**Psychotherapist-Patient Contract**

**Welcome to my practice!** This document contains important information about my professional services and business policies. Please read it carefully! When you sign this document, it will represent an agreement between us.

**Psychological Services**

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. **Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part.** In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who remain consistent by attending their scheduled appointments. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Comprehensive Psychological Evaluations are another service offered at The Brain Center. Psychological Evaluations consist of several individual sessions in which various tests are administered to help in the diagnostic process and treatment planning. Once Psychological testing has been completed Dr. Kocsner will then gather all the data and put into a form of a Psychological Report which you will receive a copy. Due to the individual nature of psychological testing and the insurance companies unique process of such services your financial responsibilities regarding psychological testing will be communicated with you specifically by office staff. Additional fees/co-payments may be included. **It is each patient’s responsibility to verify his or hers benefits with the insurance company prior to psychological testing.**

**Dr. Kocsner does not do custody or workman’s compensation evaluations.**

**Policies and Procedures**

*Please read this information and feel free to discuss any questions you may have. Please keep a copy for your records.*

**Health Insurance Portability and Accountability Act (HIPAA)**

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. The Georgia Notice, which is attached to this agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of this session. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

**Confidentiality**

All communication between client and therapist will be held in confidence,and will not be revealed to anyone unless you (or parent, in the case of a minor) given written authorization to release this information. Your legal right to privileged communication between a licensed psychologist and a client will be upheld unless overruled in a court of law during a legal proceeding. Georgia law requires that confidentiality be waived when the patient’s or other’s personal safety is threatened or when disclosure of child abuse is made to the therapist. If we determine that a patient presents a serious danger of violence to another, we may be required to take protective actions. These actions may include notifying the potential victim, and/or contacting the police, and/or seeking hospitalization for the patient. If such situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit our disclosure to what is necessary.

Occasionally, your therapist may choose to consult colleagues about your case. Your identity will be protected during these consultations. Consultations will be noted in your PHI or clinical record. We request that you complete a Release of Information Consent form so that we may be in contact with your personal physician. Information routinely released to insurance companies for reimbursement for services shows only a diagnosis, the dates of service, charges and payments. In order to file your insurance, it is necessary for you to sign the Release of Information form.

You may recognize other people here. We expect you to maintain confidentiality concerning the identities of these people. If it is necessary to contact you at home or work, we will be discrete. You should be aware that we employ administrative staff. In most cases, we need to share protected information with these individuals for administrative purposes, such as scheduling, billing and quality assurance. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

**Contacting Us**

Due to our work schedules, we are often not immediately available by telephone. While we are usually in the office between 8am and 4 pm, we probably will not answer the phone when we are with patients. When we are unavailable, our staff or our voicemail answers our phone. We will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform us of some times when you will be available. If you are unable to reach us and feel that you can’t wait for us to return your call, contact your family physician or the nearest emergency room and ask for the psychologist on call. If we will be unavailable for an extended time, we will provide you with the names of colleagues to contact, if necessary.

**Professional Records**

You should be aware that, pursuant to HIPAA, we keep Protected Health Information about you in two sets of professional records. One set constitutes your PHI. It includes information about your reasons for seeking therapy, a summary description of the ways in which your problem impacts on your life, your diagnosis, the goals we set for treatment, your progress towards goals, your pertinent medical history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier.

**Medical Support Services**

Sometimes the most effective and efficient treatment of psychological problems requires the use of medication and/or hospitalizations. Your private physician or a psychiatrist may be consulted to assist in these manners.

**Minors and Parents**

Unemancipated patients under 18 years of age and their parents should be aware that the law allows parents to examine their child’s treatment records unless we believe that doing so would endanger the child or be counter therapeutic. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is [sometimes] our policy to request an agreement from parents that they consent to give up their access to their child’s records. If they agree, during treatment, we will provide them only with general information about the progress of the child’s treatment, and his/her attendance at scheduled sessions. Any other communication will require the child’s authorization, unless we feel the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

**Termination of Treatment**

Termination of treatment should always be discussed with your therapist. Termination will occur automatically if you have not been seen in a therapy session for 6 weeks from the date of your last scheduled session, unless there is a prior agreement to leave your case open for a specified amount of time.

