WSP

Washington School Of Psychiatry

Registration for Clinical Services

Date: _____

Name: _____ Birthdate: _____
Street: _____
City: _____ State: _____ Zip: _____
Email: _____ Phone:(C) _____

Social Security Number: _____- _____- _____

Relationship Status: Single ☐ Married ☐ Partner ☐ Separated ☐
Divorced ☐ Widowed ☐

Race (Optional)
White ☐ African American ☐
African ☐ Asian/Pacific Islander ☐

Ethnicity (Optional)
Hispanic ☐
Other Ethnicity-Print _____
Other Race-Print _____

Occupation: _____ Employed by: _____

Education: _____
(Highest Grade Completed)

By whom were you referred: _____

Your physician's name: _____
Address: _____ Telephone: _____

Are you currently receiving treatment for any physical illness? ☐
Please specify: _____

Are you currently under the care of another mental heath professional? ☐
Please specify: _____

Have you, or a family member, ever received services from the Treatment Center? ☐
If yes, Who? _____ When? _____

EMERGENCY CONTACT:
Name: _____ Address: _____
Phone: _____ _____

5028 Wisconsin Ave., NW, Suite 400 · Washington, DC 20016-4118
Phone: 202-537-6050 · Fax: 202-237-2730 · www.wspdc.org

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Washington School Of Psychiatry

GROSS ANNUAL INCOME: EMPLOYER:

Self _____ _____
Partner _____ _____

FAMILY MEMBERS:

NAME: AGE:

Self _____ _____
Partner _____ _____
Dependents _____ _____

PLEASE HAVE YOUR INSURANCE CARD XEROXED BY OFFICE STAFF

If you have insurance, we will submit the claims to the insurance company as a courtesy. We are out-of-network with all insurance companies except for Medicare. The initial fee for psychotherapy will be $200.00 and all 50 minute psychotherapy session fees are calculated by using a formula that takes into account family income and the number of dependent family members. In order to determine your fee and to assign you a therapist, we need the following information. Incomplete information will delay the process.

The initial psychiatrist visit will be $200.00 and all follow-up visits are $100.00 for 20 minutes and $125.00 for 30 minutes.
Patients coming from either the psychotherapy or psychiatry clinic will pay $100.00 for the initial visit.

I. INSURANCE COVERAGE

Name of Company: _____ Telephone: _____
Address: _____
I.D Number: _____ Group Number: _____
If insurance is held by another policy holder, please include: _____
Name _____ Social Security Number _____ Date of Birth_____

I HEREBY AUTHORIZE THE TREAMENT CENTER TO VERIFY MY INSURANCE BENEFITS:

_____ _____
Signature Date

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Washington School Of Psychiatry

STATEMENT/AGREEMENT OF TREATMENT CENTER PAYMENT POLICY

The patient is responsible for the full amount of payment for each therapy session at the time of the session. This is to be paid to your therapist or, in the case of a credit card payment, to the business office or the receptionist.

I, _____, understand and agree to abide by the payment policy outlined by the Treatment Center of the Washington School of Psychiatry on the _____ day of _____, 20 ____.

_____ _____

Signature Date

PATIENT AUTHORIZATION FORM

I, _____, hereby authorize the Washington School of Psychiatry to submit the necessary paperwork on my behalf to my insurance company and to request reimbursements that will be made directly to myself or the insured party.

I certify that the information I have reported about my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim to my insurance carrier.

This authorization may be revoked by me at any time in writing. I permit a copy of this authorization to be used in place of the original.

_____ _____

Date Signature of beneficiary

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Washington School Of Psychiatry

Notice of Therapist's Policies and Practices to Protect the Privacy of Your Health Information

I acknowledge the receipt of this document.

_____ _____

Patient/Client Signature Date

_____

Printed Name

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GENERAL INFORMATION FOR PATIENTS

PAYMENT OF FEES:
The Treatment Center is a private, non-profit clinic. Since our only source of income is from patient fees, we depend on patients' prompt and responsible payment for their treatment to maintain our financial stability.

Payment for each therapy session is expected at the time of the session. All patients are given a superbill to show receipt of current services. If a patient does not pay the fee for two consecutive sessions, therapy may be suspended until the full payment is received. Questions about payment should be discussed with one's therapist.
There will be a $50.00 charge for returned checks.

CANCELLATIONS:
Once an appointment time has been arranged, this time is reserved.

If an appointment is cancelled less than 24 hours before the scheduled appointment, the patient will be responsible for the full fee of the missed session.

PATIENTS ARE RESPONSIBLE FOR PAYMENT OF MISSED SESSIONS UNLESS A PRIOR ARRANGEMENT HAS BEEN MADE WITH THE THERAPIST.

CHANGE OF STATUS:
Fees are calculated on an adjustable scale based on income. If a patient's financial situation changes significantly, a new financial information form must be completed, and the fee will be modified accordingly. Please ask your therapist for a new financial information form if:

- your insurance coverage is changed or terminated,
- your family income increases or decreases, or
- the number of your dependents changes.

EMERGENCIES:
In case of an actual emergency, please call 911. If you need to leave a message after business hours, please call (202) 537-6050 to access your therapist's voicemail.

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Many TC therapists are involved in continuing education activities, some of which involve supervisory consultation.

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The Treatment Center has a building-wide "no smoking" policy.

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WASHINGTON, DC NOTICE FORM

Notice of Therapists' Policies and Practices to Protect the Privacy of Your 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.

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 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 our 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 [offices, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of our [offices, clinic, practice group, etc.], 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 am 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 conversations during a

private, group, joint, or family counseling session, which we have kept separate from the rest of your 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 without Authorization

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

- *Child Abuse* – If we know or have reasonable cause to suspect that a child known to us in our professional capacity has been or is in immediate danger of being a mentally or physically abused or neglected child, we must immediately report such knowledge or suspicion to the appropriate authority.

- *Adult and Domestic Abuse* – If we believe that an adult is in need of protective services because of abuse or neglect by another person, we must immediately report this belief to the appropriate authorities.

- *Health Oversight Activities* – If any of the DC oversight boards is investigating us or our treatment centers, we may be required to disclose PHI to the oversight board.

- *Judicial and Administrative Proceedings* – If you are 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 D.C. 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 we believe disclosure of PHI is necessary to protect you or another individual from a substantial risk of imminent and serious physical injury, we may disclose the PHI to the appropriate individuals.

- *Worker's Compensation* – If we are treating you for Worker's Compensation purposes, we must provide periodic progress reports, treatment records, and bills upon request to you, the D.C. Office of Hearings and Adjudication, your employer, or your insurer, or their representatives.

IV. Patient's Rights and Psychologist'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. You may be denied access to Psychotherapy Notes if we believe that a limitation of access is necessary to protect you from a substantial risk of imminent psychological impairment or to protect you or another individual from a substantial risk of imminent and serious physical injury. We shall notify you or your representative if we do not grant complete access. 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.

Therapists' Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our 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 the therapist intends to revise his/her policies and procedures, he/she must describe in the notice to patients how the therapist will provide patients with a revised notice of privacy policies and procedures (e.g., by mail, e-mail).

V. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on June 1, 2008

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