Northshore Psychological Associates, LLC
PATIENT REGISTRATION FORM

Patient Name: _____ Gender: _____ Date of Birth: ____/____/____
Address: _____ City / State / Zip

Age: _____ Social Security Number: (last 4 digits) xx-xxx-_____
Home Phone: (____) ____-_____ Marital Status: _____
Cell Phone: (____) ____-_____ **Best Daytime Phone:** (____) ____-_____
Referring Physician: _____ Primary Care Physician: _____
Employer: _____ Work Phone: (____) ____-_____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____ ID Number: _____
Primary Holder: _____ Group Number: _____
NOTE- If the Policy Holder is not the patient, please provide the following:
Policy Holder's Social Security Number: ____-____-____ Date of Birth: ____/____/____
Relationship to Patient: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____ ID Number: _____
Primary Holder: _____ Group Number: _____
NOTE- If the Policy Holder is not the patient, please provide the following:
Policy Holder's Social Security Number: ____-____-____ Date of Birth: ____/____/____
Relationship to Patient: _____

Is your visit due to a MOTOR VEHICLE ACCIDENT? **Yes:** _____ **No:** _____
Date of Accident: ____/____/____ Insurance Carrier: _____
Claim Number: _____ Phone Number: (____) ____-_____

Is your visit due to a WORK RELATED INJURY? **Yes:** _____ **No:** _____
Date of Accident: ____/____/____ Insurance Carrier: _____
Claim Number: _____ Phone Number: (____) ____-_____

EMERGENCY CONTACT: In case of an emergency, we will attempt to contact the person listed below:

Name: _____ Relationship: _____
Home Phone: (____) ____-_____ ***and/or*** Cell Phone: (____) ____-_____

*******Please complete and SIGN the reverse side of this form*******

Northshore Psychological Associates, LLC

Patient Name: _____ **Date of Birth:** _____

Consent for Treatment and Authorization to Release Information

I hereby consent to medical care from Northshore Psychological Associates, LLC and its appropriate personnel, for myself, or the above named patient, through appropriate assessment and treatment procedures.

I further authorize the release of any and all medical records and information acquired in the course of my or the above named patient's evaluation to those individuals that my doctor feels appropriate for my continued medical care.

It is understood that I may withdraw this consent at any time by contacting any member of Northshore Psychological Associates, LLC in writing.

Statement of Financial Responsibility

Our office requests that you read your insurance policy and be fully aware of any limitations of the benefits provided. You should be aware that the insurance agreement is between you and the insurance company. We will verify your coverage and bill your insurance carrier on your behalf, but it is your responsibility to know the limitations of your policy. Any charge incurred beyond the reimbursement of your policy will be your financial responsibility.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect and appreciate these payments at the time of service for each visit. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, you will be responsible for your balance in full.

I have read the above and understand my financial obligation.

Payment Agreement

I authorize payment to Northshore Psychological Associates, LLC of any medical benefits which would otherwise be payable to me and which were established by my insurance company. The amount to Northshore Psychological Associates LLC shall not exceed the practice's regular charges for services.

I also authorize the release of my medical records to my insurance company/companies or other third party payers or my employer as necessary to complete and process my insurance claims. I understand that I am responsible for the payment of charges that are not covered by my insurance company.

*****Patient Signature:** _____ **Date:** _____

Guarantor Signature: _____ **Date:** _____

*******Please complete and SIGN the reverse side of this form*******

NORTHSHORE NEUROSCIENCES
Northshore Psychological Associates, LLC

PERSONAL INFORMATION SHEET

Patient Name: _____ **Date of Birth:** _____/_____/_____

***Please indicate why you requested services at this time:** _____

_____

PATIENT FAMILY HISTORY

Family Status: Single Married Divorced Widowed Separated Cohabitating Child

Name of Spouse/Parent/Significant Other: _____

Number of years married or cohabitating: _____

Spouse/Significant Other's Employer: _____

Names of Children: _____ **Age:** _____

_____ _____

_____ _____

_____ _____

PATIENT MEDICAL INFORMATION

Family Physician: _____ **Phone:** (_____) -_____-_____ **Last Seen:** _____

Do you have any physical illness for which you are currently receiving treatment? Yes No

If yes, please describe: _____

Please list any current medications: _____ **Dosage:** _____

_____ _____

_____ _____

_____ _____

Have you had any past psychiatric or psychological services? Yes No

If yes, where: _____ **Last Seen:** _____

VOCATIONAL STATUS

Full-time Employed **Part-time Employed** **Occupation:** _____

Unemployed **Disabled** **Retired** **Homemaker** **Other:** _____

Full-time Student **Part-time Student**

Education: _____ **Yrs Completed:** _____

*****PLEASE SIGN THE REVERSE SIDE OF THIS FORM*****

Northshore Psychological Associates, LLC

I acknowledge that I have received a copy of the Notice of Privacy Practices from Northshore Psychological Associates, LLC.

_____ _____

Date ***Signature***

_____

Print full name

If you are the legal representative of _____

Patient Name (please print)

Please check off the basis of your authority:

_____ Parent of Minor
_____ Power of Attorney (attach copy)
_____ Guardianship Order (attach copy)
_____ Other: _____

Do we have permission to leave a message on your telephone answering machine?

