



PsychEd Solutions, P.A.
 18425 NW 2nd Ave 5th Floor PH 13 MIAMI, FL 33169
 PHONE: (954) 257-7433 FAX: (877) 478-5333
 Email: psychedsolutions25@yahoo.com

DATE: _____

CONFIDENTIAL CLIENT REGISTRATION FORM

Last Name: _____ First Name: _____

DOB: ____/____/____ Age _____ Social Security #: _____

Gender: Male Female Trans M-F Trans F-M Other _____

Name of parent/guardian (if under 18 years): _____

Marital Status: Married Single Divorce Widow Separated Other Minor

Family Information: Single Mother Single Father Both Parents at Home Foster Care Parents

Ethnicity: Hispanic Origin Non-Hispanic Origin Race: _____ Preferred Language: _____

Religious Group: Catholic Christian Jewish Muslim Protestant Other: _____

Street Address: _____ City: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____
 May we leave a message? Yes No May we leave a message/text? Yes No

Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Are requested services mandated by court? No Yes

Case Worker's Name: _____ Work Contact #: _____ Cell#: _____

How did you hear about Baron Counseling Services, if referred by whom? _____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

Do you have a Primary Care Doctor? No Yes
 If Yes, Primary Care Physician's Name: _____ Phone #: _____

Are psychotropic meds being prescribed? No Yes If Yes, prescribed by: _____ MD RN CS/NP PCP

Current Medication(s): _____

Any previous mental health services (psychotherapy, psychiatric services, etc.)? No Yes, previous therapist/practitioner: _____

EMPLOYMENT INFORMATION

Employment Status: F/T P/T Retired Self- Employed Unemployed Other: _____

Annual Household Income: Under \$13,000 \$13,000-\$20,000 \$20,000-\$30,000 \$30,000-Above

School Status: Passing Failing Truant Drop Out Suspended Other: _____

Attending School: _____ Grade: _____

****PRACTICE POLICIES AND PROCEDURES****

Welcome & Thank you for trusting and choosing Psyched Solutions, P.A. Founded by Dr. Brinson, Psyched Solutions, P.A. offers effective outpatient, individualized solutions. We specialize in psychological and psychoeducational evaluations for children, teens and adults. We also treat several mental health disorders and provide neutral ground for individuals, couples and families. Our focus is on helping individuals heal, energize, and become aware of their inner strengths. We achieve this by providing a neutral, safe space; listening to your concerns and customizing an individualized treatment plan. Our goal is to help you grow from your struggles, heal from your pain and move forward to where you want to be in your life.

BILLING AND PAYMENT Your insurance policy is a contract between you and your insurance carrier. You are ultimately responsible for payment-in-full for all services Psyched Solutions, P.A. provided to you. Any charges not paid by your insurer will be your responsibility, except as limited by our contract (if any) with your insurance carrier. **Payment is required at each session.** The fee for your treatment and other services starts from \$75-\$2,800 per session. Except for very brief reports or messages, (up to 10 minutes). You will be charged for phone therapy, report writing, FMLA paperwork or other professional services. Many health insurance policies cover the services of psychotherapists. Some insurance coverage requires you to pay only co-pay at your visit **Copayments for office visits are due at the time of service; nevertheless, reimbursement varies considerably from policy to policy. Most policies have annual deductibles, co-payments and/or other benefit limits. Read your policy carefully and be aware of what is or is not covered.** You may wish to call the member services number on the back of your card to find out the details of your coverage. If you are having difficulty paying your bill, a payment schedule can be discussed. Patients who owe money and fail to make arrangements to pay may be referred to a collection agency.

MISSED APPOINTMENTS AND LATE CANCELS If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment. **After three “NO SHOW”** and or excessive late or last minute cancelled appointments, you will be discharged from our practice and we will no longer see you as a patient. **A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency.** A bill will be issued directly to all clients who do not show up for or cancel an appointment.

INSURANCE INFORMATION We participate in many but not all insurance plans. **It is your responsibility to contact your insurance company to verify that Angela Brinson (Rendering Provider) and/or Psyched Solutions, P.A.** participates in your behavioral health plan. Out of network charges may have higher deductibles and copayments. If your insurance carrier pays you directly, you are solely responsible for payment and agree to forward the payment to Baron Counseling Services immediately. If insured, it is your responsibility to ensure that services provided to you are covered benefits and authorized by your insurer. We are happy to answer any additional questions and make alternate financial arrangements if the situation warrants it.

EMPLOYEE ASSISTANT PROGRAMS If you are using your Employee Assistant Program (EAP) to pay for your counselling sessions, you must contact them to obtain a referral to **Angela Brinson and/or Psyched Solutions, P.A.** I cannot do this for you. You will be given a limited number of sessions. You should be clear on the number of sessions authorized. This counseling is provided at no cost to you; however, if you need continued counseling beyond the number of sessions authorized by your EAP or if you need mental health treatment beyond the scope of the type of counseling provided through the EAP, it will be your responsibility to determine whether or not those outside services are covered under your medical benefit plan and to pay any charges for services not covered by your medical benefit plan.

