AUSTIN PSYCHOLOGICAL
AND TESTING CENTER

2403 West Ben White Boulevard Austin, TX 78704
Office 512.707.2782  512.707.2783 fax
Website: www.austintestingandtherapy.com
Email: f.garces@austintestcenter.com

# New Patient Information

Patient Name: _____

D.O.B_____SS# _____

Contact Number: _____ Alternate Number: _____

Current Mailing Address:_____

City: _____State:_____Zip:_____

E-mail:_____

Insurance Carrier: _____

Policy #: _____Group #: _____

Is primary card holder different than the above?  Yes or No
If so, Please fill out Primary Card Holder information below.

Card Holder's Name: _____

Card Holder's D.O.B. _____ SS#_____

Do you have a secondary Insurance? Yes or No

If so, please fill out the following information.

Insurance Carrier: _____

Policy #:_____

Group #: _____

**Please allow 2 business days notice if you are unable to attend your scheduled appointment or you will be charged a $50.00 cancellation/no show fee.**

*I hereby authorize the clinician to release all information necessary to secure payment of benefits from my insurance company. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I fully understand that I am financially responsible for all charges whether or not paid by insurance company.*

**Signature:** _____

**Printed name of person completing this document:** _____

**Relationship to the patient**: _____

Austin Psychological & Testing Center
2403 West Ben White Boulevard, Austin, TX 78704
Office 512.707.2782  512.707.2783 fax
Website: www.austintestingandtherapy.com
Email: info@austintestingandtherapy.com

*Complete, Integrated Care for Families and Individuals*

# New Patient Policy Checklist

**Please read the following items carefully and initial next to each item indicating that you have read and fully understand it. Please ask the office staff if you have any questions.**

_____ I understand that the reminder phone call I receive 24 business hours before my appointment is offered as a courtesy. It is my responsibility to maintain knowledge of all of my appointment dates and times.

_____ I understand that a failure to cancel or reschedule my appointment with at least 48 business hours notification to the office staff will result in a $50 No-Show fee charged to my account.

_____ I understand that I must pay any No-Show fees before I can be seen for any follow-up appointments.

_____ I understand that payment is due at the time services are rendered. There will be a $10 fee if payment is not made at the time of service.

_____ I understand that there will be a $25 fee for all returned checks.

_____ I understand that an authorization from my insurance company does not guarantee payment from my insurance company.

_____ I understand that I am responsible for any amount denied or unpaid by my insurance company.

_____ I understand that I am responsible for notifying the office staff of any changes to my personal information.

_____ I understand that I am responsible for any fees or denied insurance claims that may result from my failure to provide the office staff with correct and up to date information.

_____ I understand that I may be asked to help the office staff in obtaining authorizations from my insurance company if I fail to provide accurate information, or if the insurance company is not cooperating with the office staff.

_____ I understand that this checklist will be held in my Austin Psychological and Testing Center record.

**Printed name of person completing this document:** _____

**Name of Patient** _____**Relationship to the patient**: _____

AUSTIN PSYCHOLOGICAL
AND TESTING CENTER

*2403 West Ben White Blvd*
*Austin, Texas 78704*
*Telephone: 512-707-2782 Fax: 512-707-2782*

***Complete, Integrated Care for Families and Individuals***

## APTC Practice Procedure Updates

Patient records will be released within 72 hours by the Practice Manager once request has been made. If it involves a minor other documentation such as divorce decree, guardianship papers, or any other documentation to show you have legal right to obtain the minors' records which may take more than 72 hours.

- Patient records or medical history will not be discussed over the phone.
- No records will be released without a signed authorization for release.
- Charges will be **$50.00** for a **No-Show**
- There will be a **$15.00** charge **for medical records release**, as well as second copies of reports for individuals.
- If you choose to have testing processed before we have obtained authorization from your insurance carrier you are responsible for payment in full before services are rendered.
- Phone conversations are not billable under insurance. If you need a phone consultation you are responsible for the fee which is **$100.00 an hour**, and can be prorated.

Patient Name | Signature of Patient or Guardian | Date

AUSTIN PSYCHOLOGICAL
AND TESTING CENTER

*2403 West Ben White Blvd*
*Austin, Texas 78704*
*Telephone: 512-707-2782 Fax: 512-707-2782*

***Complete, Integrated Care for Families and Individuals***

## Patient Authorization

I the undersigned hereby authorize the office of Austin Psychological and Testing Center including but not limited to APTC staff and agents, to release any and all medical information about me, including but not limited to my medical records, that is necessary to process any claims for insurance or reimbursement.

I hereby also authorize and assign payment of any and all medical benefits to Austin Psychological and Testing Center for services rendered.

This authorization shall remain in effect until I specifically notify Austin Psychological and Testing Center in writing that I am revoking this authorization.

## No Show/Late Cancellation Policy

We have a very strict **late Cancellation / No Show Policy**. We request **48 hours** notice to cancel any appointment or you will receive a bill in the mail for a **$50.00** fee that you will be responsible for unless you provide us with a doctor's excuse. All no show bills will go out every Friday. You will not be able to schedule another appointment unless payment is made (or arrangements made.) Any uncollected fees will be turned over to collections at the end of the Quarter.