**Financial Agreement and Insurance**

During your initial visit to our office, we will discuss the hourly charge for our services the terms of payment, filing for health insurance, reimbursement and any other questions you may have regarding our administrative and financial procedures. Our primary concern is to provide you with the best professional service we can offer you. Further, we feel that everyone benefits when definite financial arrangements are agreed upon.

Accordingly, the following procedures are provided for your information:

1. For therapy, your initial consultation is **$150.00** with a subsequent 45-minute individual session being billed at **$125.00**, family sessions being billed at **$150.00**, and 30 minute individual sessions being billed at **$100.00**.

**Co-payments/Deductibles/Co-Insurances are due at the time of each session.**

For psychological assessment, the fees will vary depending on the specific evaluation required. Co-payments or deposits based on the estimated cost of the assessment are due at the time of your appointment.

1. It is your responsibility to pay your bill. Our office will be glad to file your primary and secondary insurance for you (please provide office with a copy of your insurance card). We cannot file for tertiary insurance. A statement will be mailed to you monthly. Exceptions are made for those who have insurance carriers that are contracted with our office. **Inevitably, if your insurance company is unwilling to pay, it is your responsibility to make a payment and contact the insurance company.**
2. If you have health insurance policy, it will usually provide some coverage for mental health. We will provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, **you (not your insurance company) are responsible for full payment of our fees.** It is very important that you find out exactly what mental health services your insurance policy covers and if you need to obtain a preauthorization. You should carefully read the section in your insurance coverage booklet that describes mental health services. If your employer offers an Employee Assistance Program (EAP), it is your responsibility to inform our office of this coverage prior to being scheduled. ***Our practice does not participate in the EAP program***. If you have any questions about the coverage, call your plan administrator.

“Managed health care plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short term treatment approaches designed to work out specific problems that interfere with a person’s usual of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. You should also be aware that your contract with your health insurance company requires that we provide it with information relevant the services we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire personal health Information. In such situations, we will make every effort to release, not only their minimum information about you that is necessary for the purpose requested. By signing this agreement, you agree that we can provide requested information to your carrier. It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above [unless prohibited by contract].

1. Interest charges may be added to the balances on accounts beyond 60 days past due. Collection procedures may be pursued after 60 days.
2. Since your time is reserved exclusively for you, you will be held responsible for any appointment cancelled without prior notice. **Please see attached cancellation/missed appointments policy.**
3. In addition to weekly appointments, we charge $**125.00** per hour for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, any telephone conversations that are clinical in nature, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if we are called to testify by another party. Because of the complexity of legal involvement, we charge **$250.00** per hour for preparation and attendance at any legal proceeding as well as consultation time with attorneys.
4. Checks that are returned for non-Sufficient funds will carry a **$35.00** penalty or be turned over to a collection agency if payment is not made to this office in cash or money order within 10 days of notification.
5. You are encouraged to ask questions regarding any aspect of your treatment in this office.
6. In respect to minor children, the custodial parent or legal guardian needs to provide signatures on all documents.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client Date

 (If client a minor, parent or legal

Guardian’s signature)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Parent/Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Client Name

**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 review it carefully.**

We care about our patients’ privacy and strive to protect the confidentiality of your medical information at this practice. New federal legislation requires that we issue this official notice of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. This practice is required to abide by the terms of the Notice of Privacy Practices currently in effect, and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

**Who Will Follow This Notice.** Any health care professional authorized to enter the information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or healthcare operations described in this Notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

**How We May Use and Disclose Medical Information About You.** The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples are provided for each category of uses or disclosures. Not every possible use or disclosure in a category is listed.

**For Treatment.** We may use medical information about you to provide you with medical treatment or services.

Example: In treating you for a specific condition, we may need to know if you have allergies that could influence which medications we prescribe for the treatment process.

**For Payment.** We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may be collected from you, an insurance company or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

**For Health Care Operations.** We may use and disclose medical information about you for health care operations to assure that you receive quality care. Example: We may use medical information to review our treatment and services and evaluate the performance of our staff in caring for you.

