Masino
Mental Health
Services

**Patient Name:** _____ **Date**_____
First Middle Last

**Home Address:** _____
Street City State Zip

**Phone:** _____**home** _____**cell** _____**work**

**Social Security Number:**_____ **Date of Birth:** _____

**Email Address:** _____

**Marital Status:** ___ **Single** ___**Married** ___ **Other**

**Presenting Problem:** _____

**Responsible Party (*complete this portion if patient is a minor)***

**Name:** _____
First Middle Last

**Address:** _____
Street City State Zip

**Phone:** _____**home** _____**cell** _____**work**

**Social Security Number:**_____ **Date of Birth:** _____

**Email Address:** _____

**Marital Status:** ___ **Single** ___**Married** ___ **Other**

Thank you for choosing **Masino Mental Health Services, Inc.** We are interested in knowing how we were selected to serve you.
Please indicate how you were referred to us:

_____ Yellow Pages

_____ Friend/Relative

_____ Internet

_____ Other

_____ Physician

_____ Another Therapist

_____ Insurance Company

Theodore P. Masino, Psy.D. | Clinical Psychologist | FL. License: PY6920
1008 Airport Road, Ste. D | Destin, FL 32541 | PH 850-424-5210 | FX 850-424-3220

**Primary Insurance Information:**
*Please provide your insurance card so that we may have a copy on file.*

**Insurance Company:_____** **Policy ID/Member #: _____**

**Policy Holder's Name:_____** **Group Number: _____**

**Secondary Coverage**

**Company:_____** **Policy#:_____**

**IF TRICARE**

**Sponsor's Social Security: _____**

**____ Prime – Active Duty** **_____Prime – Retired** **_____ Standard – Active Duty** **_____ Standard Retired**

## *For Office Use Only*

**Insurance Co. Phone #: _____** **Date of Call: _____** **In Network : ___ Yes ___ No**

**Person Spoke with?_____** **Policy Effective Dates:_____**

**Insurance Pays:_____** **Co-pay:_____** **(or)** **Co-ins:_____**

**Deductible:_____** **Amount met to date:_____** **Yr. Begins_____**

**Yearly plan max # of sessions:_____** **Used:_____** **Dollar Amount:_____**

**Max out of Pocket:_____** **Amt. met to date:_____** **Lifetime Max:_____**

**Provider Type Covered:_____**

**Address for Claims:_____**

**Tricare:** **Standard____** **Prime_____** **Active Duty_____** **Retired_____**

**<u>Managed Care</u>**

**# Sessions Approved:_____** **Dates Covered:_____** **CPT Codes:_____, _____**

**Auth#_____** **Action for next auth._____**

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**Informed Consent for Mental Health Evaluation/Treatment**

Initials

_____ I hereby voluntarily consent to a mental health evaluation including psychological testing. I understand that these are primarily non-invasive, pencil-and-paper tests given for my benefit to better understand my health care condition. I know that the results and issues discussed are private and cannot be communicated to anyone else without my consent.
*(This is consent for your initial evaluation)*

_____ I hereby voluntarily consent to mental health treatment or rehabilitation. I understand that this primarily includes psychotherapy (talk therapy), either individually or with my family. I know that the issues I discuss are private and cannot be communicated to anyone else without my consent.
*(This is consent for your treatments after your initial evaluation)*

_____ I have been requested to participate in a court-ordered psychological evaluation/treatment program. The results of the evaluation or treatment progress will be reported to:

_____

_____ I voluntarily consent to the following Testing/Treatment:
*(This is consent for psychological testing for <u>yourself</u>)*

_____ I voluntarily give consent for my child to receive the following Testing/Treatment:
*(This is consent for psychological testing for <u>your child</u>)*

Name of Client/Patient: _____ SSN: ____/___/_____ DOB:___/___/_____

Date service is to begin: _____/___/_____

_____ _____
Signature of Client/Patient Date

Client/Patient is a minor_____ or is unable to consent because_____.

My relationship to the client/patient is _____ and I have signed this Consent on his/her behalf.

_____ Parent/Guardian Signature Date _____

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**Financial Policy**
Thank you for choosing Masino Mental Health Services, Inc. We are committed to your successful treatment. The following is our financial policy which we request that you read, understand, and sign prior to treatment.

**Insurance**
Your insurance policy is between you and your insurance company. We are not party to that contract. If your insurance plan requires authorization for outpatient mental health services, you must obtain this authorization prior to treatment, and provide our office with the referral/authorization number, the date range of authorized treatment, and the number of sessions authorized.
If services are not covered by your insurance policy, you are responsible for all session fees. We do accept assignment of benefits from insurance companies with which we are participating providers. All Tricare/Champus clients must obtain a doctor's referral in order to file the insurance claims.
If the client does not obtain a referral and insurance cannot be filed, the client is responsible for the entire session charge. We will file your insurance claims for you, either by paper claim or electronically, unless otherwise specified by you.

