PATIENT DATA SHEET – CONNOR AND ASSOCIATES, PLLC

Patient Information: **Referred by:** _____

First_____MI_____Last_____

Address_____City_____ ST_____Zip_____

Home (_____) _____ Work (_____) _____ Cell (_____) _____
Okay to call or leave message at: home: Yes No work: Yes No
SS#_____ DOB_____ Age_____ Gender ____M ____F

Would you like us to contact your primary physician? □ Yes □ No Name:_____Phone:_____

Are you currently seeing a psychiatrist? □ Yes □ No Name:_____Phone:_____

Emergency Contact_____Phone No._____

Responsible Party Information:

First_____MI_____Last_____

Address_____City_____ ST_____Zip_____

Home (_____) _____ Work (_____) _____ Cell (_____) _____

SS#_____ DOB_____ Relationship to Patient_____

Primary Insurance Information:
Ins. Co._____ Plan Name_____

ID#_____Group #_____

Insured's Employer_____Relationship to patient__Self __Spouse __Parent __Other

Insured's Name_____

Address_____City_____ ST_____Zip_____

Home (_____) _____ SS#_____ DOB_____

Information Below For Office Use Only:

Clinician_____Initial Appt_____/_____/_____ Visits per year_____Other_____

Dt of auth_____/_____/_____ To_____/_____/_____ Authorization #_____

CPT Code/Allowed: 90801____ 90806_____ 90847_____ Other_

Claims address_____

DX: Axis I_____Axis II_____Axis III_____Axis IV_____

Axis V: Pre_____ Post _____ Presenting Problem_____

Discharge/Treatment Summary/Disposition_____

Last Clinical Visit _____/_____/_____ File Closed _____/_____/_____ Mutual Termination Yes____ No____

Child Information Questionnaire and Consent to Receive Treatment

Childôs Name_____ Date of Birth_____

Motherôs Name_____ Fatherôs Name_____

Emergency Contact: _____ Relationship _____

Emergency Contact Phone #: H _____ C _____ W_____

Primary Physician_____ Date of last Visit _____

List any physical health problems for which your child is receiving treatment:_____

_____

List current and past medications including psychiatric medications: _____

_____

Briefly describe reason for seeking help at our office:_____

_____

Briefly describe any prior mental health treatment with dates: _____

_____

Is child currently or potentially in the future, the subject of a custody/visitation action? __ Yes __ No

Has childôs participation in treatment been court ordered? __ Yes __ No

If treatment is court ordered, please indicate reason and provide copy of corresponding court order:

_____

Marital Status of Parent(s): __ Single __ Married __ Separated __ Divorced __ Widowed __ Foster

If not married, please indicate custodial agreement (check one):

___ Joint Custody with joint legal decision-making ___ Joint Custody with sole legal decision-making
___ Sole Custody with joint legal decision-making ___ Sole Custody with sole legal decision-making

If sole legal decision-making, name responsible parent: _____

NOTE: If there is joint legal decision-making, both parents must sign consent for child to be treated.

(Child Information and Consent - Page 2)

Please list siblings and all others in childôs home:

Name	Relationship to child	Age	Occupation

Briefly describe any current or past history of:

Traumatic events including physical, sexual or emotional abuse: _____

_____

Emotional and/or behavioral problems: _____

_____

Academic problems: _____

_____

Peer or social problems: _____

_____

Eating or weight problems: _____

_____

Legal or criminal issues: _____

_____

Drug or alcohol abuse/dependence: _____

_____

Thoughts of harming self or attempt to harm self at any time: _____

_____

Authorization for Treatment/Psychological Services

As Custodial Parent/Legal Guardian of _____, I understand the nature and limitations of treatment and authorize Connor and Associates, PLLC and my childôs therapist to provide outpatient psychological services. I understand that my child is entitled to confidentiality and the therapist will determine whether and when to share information with me regarding his/her treatment or to seek parental/guardian participation in the treatment process. I further understand that the therapist is legally and ethically bound to report any suspicion of abuse, neglect or other perceived potential harm toward the child to the appropriate agencies.

Signed_____Date_____

Signed_____Date_____

NOTE: The parent/guardian transporting the child to his or her appointment is responsible for paying co-pays, deductibles, etc. at time of service. The parent is also responsible for costs associated with correspondence or reports requested by said person to be sent to primary physicians, the courts, legal representative, etc. Cost for such service is determined by the amount of time required to prepare the document. Please check with your provider regarding those fees.