Patient Name Signature of Patient or Guardian Date

## Patient Consent Form

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is necessary we will provide the information necessary to your health care provider for treatment or payment on your behalf.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of

treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or discloser of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent. If you have any objections to this form, please ask to speak with our HIPPA Compliancy Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

## Patient Services Agreement

Welcome to my practice. This document (the Agreement) contains important information about my 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. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. **The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully.**

We can discuss any questions you have about the procedures. 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 me unless I have taken action in reliance on it; if there are obligations imposed on me 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.

## Psychological Evaluations

When you come in for your Initial visit, you will be asked to do many different tasks while you are here, which may include filling out questionnaires. Some of your time might be spent alone in a room, with the clinician coming in and out of the room at various points to check on you and answer any questions you might have. Testing sessions are longer than therapy sessions and we can, and will, break your testing session into two different appointments for you to help prevent test fatigue. Due to test fatigue or inattention we tend to schedule children under 10 years of age earlier in the day/morning.

If you have ever had services at a student psychological clinic, you might have noticed that your sessions were either audio or video recorded. This is because student clinics are training clinics. In private clinics, such as our practice, audio and video recording of therapy and testing sessions are at the discretion of the psychologist. All unauthorized audio and video recording of therapy and testing sessions is forbidden. Testing sessions cannot be recorded due to the confidential, sensitive nature of the testing materials and the copyright laws we are legally bound by with the test publishers. If you feel there is a need to audio or video record your therapy sessions, please speak with me immediately and we can discuss the best way to address your concerns and needs, while respecting the privacy of all involved parties.

## PROFESSIONAL FEES

Our office fee for an initial session is $150. Other services include report writing, telephone conversations lasting longer than 5 minutes, 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 me. 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 I am called to testify by another party. Because of the difficulty of legal involvement, I charge $150 per hour for preparation and attendance of any legal proceeding.

## CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office between 8 A.M and 5 P.M. my telephone is answered by the front office staff. I 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 me of some times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. My practice manager is Frances Garces; she is generally in the office everyday and can assist and take care of any issues or concerns.

## LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. I can only release information about your treatment to others if you have signed a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

You should be aware that I practice with other mental health professionals and that I employ administrative staff. In most cases, I need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. 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. All reports and medical records have to go through myself or my Practice Manager before release.

Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

If a patient seriously threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection. Texas law provides that a professional may disclose confidential information only to medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the patient to the patient or others, or there is a probability of immediate mental or emotional injury to the patient.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.

If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

If a patient files a worker's compensation claim, I must, upon appropriate request, provide records relating to treatment or hospitalization for which compensation is being sought.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

If I have cause to believe that a child under 18 has been or may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct), or that a child is a victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect, or exploitation, the law requires that I make a report to the appropriate government agency, usually the Department of Protective and Regulatory Services. Once such a report is filed, I may be required to provide additional information.

If I determine that there is a probability that the patient will inflict physical injury on another, or that the patient will inflict imminent physical, mental or emotional harm upon him/herself, or others, I may be required to take protective action by disclosing information to medical or law enforcement personnel or by securing hospitalization of the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

## PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, and your treatment history. Any past treatment records that I 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. Except in unusual circumstances that involve danger to yourself and others, you may examine and/or receive a copy of your Clinical Record within 72 hours of requesting it in writing.

You should be aware that pursuant to Texas law, psychological test data are not part of a patient's record. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge a copying fee of $25 (and for certain other expenses). The exceptions to this policy are contained in the attached Notice Form. If I refuse your request for access to your Clinical Record, you have a right of review, which I will discuss with you upon your request.

In addition, I also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be in your clinical record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Psychotherapy Notes unless I determine that release would be harmful to your physical, mental or emotional health.

## PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures.

## MINOR & PARENTS

If a minor is in Child Protective Services custody, or a foster child, we will have to have documentation that you have legal right to discuss or make decisions for the minor. If the patient is a minor who is involved in any custody or divorce issues you will have to provide the appropriate forms stating you have legal right to the child's records.

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records.

However, if the treatment is for suicide prevention, chemical addiction or dependency, or sexual, physical or emotional abuse, the law provides that parents may not access their child's records. For children between 16 and 18, because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is my policy to request an agreement from the patient and his/her parents 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. I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's authorization unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

## BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been made with and agreed upon with the Practice Manager, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

## INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and 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.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, we will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMO's and PPO's 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 level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed care plans will not allow us to provide services to you once your benefits end.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. We are required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record.

In such situations, I will make every effort to release the minimum information necessary about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in the computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once I have all of the information about your insurance coverage, I will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

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

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____

Patient Name Signature of Patient or Guardian Date

AUSTIN PSYCHOLOGICAL
AND TESTING CENTER

*2403 West Ben White Blvd*
*Austin, Texas 78704*
*Telephone: 512-707-2782 Fax: 512-707-2783*

## Authorization to Release Information

I_____, authorize my psychologist, Dr. Ahr and/or her administrative and clinical staff to release and exchange the following information. Please include a detailed description of which information you do want disclosed:

_____

_____

The above information should only be released to: Please write the name, phone number and fax number of the persons to whom the information is to be sent to.

_____

_____

_____

_____

I am requesting that my psychologist releases the above information for the following reason:

_____

_____

This authorization shall remain in effect until: _____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to our office address. However, your revocation will not be effective to the extent that if I have taken action in reliance on the authorization or if this authorization was obtained a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule.

_____ _____

Patient Name Date

_____

Patient or Guardian Signature