SLIDING SCALE: As a benefit to those who do not have health insurance, we are happy to offer sliding scale fees (10%-35%) for those who qualify. The amount by which your fees will be reduced depends on your gross income (\$30,000 or less). This discount may be applied to copayment, co-insurance, and/or deductible balances if applicable. Sliding scale discounts are offered based upon family/household size and annual income. *Please Note: Proof of income is required for sliding scale discount.

BY SIGING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client Name (Print) Signature of Client or Representative Date

INSURANCE & BILLING INFORMATION

PLEASE PRESENT INSURANCE CARD(S) & PHOTO ID FOR COPYING AND COMPLETE THE REQUESTED INFORMATION

Billing Type: Client Insurance EAP/Referral # _____ If using EAP/Referral Number of Sessions: _____
Type: Primary Secondary Other _____

Client's relationship to Insured: Self Spouse Child Other _____

Insurance Name: _____ Insurance Phone#: _____

Authorization #: _____ Policy #: _____ Group#: _____




Co Pay: \$ _____ Claims Address: _____

CREDIT CARD AUTHORIZATION

To better serve our clients and simplify your billing experience, our office offers credit card acceptance. Charge card information is filed with your confidential client information and kept secure.

Client Name: _____

Client Billing Address: _____

Type of Card:    

Card Number: _____

Expiration Date: _____ Security Code: _____
(last three digits on card, last four on AMEX)

The undersigned guarantees performance of the financial provisions of this agreement.

Card Holder Name: _____

Signature of Card Holder: _____ Date: _____

____ (initial) Being the authorized cardholder or the Corporate Officer, by signing above I understand and agree to the terms set forth in this agreement, agree to pay, and specifically authorize to charge my credit card for the services provided. I further agree that in the event my credit card becomes invalid, I will provide a new valid credit card upon request, to be charged for the payment of any outstanding balances owed. I furthermore confirm that I have received all services at satisfactory.

____ (initial) Charges made for actual services performed by our office are non-refundable. In the event of pre-payment any unused funds will be refunded or credited towards next session.

****NOTICE OF PRIVACY PRACTICES****

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

OUR PLEDGE REGARDING HEALTH INFORMATION: We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by this mental health care practice. We are required by law to:

- Make sure that protected health information (“PHI”) that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- We can change the terms of this Notice, and such changes will apply to all information we have about you. The new Notice will be available upon request, in our office and/or on our web portal.

CERTAIN USES & DISCLOSURES REQUIRE YOUR AUTHORIZATION: Psychotherapy Notes. We do keep “psychotherapy notes” as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

- a. For our use in treating you.
- b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy.
- c. For my use in defending myself in legal proceedings instituted by you.
- d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.
- e. Required by law and the use or disclosure is limited to the requirements of such law.
- f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes.
- g. Required by a coroner who is performing duties authorized by law.
- h. Required to help avert a serious threat to the health and safety of others.

Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes. Sale of PHI. As a psychotherapist, we will not sell your PHI in the regular course of my business.

CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons: When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone’s health or safety. For health oversight activities, including audits and investigations. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so. For law enforcement purposes, including reporting crimes occurring on my premises. To coroners or medical examiners, when such individuals are performing duties authorized by law. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions. For workers’ compensation purposes.

****The Right to See and Get Copies of Your PHI.** **Other than “psychotherapy notes,” you have the right to get an electronic or paper copy of your medical record and other information that we have about you. We will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and we may charge a reasonable, cost-based fee for doing so. **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI, or that a piece of important information is

****STATEMENT OF RIGHTS****

Psyched Solutions, P.A. is committed to ensure that you receive professional and humanistic services, directed towards your needs in a manner that protects your dignity and feelings of self-worth. To this end, the following Statement of Rights has been formulated.

CIVIL RIGHTS You have the right to be treated with dignity and respect. You retain all rights, benefits and privileges guaranteed by law. **DISCRIMINATION** Services will be provided to you and/or your family members without discrimination, ethnic background, personal or social creed, racial membership, sex, religion, or age will not affect our services to you. You will not be refused any services based on lack of, or limited, personal financial resources. Travel and loss of work time will be discussed and kept at a minimum. No physical barriers will preclude treatment. Services will be provided with a minimum waiting time. Agency services hours will be reasonably convenient to all requesting services.

CONFIDENTIALITY Your medical and social service records are confidential and cannot be released to anyone without express consent given by you or your guardian. However, the Court without your permission can subpoena your records, especially if you are court-mandated to treatment. Also, knowledge of child abuse, elder abuse, and intent to harm other or yourself must, by law be reported in addition to knowledge of communicable diseases (e.g., hepatitis). You have the right to review and approve any information being requested by another agency that is providing services to you. You have the right to an individual plan for treatment and will be expected to participate in your plan of treatment. You have the right to know the name and professional credentials of anyone working with you. You may request to participate in any staff meeting regarding yourself. You may review your clinical record upon written request. You will be advised of the positive effect and possible complication of any drugs or medication prescribed by any physician involved in your treatment. You have the right to refuse to participate in or be interviewed for research purposes. You have the right to refuse any electronic and/or visual recording of your treatment without your expressed written approval. You have the right to terminate treatment at any time.