Connor & Associates Psychological Services, PLLC
34 Erlanger Road
Erlanger, Kentucky 41018
(859) 341-5782 Fax (859) 341-5783

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Consent to Receive Treatment

I authorize outpatient psychological services to be provided to myself and/or my dependent(s) by Connor and Associates and the service provider. I agree to engage the service provider for services that may include any of the following: Individual, Group, Family or Child Therapy, Evaluation/Testing and Consultation. I agree to comply with all agency policies and fees as outlined below. It is understood that consent for services can be withdrawn at any time with the provision of such in writing to the service provider. This consent will remain in effect until such time as the client revokes it, treatment is completed or transfer of care is made.

Practice Policies

Fees/Insurance Policy

- ***All fees must be paid at time of service*** including co-pays, deductibles, evaluation fees, out of pocket fees, etc.
- Phone calls, letters, e-mails, reports and consultations on behalf of the client (outside of therapy sessions) will be billed in 15-minute intervals at a rate of $135.00 per hour. These fees are not billable to insurance and must be paid by the client on an out of pocket basis.
- A fee of $25.00 per document will be charged for completion of paperwork for disability insurance, family medical leave, etc.
- A returned check fee of $35.00 plus the amount of the original check will be charged for checks returned due to insufficient funds.
- Failure to resolve an outstanding balance in a timely manner may result in suspension of service until such time debt is paid.
- If an account should become delinquent, the responsible party is aware that the account information will be turned over to collections and he/she will be responsible for the agencyôs collections fees as well as the outstanding balance.
- The client, parent or guardian is responsible for notifying staff of a ***change of insurance*** as soon as possible or will otherwise be responsible for fees due to any lapse in coverage

Appointments and Cancellation Policy

- Appointments are 45 minutes in length
- 24-hour advance notification is required for cancelling an appointment.
- There is a $50.00 charge to the client for the first two no-shows/late cancellations. Thereafter, a fee of $85.00 will be charged for any additional no-shows or late cancellations.
- ***Unless there is a 24-hour notice, a missed appointment fee will be charged regardless of the reason for the missed appointment.*** We understand that situations sometimes arise that the client cannot predict or control; however, missed appointments result in lost time and income to the practice, regardless of the reason for the occurrence. Rare or special exceptions to this policy may occur at the sole discretion of the therapist.
- No show and/or late cancellation fees are due at or before the next scheduled date of service
- Excessive no shows or late cancellations may result in suspension or termination of service.

***** *Fees are subject to change without prior notice.*

Confidentiality Policy

- When seeking psychological services, you have the right to expect that issues discussed during the course of your treatment will be kept confidential; however, there are exceptions to confidentiality by state law and rules of our profession as follows:
    - Receipt of a subpoena or court order for records or testimony
    - Threat of actual or potential harm to the client or another
    - Alleged or potential for abuse to or by the client, guardian or another party
    - Group supervision in some cases is required (i.e., vacation coverage)
    - Insurance companies may require periodic treatment reviews and/or auditing of charts in which limited client information may be shared to insure reimbursement for treatment.
    - Account information may be submitted to collections if an account becomes delinquent

Clinical Emergencies Policy

- Emergency consultations are reserved for ***true clinical emergencies*** in which someone is in ***danger and/or at risk for harm***. If you have a clinical emergency, you may contact your therapist via the office voicemail process, which will instruct you on how to reach him or her. If your therapist is not available to respond, you are advised to go to the nearest hospital emergency room or contact the local crisis hotline.

Child Supervision Policy

- Connor & Associates cannot accept responsibility for unattended children. Please make arrangements for proper supervision and be considerate of other clients in the waiting room.

Termination from Treatment Policy

- As a client, you have the right to terminate treatment at any time unless otherwise ordered by the Court. The providers of Connor & Associates also reserve the right to terminate clients from our practice for any reason we deem to be appropriate and/or necessary including:
    - Verbal abuse to the support staff, owners, contractors or other clients. This includes but is not limited to threatening, name-calling and verbal aggression
    - Physical assault or threat to assault support personnel, partners, contractors, other clients or property
    - Refusal to follow essential treatment recommendations that could result in harm to yourself or others
    - Repeated no shows and/or late cancellations
    - Other individual reasons

I consent for my child to receive treatment/services from Connor and Associates and his/her treatment provider. I further have read each practice policy and agree to adhere to these policies, without exception.

