL INFORMATION

Primary Insurance: ____

Member ID #: ______________________ Group ID #: __________________

Secondary Insurance: ____

Member ID #: ______________________ Group ID #: __________________

Guardian and/or Policy Holder and relationship to client

____

Guardian/Policy Holder's Social Security Number: _____________________________

Guardian/Policy Holder's Date of Birth: ____________________________________

Consent to Bill Insurance:

1. I authorize use of this form to release information for all my insurance submissions.
2. I understand I am responsible for the full amount billed for services provided.
3. I understand I am expected to pay the deductible, co-pay or outstanding balance at the time of service.
4. I authorize direct payment from the insurance company to this provider.
5. I permit a copy of this authorization to be used in place of the original.

____ ________________

Responsible Party Signature Date

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. *Please Read Carefully.*

Treatment: Mental health providers do not disclose information to other health care professionals without your written consent.

Payment: Your health information may be used to seek payment from your health plan. For example, your health plan may request and receive information regarding your dates of service, services provided, and the medical condition treated. Should your account become delinquent, your information may be used to seek payment through a collection agency.

Communication: All communication is kept confidential. If you choose to communicate via text message or e-mail you understand this cannot be guaranteed confidentiality. Only communication via e-mail or text is to schedule, change, or cancel appointments. If you review or post any information on our website or social media, we are not responsible for your name being associated with Castillo Psychological.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities of this mental health practice. For example, information on the services you receive may be used to support budgeting and financial reporting and activities to evaluate and promote quality.

Law Enforcement: Your mental health information may be disclosed to law enforcement when a legitimate subpoena or court order is presented. Further, information regarding physical, sexual or emotional abuse of a child or an elderly person and potentially imminent suicide and/or homicidal behavior, may be released to law enforcement without your knowledge.

Licensing Boards: Revelation that another mental health provider has engaged in a sexual relationship with a client must be reported to the licensing board for that provider. The client involved may remain anonymous in such a report.

Additional Uses of Information: Mental health professionals in this office do NOT mail appointment reminders. Your health information will not be used to provide you with information about treatments through the mail and will not be used for fundraising purposes.

Other Uses that Require Your Authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Individual Rights: You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your protected health information.
2. The right to receive confidential communications concerning your medical condition and treatment.
3. The right to inspect and copy your protected health information.
4. The right to amend or submit corrections to your protected health information.
5. The right to receive an accounting of how and to whom your protected health information has been disclosed.
6. The right to receive a printed copy of this notice.

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.
Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal or state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice. The revised policies and practices will be applied to all protected health information that we maintain.

Request to Inspect Protected Health Information: As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Dr. Janette Castillo, Ph.D.
1605 S. Main
Las Cruces, NM 88005

If you believe that your privacy rights have been violated, you should call the matter to my attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person: The name and address of the person you can contact for further information concerning our privacy practice is:

Dr. Janette Castillo, Ph.D.
1605 S. Main
Las Cruces, NM 88005

Castillo Psychological, LLC

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I have been provided a copy of the Information to New Clients, Mental Health Policies and Procedures, and Privacy Practices. I agree to participate in treatment with

_____Janette E. Castillo, Ph.D.

____ ________________
Signature of Client Date

If the client is a minor: I am the legal guardian/custodial parent of

____________________________ and give my permission to Janette Castillo, Ph.D. and therapists employed at Castillo Psychological, LLC to provide psychological or counseling services to my child.

____ ___________________
Signature of Parent/Guardian Date