

Psynergy Behavioral Health

Date _____

Patient

First _____ M _____ Last _____

Home# () _____ - _____ Address _____

City _____ State _____ Zip _____ Sex _____ Birthdate _____

Social Security# _____ Single/Married/Other _____

Number of Children _____ Occupation _____ Employer _____

Work# () _____ - _____

Spouse/Legal Guardian

Name of Legal Guardian, Wife or Husband _____

Social Security# _____ Birthdate _____

Occupation _____ Employer _____ Work#() _____ - _____

Emergency Contact _____ Phone# () _____ - _____

Medical Doctor Consulted within the past year:

Name _____ Condition: _____

Name _____ Condition: _____

Please list all medical conditions that you have had in the past or have now:

Reason for appointment

Date started _____ Have you had this before? Y/N Injury Related? Y/N

List all Previous Surgeries:

Date _____
Date _____

Are you allergic to any medications? Y/N What Kind? _____

Are you taking any medications? Y/N What Kind? _____

Are you Pregnant? Y/N Date of last menstrual period? _____

Patient Signature _____

Synergy Behavioral Health
David P. Schwartz, Ph.D.
Marilyn R. Wander, Ph.D.
Licensed Psychologists

Psychotherapist-Patient Services Agreement
(Ohio)

Welcome to our practice. This document (the Agreement) contains important information about our professional services, business policies, and HIPAA (Health Insurance Portability and Accountability Act). Please read the *Ohio Notice Form* for details explaining your privacy rights. The law requires that we (Dr. Schwartz or Dr. Wander) obtain your signature acknowledging that we have provided you with this information. Although these documents are long, 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. This document is an agreement between you and your psychologist (Dr. Schwartz or Dr. Wander). Statements that follow that use the term "I" refer to your psychologist.

PSYCHOLOGICAL SERVICES

Risks and benefits—You may experience uncomfortable feelings like sadness, guilt, anger, or anxiety. On the other hand, 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.

Initial sessions—Our first session or two will focus on an evaluation of your needs. Following the evaluation I will offer my impressions and a treatment plan. You will have the opportunity to agree or disagree with my impressions and make any additions or deletions to the treatment plan. If you feel comfortable working with me, you may decide to continue therapy. However, if you have doubts or questions about my procedures, please bring them up so we can discuss them. If you prefer to find another mental health professional, I will be glad to assist you as needed.

health insurance billing (staff members have been trained in protecting your privacy and have agreed not to release any information outside of the practice, 4) Disclosures required by health insurers or to collect overdue fees. **In some situations I am required to disclose information without your consent or authorization.** These include 1) If you are involved in a court proceeding, your PHI is protected by the psychologist-patient privilege law, however I will release information if you or your legal representative give written authorization. I must release information if there is a court order (a subpoena is not a court order). 2) If a government agency requests information for health oversight activities, I may be required to provide it. 3). If a patient files a complaint or a lawsuit against me, I may disclose relevant information in order to defend myself. 4). If a patient files a worker's compensation claim, the patient must sign a release so that I may release the information, records or reports relevant to the claim. **In some cases I am legally obligated to take actions to protect others from harm.** These include 1) If there is suspicion of abuse or neglect to a child under the age of 18 or to a mentally retarded, developmentally disabled, or physically impaired child under the age of 21, I must file a report with the Public Children's Services Agency and I may be required to provide additional information. 2) If senior adult is being abused, neglected, or exploited, I am required to report this to the county Department of Job and Family Services. 3) If I know or have reasonable cause to believe that a patient has been the victim or domestic violence, I must not that information in the patient's records. 4) If I believe a patient presents a clear and substantial risk of imminent serious harm to him/herself or someone else, I must disclose that information to appropriate public authorities, potential victims, relevant professional workers, and family members. **Under these circumstances, I will make every effort to fully discuss the situation with you and to limit my disclosure to what is necessary. 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.

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 of service**, 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. [In circumstances of unusual financial hardship, I may be willing to negotiate a fee adjustment or payment installment plan.] If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I 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 me to disclose otherwise confidential information. In most collection situations, the only information I 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-- 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 I can in helping you receive the benefits to which you are entitled; however, **you (not your insurance company)** are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. "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 level of functioning. It may be necessary to seek approval for more therapy after a certain number of

signed, written Authorization. Except for BWC, insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may ask to examine and/or receive a copy of your Psychotherapy Notes. I have the right to determine the appropriateness of such a disclosure. We can discuss this if it becomes a relevant issue.

Patient Rights-- HIPAA provides you with several new or rights including requesting that I amend your record; requesting restrictions on what information 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. In the case of worker's compensation some of these rights may not apply. I am happy to discuss any of these issues with you.