Signature of Responsible Party: _____

Relationship to the Client: _____ Date: _____

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you with your consent.

Payment: We may use and disclose your health information to obtain payment for services provided to you per your consent.

Healthcare Operations: We may use and disclose your general health information (excluding personally identifying information) in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, and evaluating practitioner and provider performance. We may use or disclose your general health information (excluding personally identifying information) in order for us to review our services and to evaluate our staffôs performance. We may also use or disclose your health information to obtain a medical consultation regarding your care or treatment.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you or someone in your home is a possible victim (or perpetrator) of abuse, neglect or domestic violence. We may disclose health information to appropriate authorities if we reasonably believe that you are a serious danger to yourself or others.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. If you authorize release of information, we may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

Persons Involved in Care: We may use or disclose health information to notify or assist in notification of a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the personôs involvement in your healthcare.

Required by Law: We may use or disclose your health information when we are required to do so by law, such as in legal response to valid judicial, administrative subpoenas or court orders.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized, federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may provide you with appointment reminders (such as voicemail messages, postcards, or letters) unless you make a specific request to the contrary. (See alternative communication section ï page 3).

PATIENT RIGHTS

Access: You have the right to view or obtain a copy of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. You may request that we provide copies in a format other than photocopies. We will use the format requested unless it is not practical for us to do so. We will respond to your request for access within 30 days of receiving the request. We reserve the right to charge you a reasonable cost-based fee for expenses such as photocopying and staff time after the first request for copies. We will charge $0.10 a page, $15.00 per hour for staff time and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your health information for a fee. If we deny your request to review or obtain a copy of your health information, you may submit a written request for a review of that decision. The person conducting the review will not be the person who denied your request. In some circumstances, our denial of a request by you to inspect and/or receive copies of your information is not subject to review.

Disclosure Accounting: You have the right to receive a record of disclosures made by us of your health information when you submit a written request. This record will not include: disclosures made for treatment, payment or health care operations; disclosures made directly to you; disclosures authorized by you pursuant to a signed authorization; or disclosures made for law enforcement purposes. You may request one such record at no charge every twelve (12) months. The record request must state the time period desired and may not exceed six (6) years prior to the date of the request and may not include any dates prior to April 14, 2003. The first disclosure record request in a 12-month period is free; additional requests will be provided for a fee. We will inform you of the fees before you incur any costs.

Restriction: You have the right to request that we place additional restrictions on our use and disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except when required by law or in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request. We will make reasonable efforts to accommodate your request.

Amendment: You have the right to request that we correct your records if you believe information in your record is incorrect or that important information is missing, by submitting a written request that provides your reason for requesting the amendment. We have the right to deny your request to amend a record if the information was not created by us; if it is not part of the health information maintained by us; if it is not part of the information which you would be permitted to inspect and copy; or if in our opinion that record is accurate.

Questions and Complaints:

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, you may contact (in writing) our Privacy Officer (listed below). You may also send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. We will provide you the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Privacy Officer: Ed Connor, Psy.D.
34 Erlanger Road
Erlanger, KY 41018
Facsimile #: 859-341-5783

Connor and Associates, PLLC
General Psychological Services
34 Erlanger Road
Erlanger, KY 41018

Acknowledgement Form

I acknowledge that I have received a copy of the Notice of Privacy Practices. The effective date of the notice is: 09/23/2013

Client's Name:_____ Date:_____

Signature of Client or Authorized Guardian:_____

Relationship of Authorized Guardian to Client:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ Emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (specify) _____

Connor and Associates, PLLC

Smoke-Free Policy

To protect and enhance the health and well-being of all patients, employees, and visitors, Connor and Associates, PLLC shall be entirely smoke free effective April 16, 2012. The use of all tobacco products, including chewing tobacco, will not be permitted in the building or on the surrounding property of Connor and Associates.

Employees, patients, and visitors may smoke in their personal vehicles, but we ask that the smoke and tobacco products be completely contained within the vehicle, so as not to expose others to tobacco or unnecessary second hand smoke.

Connor and Associates, PLLC appreciates your compliance with this policy.

I acknowledge receipt of and understanding of Connor and Associates Smoke Free Policy. The policy is effective April 16, 2012 until further notice.

_____

Signature

_____

Name (Please Print)

_____

Date