Yes No

_____

Initialed by Employee

Northshore Psychological Associates, LLC
Psychotherapist-Patient Services Agreement

Welcome to Northshore Psychological Associates, LLC. 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 Heath 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 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 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 SERVICES

The services you receive here may consist of psychological and neuropsychological testing as well as psychotherapy. Psychological testing is usually indicated or requested when there is a particular question to be determined, such as diagnosis, sources of conflict, general intellectual functioning, and level or extent of depression or a person's coping resources. Such testing can consist of self-administered test done with an examiner. Neuropsychological testing involves the application of various tasks to assess the functions of a person's thinking. It typically involves the assessment of attention, language, memory, reasoning, visuospatial and other abilities.

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 many benefits. 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.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

Our therapy sessions are typically fifty to sixty minutes in length and will be scheduled at a mutually agreed time. The frequency of these sessions varies, depending of your issues and the treatment approach we are taking. The sessions could be longer or less frequent. Once this appointment is scheduled, you will be expected to pay for it unless you provide 24 hours of advance notice of cancellation, or unless we both agree that you were unable to attend due to circumstances beyond your control. Psychological and neuropsychological testing typically takes a number of hours to complete. Sometimes such testing should be spread over several days, although it is usually best to complete the testing as quickly as possible.

PROFESSIONAL FEES

The fee for an initial evaluation is $170 per hour. Neuropsychological/ psychological testing is billed at the rate of $145 per hour with a doctor and $90.00 per hour with a testing technician. Half hour therapy sessions are $90. Our fee is $140 per 45 minute session and $200 per hour session for therapy and for all other services. It is our practice to charge this amount, billed in 15 minute increments for other professional services such as report writing, telephone conversations which last longer than 15 minutes, attendance at meetings or consultations with other

professionals which you have authorized, and preparation of records or treatment summaries. If you are involved in litigation which requires our participation, you will be expected to pay for the professional time required even if we are compelled to testify by the other party. Because of the difficulty and depth of legal involvement, please ask for our separate Forensic Fee Statement.

CONTACTING US

Our usual office hours are 8:00 am to 5:00 pm, Monday through Friday. While we are not usually immediately available by telephone, the office staff will be happy to take a message which we will return as soon as possible. We typically return emergency phone calls within one hour. On weekends and after hours, our answering service takes messages 24 hours a day. Occasionally your psychologist may not be available in which case one of the other psychologists in the practice will be providing coverage. During his/her planned absences or vacations, your psychologist may discuss essential details of your case with the covering psychologist so that services will be in a professional fashion.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign 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 your 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.

- 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.

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 the professional services I provided you, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your 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.

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 reason to suspect, on the basis of my professional judgment, that a child is or has been abused, I am required to report my suspicions to the authority or government agency vested to conduct child abuse investigations, usually the Department of Public Welfare. I am required to make such reports even if I do not see the child in my professional capacity. I am also mandated to report suspected child abuse if anyone aged 14 or older tells me that he or she committed child abuse, even if the victim is no longer in danger. I am also mandated to report suspected child abuse if anyone tells me that he or she knows of any child who is currently being abused. Once such a report is filed, I may be required to provide additional information.

- If I have reason to believe that an elderly person or other adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), the law allows me to report this to appropriate authorities, usually the Department of Aging, in the case of an elderly person. Once such a report is filed, I may be required to provide additional information.

- If I believe that one of my patients presents a specific and immediate threat of serious bodily injury regarding a specifically identified or a reasonably identifiable victim and he/she is likely to carry out the threat or intent, I may be required to take protective actions, such as warning the potential victim, contacting the police, or initiating proceedings for hospitalization.

- Lastly According to Section 1518 of the Pennsylvania Vehicle Code all health care personnel, i.e. all physicians, podiatrists, psychologists, chiropractors, physician assistants, certified registered nurse practitioners, and other persons authorized to diagnose or treat disorders and disabilities defined by PennDOT's Medical Advisory Board, must report to PennDOT within 10 days, in writing, the full name, address, and

date of birth of any patient 15 years of age or older, who has been diagnosed as having a condition that could impair his or her ability to safely operate a motor vehicle.

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

Both law and the standards of our profession require that we keep appropriate treatment records. You are entitled to receive a copy of the records unless we believe that seeing them would be emotionally damaging, in which case we will be glad to provide them to an appropriate mental health professional of your choice. Because these are professional records that can be misinterpreted and/or upsetting to lay readers, we recommend reviewing them together so we can discuss what they contain. If you wish to see your record, discuss this with your psychologist who may review it with you in his/her presence.

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. I am happy to discuss any of these rights with you.

MINORS & PATIENTS

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. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes my 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, I 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 and 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. 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 payments 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 the 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 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.

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, I will provide you with whatever information I can based on my 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, I 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 more difficult to determine exactly how much mental health coverage is available. "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 our 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 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 INDICATED THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS DURING OUR PROFESSIONAL RELATIONSHIP AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

Client/Guardian	Date
Witness	Date