Minors and Parents--Patients under 14 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records unless I decide that such access would injure the child or we agree otherwise. **Children between 14 and 18** may independently consent to and receive up to 6 sessions of psychotherapy (provided within a 30-day period) and no information about those sessions can be disclosed to anyone without the child's agreement. While privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, parental involvement is also essential to successful treatment. For children 14 and over, it is my policy to request an agreement between my patient and his/her parents allowing me to share general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Any other communication will require the

One set constitutes your Clinical Record. It includes your initial evaluation, 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 if you request it in writing and the request is signed by you and dated not more than 60 days from the date it is submitted. 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 \$1 per page for the first ten pages, 50 cents per page for pages 11 through 50, and 20 cents per page for pages in excess of fifty, plus \$15 fee for records search, plus postage. The exceptions to this policy are contained in the Ohio 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 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 included 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, and, except for BWC, they cannot receive a copy of your Psychotherapy Notes without your

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 me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.] **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. I am 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 only the minimum information 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 a 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 I submit, if you request it. **By signing this Agreement, you agree that I can provide requested information to your carrier.** Once we have all of the information about your insurance coverage, we 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 [unless prohibited by contract].

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.

Signature: _____ Date: _____

Meetings—If you decide to continue in therapy, we will meet for 50-minute sessions either weekly, bi-weekly, or monthly depending upon your needs. .
You are expected to pay for scheduled sessions unless you provide 24 hours advance notice of cancellation. (Insurance companies do not provide reimbursement for cancelled sessions.) In some circumstances I may wave these charges.

Professional Fees—

Psychological evaluations: \$300

Biofeedback evaluations: \$200

Psychological or biofeedback sessions: \$150

Legal consultations (including preparation and travel time): \$200 per hour

Report writing (other than evaluations), telephone conversations lasting longer than 10 minutes, consultation with other professionals, preparation of records or treatment summaries, or any time spent performing any other services you request of me will be charges at a rate of \$25 per each ten minute period.

Contacting me—You may contact me by calling the office (515-863-2273). I will return your call as soon as possible during the work week. Calls made on the weekend will be returned on Monday. In an emergency you may reach Dr. Schwartz at 513-863-2273 or Dr. Wander at 513-470-7339 or you may contact your family physician or go the nearest hospital emergency room. If I am away for an extended period, I will provide you with the name of a colleague to contact for emergency purposes.

Limits on Confidentiality—The law protects the privacy of all communications between a patient and a psychologist except for certain exemptions. In most cases I can only release information about your treatment if you sign a written authorization form which meets the legal requirements imposed by HIPAA. Other situations require only that you provide written, advance consent. Some of these situations include 1) Patients filing BWC claims, 2) Consultations with other health or mental health professionals who are also legally bound to keep information confidential, 3) Staff that performs

Psynergy Behavioral Health
Clinical Psychology and Behavioral
Dr. David P. Schwartz
Dr. Marilyn R. Wander
(513) 863-2273
(513) 863-6022 (fax)

Good
job!

I have read and understand the Ohio Notice Form (H



_____ S

_____ Date

Assignment of Benefits: INSURANCE

I authorize my insurance company to pay by check made out to Psynergy Behavioral Health and mail directly to P.O. Box 13346, Hamilton, Oh 45013. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this claim.

Policy Holder or Claimant Signature _____

Policy Holder Social Security Number _____

Assignment of Benefits: WORKER'S COMPENSATION

I authorize my Managed Care Organization to pay by check made out to Psynergy Behavioral Health and mail it directly to P.O. Box 13346, Hamilton, Oh 45013. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this claim. Should I elect to settle my claim either fully or in part and the settlement does not include Psynergy Behavioral Health I agree to pay for all unpaid services rendered by Psynergy Behavioral Health.

Patient Signature _____

Assignment of Benefits: PERSONAL INJURY

I authorize my Attorney and or Car Insurance Company to pay by check to Psynergy Behavioral Health and mail directly to P.O. Box 13346, Hamilton, Oh 45013. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this claim. Psynergy Behavioral Health will accept up to \$5000.00 of liability on my personal injury case any amount beyond that will need to be paid for by my medical insurance or cash at the time of service. Should I elect to settle my claim either fully or in part and the settlement does not include Psynergy Behavioral Health I agree to pay for all unpaid services rendered by Psynergy Behavioral Health.

Patient Signature _____

CONSENT TO TREAT A MINOR

I _____, give my permission for Psynergy Behavioral Health and appointed staff to render medical services and treatment to _____.

GuardianSignature _____ **Relationship** _____

AUTHORIZATION TO TREAT

I, the undersigned patient, hereby authorize Psynergy Behavioral Health and appointed staff to render medical services and treatment to myself. I also agree that all providers of Psynergy Behavioral Health have my permission to share my medical information with each other if deemed necessary when I m receiving treatment from multiple providers of Psynergy Behavioral Health.

PatientSignature _____

FINANCIAL RESPONSIBILITY

I understand and agree that I am responsible for all financial obligations for all services for the above patient account. I further understand that there is a \$25.00 missed appointment fee for all psychology appointments not cancelled with a 24 hour notice. I also agree that there will be a \$25.00 fee for any returned checks.

Patient Signature _____