**Other Uses or Disclosures That Can Be Made Without Consent or Authorization**

* As required during an investigation by law enforcement agencies
* To avert a serious threat to public health or safety
* As required by military command authorities for their medical records
* To workers’ compensation or similar programs for processing of claims
* In response to a legal proceeding
* To a coroner or medical examiner for identification of a body
* If an inmate, to the correctional institution or law enforcement official
* As required by the US Food and Drug Administration (FDA)
* Other healthcare providers’ treatment activities
* Other covered entities’ and providers’ payment activities
* Other covered entities’ healthcare operations activities (to the extent permitted under HIPAA)
* Uses and disclosures required by law
* Uses and disclosures in domestic violence or neglect situations
* Health oversight activities
* Other public health activities

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Uses and Disclosures of Protected Health Information Requiring Your Written Authorization.** Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will thereafter no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care we have provided you.

**Your Individual Rights Regarding Your Medical Information Complaints.** If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations or to someone who is involved in your care or the payment for your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

**Right to Request Confidential Communications.** You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

**Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing or other supplies associate with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

**Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

**Right to an Accounting of Non-Standard Disclosures.** You have the right to request a list of the disclosures we made of medical information about you. To request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years, and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (example: on paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

**Changes To This Notice.** We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date in the upper right corner of the first page.

**Notice of Privacy Practices**

**Patient Acknowledgement**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have received this practice’s Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and practice’s legal duties with respect to my protected health information. The Notice includes:

* A statement that this practice is required by law to maintain the privacy of protected health information.
* A statement that this practice is required to abide by the terms of the notice currently in effect.
* Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
* A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
* A description of uses and disclosures that are prohibited or materially limited by law.
* A description of other uses and disclosures that will be made only with my written authorization and I may revoke such authorization.
* My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
	+ The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
	+ The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
	+ The right to receive confidential communications of protected health information.
	+ The right to inspect and copy protected health information.
	+ The right to amend protected health information.
	+ The right to receive an accounting of disclosures of protected health information.
	+ The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice’s current Notice of Privacy Practices on request.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient (if signed by a personal representative of patient):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELEASE OF INFORMATION CONSENT FORM**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby give my permission for the

 First Name Last Name

following release of information by Dr. Franciska Kocsner at The Brain Center:

The items covered by this release listed below:

1. Intake Assessment
2. Psychological Evaluation
3. Treatment Plan
4. Discharge Summary
5. Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This information is being released for the following reasons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Name of agency, hospital, doctor or therapist**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mailing Address**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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City State Zip-Code

* I understand that this release may include information regarding drug and alcohol abuse and treatment, as well as psychological and psychiatric information
* I understand that the information to be released is protected under state and federal laws that do not permit re-disclosure without my further consent.
* PHI (Protected Health Information), once disclosed to others, may be re-disclosed to individuals or organizations not subject to HIPAA and may no longer be protected by HIPAA

Patient’s Name (print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Month Day Year

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature of Client (if client is a minor, parent or legal Date

Guardian’s signature)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature of Witness Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REVOCATION OF CONSENT**

In revoking consent, I understand that this does not affect any of the ways you used my protected health information while you still had my permission to do so.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature of Client (if client is a minor, parent or legal Guardian’s Signature) Date

**NO AUDIO/VIDEO RECORDING OR STILL PICTURES OF ANY KIND ARE PERMITTED BY LAW!**

Due to HIPPA laws and the privacy of others, we cannot permit any cell- phone usage on The Brain Center premises.

If these rules are being violated services will be discontinued and you will be asked to leave.

[Health Insurance Portability and Accountability Act of 1996 (HIPAA)](http://medicaleconomics.modernmedicine.com/medical-economics/news/hipaa-physician-training-critical-protect-patients-practice)

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree that phones are prohibited in our office.

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Welcome to our practice! Please take a few minutes to answer the following questions so we can better assist you with your health care needs.***

**Today’s Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of School Currently Attending (if applicable):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list phone numbers that we may contact you at and/or leave a message:

Phone Number: Leave a Message (circle one):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes / No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes / No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes / No

**Client Family History**

Is patient adopted/foster child? ( ) YES ( ) NO

Biological Mother’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_

Education/Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Biological Father’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS#\_\_\_\_\_\_\_\_\_\_\_\_\_

Education/Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who has legal Physical/Medical custody of above client? Be advised, answer this question based on legal documentation.

 ( ) Mother ( ) Father ( ) Both ( ) Other

If patient is adopted/foster court documentation must be on file with our office before patient can be treated!

Please print name(s) of legal custodian(s) of above client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal Guardian Contact Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Financial Information**

Name of Person Responsible for Bill: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*Responsible Parties Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance Company** (Insurance Company that we file the claim with first.)

