ALGOS BEHAVIORAL HEALTH SERVICES, INC.

NEW PATIENT INFORMATION RECORD

Today's Date:		Referred By:	
Patient Full Legal Name:			
Date of Birth: / /	Age:	Male / Female (circle one please)	
SSN: / /		Marital Status: Single / Married / Divorced / Separated / Widowed	
Address **(physical)**:		Drivers License#:	
City:	State:	Zip Code(9 digits):	
Home Phone: ( )	Cell Phone: ( )	Work: ( )	EXT#
Can confidential messages (i.e., appointment reminders) be left on your answering machine or voicemail? ☐**YES** ☐**NO** **If yes, which is best: cell / home / work**			
Email Address**:**			
Employer's Name:		Occupation:	
Address:	City:	State:	Zip:

PRIMARY INSURANCE

Please be sure to write down policy holder's information if you are not the policy holder

Name Of Primary Insurance:	Phone # *(Located on the back of card)*	
Subscriber ID#:	Group # :	
Name of Policy Holder:	**DOB**:	
Insured's Address:	☐**same as patient**	
City:	**State:**	**Zip Code(9 digits):**
Policy Holder's Employer:		
Patient Relationship to Policy Holder: SELF / SPOUSE / CHILD / PARTNER		

SECONDARY INSURANCE

Please be sure to write down policy holder's information if you are not the policy holder

Name Of Secondary Insurance:	Phone # (*Located on the back of your card*):	
Subscriber ID#:	Group # :	
Name of Policy Holder:	**DOB**:	
Insured's Address:	☐**same as patient**	
City:	**State:**	**Zip Code(9 digits):**
Policy Holder's Employer:		
Patient Relationship To Insured: SELF / SPOUSE / CHILD / PARTNER		

EMERGENCY CONTACT PERSON

Name:	Relationship: Spouse / Brother / Sister / Mother / Father / Other:	
Home Phone: ( )	Work Phone: ( )	EXT:

Revised 01/10/17

ALGOS BEHAVIORAL HEALTH SERVICES, INC.
Financial Policy

Thank you for choosing Algos Behavioral Health Services, Inc as your health care provider. The following is a summary of our financial policies. Please read the information carefully and sign or initial where noted below. We must obtain a copy of your driver's license and a current, valid insurance card. Failure to provide a current, valid insurance card and/ or information prior to your visit will result in payment due in full at the time of visit.

Initial below please:

_____ 1. **PAYMENTS**. **All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your appointment**.
Initial We accept cash or credit card (Visa, MasterCard, or Discover). Unpaid accounts may be referred to an outside collection agency.

_____ 2. **CANCELLATIONS**. To reserve the hour of the clinician's time, we request a credit card to assure you of the availability of the
Initial doctor. There is a fee of **$50.00** for a missed appointment or late cancellation. You can avoid this charge if you cancel 24 or more hours prior to the appointment. Your insurance carrier will not cover this fee.
____ ** When applicable, for individuals scheduled for a testing appointment – you will be charged **$50.00** for every hour of testing that is missed or not cancelled within 24 hours. For example, if you are scheduled for 3 hours of testing, and you cancel or do not show for that appointment time, you will be charged $150.

_____ 3. **CHANGE OF INFORMATION**. You are responsible to provide us with any change regarding your address, phone number or
Initial insurance information as soon as possible.

_____ 4. **PRIVATE INSURANCE AUTHORIZATION AND INFORMATION RELEASE.**
Initial I, the undersigned, authorize payment of mental health benefits to Algos Behavioral Health Services, Inc for any services rendered. **I understand that I am financially responsible for any amount not covered by my insurance policy including but not limited to co-payments, co-insurance and deductibles.** Any payments denied by the insurance company will be forwarded to the undersigned, and the undersigned will be held responsible for payment. I also authorize Algos Behavioral Health Services, Inc to release to my insurance company any information concerning health care, diagnosis or treatment provided to me. This information will be used only for the purpose of evaluating and administering claims of benefits.