**Payments**
All payments, co-pays or deductibles are due prior to each session. Additional services will not be provided to clients whose balances exceed $100.00. Payments can be made by cash, check, money order, Visa or Master Card. If a payment or co-payment is not made at time of service, your signature below authorizes Masino Mental Health Services, Inc. to charge your credit card for the appropriate payment amount.

Initials: _____

**Appointment Cancellation Policy**
Staff members at Masino Mental Health Services, Inc. are committed to our patients and continue to accept new patients. A missed appointment is a missed opportunity and delay for another patient. Therefore, we require a credit card number to hold your appointment time. If for any reason you are unable to keep your appointment, please call at least one business day in advance to allow us to schedule another patient. A $60.00 fee will be applied otherwise. If more than two sessions are missed without proper notification, continued services will be re-evaluated. We appreciate your assistance in helping us serve you better by keeping scheduled appointments.
Please initial the appointment reservation statement below.

_____ I authorize a charge of $60.00 to my credit card if I do not make my scheduled appointment and fail to notify the office at least 24 hours in advance.

Type of Card: _____ M/C _____ Visa 16-digit credit card #:_____

Name as it appears on credit card:_____Exp.date:_____

Authorizing Signature:_____

**Billing**
Payment for all client statements is due in full upon receipt. Payment arrangements can be made in advance for some accounts. A divorce decree cannot assign responsibility for an adult's or child's account. Failure to pay your bill will result in your account being turned over to a collection agency. Only your account status will be discussed with the collection agency.

**Returned Checks**
A $30.00 service fee will be added to your account for each returned check from your bank. Only cash payments will be accepted if two NSF checks are received.
My signature below acknowledges that I have read, fully understand, and agree to all parts of the financial policy of Masino Therapy Services, LLC. I also understand that my account may be turned over to a collection agency if it becomes delinquent.

Signature of Client_____ Date_____

Signature of Parent/Guardian_____ Date_____

Witness _____ Date_____

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Masino Mental Health Services

**Notice to Patients Regarding Privacy of Health Information Practices**

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

**Understanding Your Health Record/Information**

Federal regulations developed under the Health Insurance Portability and Accountability Act (HIPAA) requires that this practice provide you with this notice regarding Personal Health Information (PHI). Each time you visit a healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information often referred to as your health or medical record serves as a:

- basis for planning your care and treatment
- means of communication among other health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third party payer can verify that services billed were actually provided
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

**Understanding what is in your record and how your health information is used helps you to:**

- ensure its accuracy
- better understand who, what, when, where, and why others may access your health information
- make more informed decisions when authorizing disclosure to others

Protected Health Information (PHI) is any health information created or received by your health care provider that contains information that may be used to identify you, such as name, address, telephone numbers, and account numbers, or your condition. It includes written or oral health information that relates to your past, present, or future mental health; the provision of health care to you; your past, present, or future payment for health care.

**Your Health Information Rights:**

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of the notice of information practices upon request
- inspect and copy your health record as provided for in 45 CFR 164.524
- amend your health record as provided in 45 CFR 164.528
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- request communications of your health information by alternative means or at alternative locations

**Our Responsibilities:**

The Practice is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice.

**Use and Disclosure of Protected Health Information in Treatment, Payment, and Health Care Options**

Your Protected Health Information (PHI) may be used and disclosed by this Practice in the course of providing treatment, obtaining payment for treatment, and conducting health care operations. Any disclosures may be in writing, electronically, by facsimile, or orally. Additionally, this Practice may also use your PHI to remind you of an appointment, inform you of potential treatment alternatives, and inform you of health-related benefits or services that may be of interest to you.

**Other Uses or Disclosures Permitted Without Authorization**

In addition to treatment, payment, and health care operations, our Practice may use or disclose your PHI without your permission or authorization in certain circumstances including:

- When legally required to comply with any Federal, state. Or local laws that involve disclosure of your PHI
- When there are risks to public health as permitted or required by law.
- To report abuse, neglect, or domestic violence if it is believed that the patient is a victim
- To conduct health oversight activities such as audits, or civil, administrative, or criminal investigations, proceedings, or actions
- For judicial and administrative proceedings authorized by an order of a court or administrative tribunal
- For law enforcement purposes
- To coroners, funeral directors, and for organ donation in such cases as identification, determination of cause of death, and/or performance in the medical examiner's duties authorized by law
- For research purposes if such use has been approved by an institutional review board or privacy board
- For specified government functions as authorized by HIPAA privacy regulations.
- In correctional institution situations when information necessary for your health, and the health and safety of other individuals

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**Notice to Patients Regarding Privacy of Health Information Practices**

If you have questions or would like additional information, you may contact the Privacy Officer at the following address:

Masino Mental Health Services, Inc.
1008 Airport Rd. Ste. D
Destin, FL 32541
ATTN: Privacy Officer

If you believe your privacy rights have been violated, you can file a complaint with the Director of Health Information Management or with the Secretary of Health Services. There will be no retaliation for filing a complaint.

My signature below indicates that I have been provided with a copy of the notice of privacy practices.

_____ _____
Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to Patient _____

**Distribution:** original maintained in patient record copy provided to patient upon request