Name of Insurance Co.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_

Name of Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy # of Insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured’s Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance Co.** (if *applicable*)

Name of Insurance Co.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy # of Insured:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Policy Holder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization to Release Information and Assignment of Benefits**

I hereby authorize Dr. Franciska Kocsner, or any member of The Brain Center’s Staff, to release to my insurance company or companies any information acquired in the course of my examination or treatment.

 You are hereby authorized to pay to The Brain Center (Dr. Franciska Kocsner), Basis Benefits and/or Major Medical Benefits for medical expenses otherwise payable to me for treatment.

 In making this assignment, I understand and agree any unpaid balance not covered by this policy will be paid by me. I understand that filing of insurance does not guarantee payment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clients Name (Printed) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client (if client is a minor, parent or legal Guardian’s signature)

**Financial Policy and Agreement**

 The following guidelines have been established in order to clarify any questions:

If you have health insurance, we will be glad to assist you in determining coverage, filing claims and seeking reimbursement. However, we cannot guarantee insurance reimbursement. All fees charged are the direct responsibility of the client.

 Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. It is your responsibility to follow up with your insurance company to make sure they pay your claims.

 If your insurance coverage for mental health services requires pre-authorizations, you must call for authorization. Your insurance company will not pay for services that have not been authorized.

 Payment for co-pays and deductibles is due at the time services are rendered. Payments may be made by cash, check, or credit cards (Visa or MasterCard).

 We cannot and will not become entangled with various arrangements set forth in divorce decrees and the like. Therefore, payment for any and all services rendered will be expected from the guardian that escorts the patients to his/her appointments. If your insurance company does not pay within 90 days, the unpaid balance is due from you.

 **Financial Agreement:** I understand the above financial arrangements. I, also understand I will receive a statement each month, if there is a balance due from me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clients Name (Printed) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client

(if client is a minor, parent or legal Guardian’s signature)

**Counseling, Confidentiality and Private Practice Agreement**

 I am aware, and I acknowledge that no guarantees have been made to me as to the results of treatment at The Brain Center.

 I agree to collaborate with Dr. Franciska Kocsner and other appropriate professional staff members for the purpose of assessments and evaluation of my current situation and to work together to identify appropriate goals and methods of achieving them.

 I understand that over the course of therapy, whatever assessments, tests, or other clinical care that is recommended will be fully explained to me, and that I have the option to accept or reject such care.

 I understand that the office may call my home or another designated location and leave a message on voice mail, or in person in reference to any items that assist the practice in carrying out health care operations, such as appointment reminders, insurance items and any call pertaining to clinical care.

 **I have read the above and give my consent to the counseling process. I have also read and understand the office of The Brain Centers statement regarding the limits of confidentiality.**

 **I have had an opportunity to ask questions to seek any clarification I needed about these important materials.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clients Name (Printed) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client

(if client is a minor, parent or legal Guardian’s signature)

**Reprocessing Claims Fee Policy**

The initial packet that you are completing upon your first visit at The Brain Center is an important document and is required by your insurance company. **Withholding insurance information or falsely reporting the patient’s insurance information is not only illegal but also causes unwanted delays in services requested.** When insurance companies become aware of another coverage they request a refund of ALL previous payments made to The Brain Center creating an unwanted financial situation.

 It is your responsibility as the patient/parent or guardian of the patient to know the patient’s insurance coverage and to report it to our office correctly before the scheduled appointments.

If you are unsure of the patient’s insurance coverage, it is your responsibility prior to your appointment to contact your insurance company for the needed information. This includes becoming knowledgeable of your Behavioral Health Benefits. It is also your responsibility to notify our office of any changes in the patient’s insurance coverage immediately!

If for any reason during your treatment at The Brain Center a claim is denied due to incorrect insurance information there will be a $25.00 reprocessing fee that will be charged to your account and is NOT payable by the insurance company. There are no circumstances that would justify excusing you from being responsible for this fee. The Brain Center staff will be happy to assist you with any concern or questions, but we cannot take the responsibility of investigating the patient’s correct healthcare coverage at the time of service.

**The Full payment of the Reprocessing Fee is required before further treatment!**

I agree and promise to abide by the above terms of the Reprocessing Claims Fee policy of The Brain Center. I fully understand the necessity of such a policy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clients Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (Guardian)