GRIEVANCE PROCEDURE If you feel that your treatment program has not been provided fairly, or reasonably, you may present your concerns, in writing to the supervisory staff. ****You have the right to legal recourse; you have the right to confer with family, attorney, physician, clergyman, and others at any time.** You may contact the Quality Assurance Coordinator for Baron Counseling Services and express your grievance Or the Department of Children and Families at 954.467.4298 if you have a grievance regarding the treating agency. Your concerns will be given priority consideration. You are under the protection under Florida Statute 491 Section 10E-16004(27) as follows: Protection of Clients – The rights of the clients who are admitted to this program shall be assured and defined in each program operating standards. This shall include operating standards, which protect the dignity, health and safety of clients.

BY SIGING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client Name (Print)

Signature of Client or Representative

Date

******CONSENT FOR PARTICIPATION******

Provider Qualifications Our agency has full staffed professionals that have the education, training and experience in conducting services. You have the right to inquire fully about the credentials, education, and experience of you or your child's therapist and to have your questions answered to your satisfaction. At Psyched Solutions, P.A., services are provided by a licensed member (Psychologist, Social Worker or Counselor) or by a master level professional with training enabling him or her to practice under the supervision of a licensed professional.

What to Expect from Services your therapist or child's therapist will work to provide the most effective services possible. Studies of counseling indicate that most people benefit substantially from the services and experience improvement in the problem areas for which services were sought. However, substantial benefits, while likely, cannot be guaranteed. Response to counseling is different for each client and should be discussed on an ongoing basis with your child's therapist. Therapy can involve a variety of different activities, which vary from person to person. In general, a licensed professional will assess your child's areas of concern and then your psychologist/therapist will provide appropriate services designed to resolve or reduce the problems. There may be individual work with your child, discussions with you possibly including way to help your child outside of therapy, testing, and/or family sessions. Therapy and/or Testing may focus on feelings, thoughts, relationships, and/or behaviors. With young children, therapy generally includes play activities used as a means of understanding and communicating with the child. Services may be provided within the homes, school and other places conducive for therapeutic exchange, at times convenient for participants, parents and community resources. We are available days, evenings and weekends as needed. Actual times of services are negotiated between the person served/guardian and therapist.

Family Involvement We at Psyched Solutions, P.A. believe that it is important that the child's family is included, as appropriate, in the services the child is receiving. We invite parent participation because we know that person's goals and gains are strengthened when the person receives the support of his/her family and these family members can facilitate treatment recommendations outside of the therapeutic sessions. Family involvement is mandated in cases where a minor is being treated unless it is clinically inappropriate for restrict or restricted by the courts of protective service recommendation. Family involvement is highly encouraged when individuals served are adults over the age of 21, as clinically appropriate.

******Confidentiality ******Historically, counseling was associated with complete confidentiality between the family and specialist. Currently, both law and professional ethics require therapists to maintain complete confidentiality in most cases. In these cases, the psychologist/therapist cannot release any information about your family without your expressed written permission. However, as a result of legal developments, there are some exceptional circumstances in which therapists are required to communicate information about therapy to persons outside the family.

Below are some exceptional circumstances in which psychologist/therapist are required to communicate information about therapy to a person outside the family. These exceptions include the following situations:

- The participant presents a clear and present danger to himself or herself and refuses to accept appropriate services the participant communicates to the therapist a threat of physical violence against a clearly identified reasonably identifiable victim, or the therapist has a reasonable basis to believe there is a clear present danger of physical violence against such a victim.
- The participant introduces his or her mental condition as a defense in legal proceeding.

- In child custody or adoption cases, the judge determines that the therapist has information bearing significantly on the participant’s ability to provide suitable care.
- The participant initiates legal action against the psychologist/therapist.
- The therapist has grounds to believe a child under the age of 18 or an elderly person (over age 60), or a handicapped adult, has been, or is at risk of being abused or neglected.
- The therapist has reason to believe that a child was prenatally exposed to a potentially addictive or harmful drug or controlled substance.
- The therapist has reason to believe a health care professional has engaged in professional misconduct.
- A judge orders the therapist to release participant’s information.

It should also be noted that insurance companies reimbursing therapeutic services and/or psychological testing require information about these services. Therefore, if you are using insurance to pay for you or your child’s services, certain information may be released to your insurer.

I indicate by my signature on the form that I consent to the therapy services and that I understand and consent to the conditions described above. I understand that this consent will remain for the duration of services being provided by Psyched Solutions, P.A.. I also understand that I may revoke this consent at any time.

I am the person who is subject to the health records that will be used or disclosed. I consent to treatment and agree to the use and disclosure of my health information as described in this consent.

OR

I am the parent, guardian, or person authorized to act on behalf of the participant whose records will be used or disclose. I consent to treatment and agree to the use and disclosure of the person served health information as described in this consent.

BY SIGING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____	_____	_____
Client Name (Print)	Signature of Client or Representative	Date