_____5. **POTENTIAL NON COVERAGE**
Initial Although other medical services may be covered by your insurance, this psychological service may not be covered and, in that case, you will be fully responsible for the entire amount**.** If the clinician is *out-of-network* with your insurance policy, you will be required to pay the full amount of the service rendered. We will NOT file claims for out-of-network services.

_____ 6. **NON-COMPLIANCE.** We reserve the right to discontinue care with you for non-compliance with any of the above
Initial policies.

_____ 7. The undersigned agrees that in the event of **default in payment** or if the account is placed with a collection agency for
Initial collection, he/she is responsible for reasonable attorney's fees, miscellaneous costs of collection, collection agency fees, and court costs, at the interest rate of 18% per annum.

For all services rendered to minor patients, the adult accompanying the patient, or the policy holder, is responsible for payment.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

X _____ **Date:** _____
Signature of Patient OR Responsible Party if a Minor

_____
Printed Patient Name

I WILL NOT BE USING INSURANCE FOR THIS SERVICE AND WILL PROVIDE ANOTHER FORM OF PAYMENT.

SIGNED: _____ **DATE:** _____

Form A: 02.13.17

Algos Behavioral Health Services, Inc.

Karri Zumwalt, Psy.D., Seán G. Connolly, Ph.D., and Geetanjali Sharma, Psy.D.

Health Insurance Portability and Accountability Act (HIPAA) Consent

General Notice
When seeking psychological consultation and/or treatment in this practice, **P**rotected **H**ealth **I**nformation **(PHI)** will be gathered about you. This information may include a clinical history, medical history, personal information, and possibly performance/responses on psychological testing instruments.

Notice to Protect the Privacy of Your Health Information

A complete description of how your **PHI** may be used and disclosed is available for your review in the **"HIPAA Notice of Privacy Practices."** A copy of this document is available at the reception desk. You may request a copy for your records.

Individual Rights

You have the right to restrict the uses and disclosures of your **P**rotected **H**ealth **I**nformation **(PHI)** for the purpose of treatment and health care. A signed consent form is usually required. This practice is not required to agree to requested restrictions, but is bound by any restrictions to which it agrees.
You have the right to revoke this consent in writing, except to the extent that our practice has taken action on the reliance on this consent. You have the right to refuse to sign this consent. This practice has the right to refuse to provide the clinical services requested, if you refuse to sign the consent or if you revoke this consent at any time.

Your signature below acknowledges:

- You have read and understand this consent;
- You have agreed to have your **P**rotected **H**ealth **I**nformation **(PHI)** used by this practice for the purposes of your consultation and treatment, to secure payment for your treatment, and for this practice's psychological care operations;
- Prior to signing this consent, you were given the opportunity to review the practice's **"HIPAA Notice of Privacy Practices;"**
- You are aware that you may now, or at any time in the future, request restrictions to the use and disclosure of your **P**rotected **H**ealth **I**nformation **(PHI)**;
- This consent may be terminated at any time, with written request, except to the extent that this practice has taken action in reliance of the consent.

X_____ _____
Signature of Client/Patient or Representative Date

Form C: 02.13.17

Authorization Form to Release Protected Health Information (PHI)

This form when completed and signed by you authorizes this psychological clinic to release Protected Health Information (PHI) from your clinical record to the person(s) you designate.

I hereby authorize my psychologist and/or clinical associate, Seán G. Connolly, Ph.D., Karri Zumwalt, Psy.D., or Geetanjali Sharma, Psy.D. and their practice management company, Algos Behavioral Health Services, Inc. and/or their administrative and clinical staff to release *the following specific clinical record and/or administrative/payment information*: (please list which information you want released)

_____results of the psychological evaluation_____

**This information should be released to only the person(s) below:

_____

_____

_____

I am requesting the release of this information for the following reasons:

__ at the request of the individual __ for continuing care __ for public agency use

__ legal purposes __ other:_____

This authorization shall remain in effect until _____ (date), or until _____ _____ (specific purpose).

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 we have taken action in reliance on the authorization, nor if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist or clinical associate 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 re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

X_____ _____

Signature of Patient Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

Form E: 02.13.17

Algos Behavioral Health Services, Inc.

S Karri Zumwalt, Psy.D., Seán G. Connolly, Ph.D., Geetanjali Sharma, Psy.D.

CONSENT TO TREATMENT AND CLINICAL ASSESSMENT SERVICES

This is to certify that I give permission to Seán G. Connolly, Ph.D., Karri Zumwalt, Psy.D., or Geetanjali Sharma, Psy.D., at Algos Behavioral Health Services, Inc. to provide psychological and behavioral health services for myself and/or child(ren), or for an adult child for whom I am the legal guardian.

I have reviewed the **Statement of Office Policies for Clinical Practice** and the specific assessment and/or treatment procedures have been explained to me.

Services:

- **_X_** Psychological Evaluation
- ___ Psychoeducational Evaluation
- ___ Behavioral Health Consultation
- ___ Behavioral Health Assessment
- ___ Individual Psychotherapy
- ___ Couple Psychotherapy
- ___ Individual Behavior and Health Intervention
- ___ Group Behavior and Health Intervention
- ___ Behavior and Health Intervention with Family Member
- ___ Neuropsychological Evaluation
- ___ Biofeedback Therapy
- ___ Group Psychotherapy
- ___ Family Psychotherapy

The specific treatment has been described in the written **Statement of Office Policies for Clinical Practice** and/or explained by the clinician. If applicable, alternatives to treatment have been explained to me. Due to the complex nature of psychotherapy and other behavioral health services, including discussing past and present emotional pain and the stresses in life, it is quite common for persons entering this type of treatment to have periods of time when they experience their feelings as more intense, and perceive their condition as possibly worse. This should be discussed as part of the treatment, and is usually temporary. Please note that it is impossible to guarantee any specific results regarding psychological treatment. However, every effort will be made to achieve the best possible results for you. Maximum benefits occur with regular attendance and your active emotional investment in the process.

The issues of confidentiality have been reviewed, and I have been assured that all communications between a professional and a client are held in strict confidence. However, I also understand that there are exceptions to those laws and regulations. I understand it is the clinician's legal responsibility to disclose certain issues for my protection and that of others, and these situations have been clarified to me. Every reasonable effort will be made to resolve issues through discussion and planning within the clinical setting, and I will be notified of any anticipated compromise of the client-therapist relationship.

I have the right to terminate the therapeutic relationship at any time that I desire, without fault, and I have the right to seek and obtain a second opinion on the procedures and/or treatment process.

Form E: 02.13.17

I understand that I am fully financially responsible for my treatment provided by the clinician, and for any balance that is not covered by my insurance company. A billing service may be used for the collection of insurance reimbursement and co-pay fees. Psychologists have the right to seek the services of a collection agency to obtain payment of past due balances.

My signature certifies that I have read and understand all the information provided by Algos Behavioral Health Services Inc., about the clinicians, the treatment to be provided, and the expense to be incurred. I hereby voluntarily give my informed consent for treatment. A copy of this authorization shall be considered valid. I understand that I will be informed of any changes concerning what is in this document and my consent will be obtained regarding these changes.

You are assured that the services will be provided in a professional manner, consistent with the rules and regulations of the Texas State Board of Examiners of Psychologists and the ethical principles of the American Psychological Association. Every effort will be made to provide services in a caring, supportive and trustworthy environment.

In addition to the specified procedure checked above, the initial goals of treatment will be established after the first or second session.

My signature certifies that I have been provided the opportunity to read/review the following relevant documents:

- **HIPAA Notice of Privacy Practices**
- **Statement of Office Policies for Clinical Practice: Psychotherapy, Psychological or Neuropsychological Testing and Behavioral Health Assessments**

My signature certifies that I voluntarily give my informed consent to the clinical services offered by this psychological practice.

X_____ _____

Signature of Client/Patient Date

_____ _____

Signature of Responsible Party (if client is a minor) Date