Haydon-Davis Counseling, Inc

Wendy H. Davis, LCSW

Licensed Clinical Social Worker

305 Kingsley Lake Drive Suite 702 Telephone: (904) 716-5619
St. Augustine, FL 32092 Fax: (248) 751-5913

PATIENT REGISTRATION FORM

Patient's Name:____
Last First Middle Initial

Address:____

____
City State Zip Home Phone

Cell Phone: E-mail:

Sex: Sng/Mar/Div/Other DOB:

Responsible Billing Name: Check here if same as above: ________

____
Last First Middle Initial

Address:____
Street City State

Zip Code Home Phone Cell Phone

Please Note: Payment is to be made at the time services are rendered. Whether or not your insurance company pays in full, a portion, or no portion of your medical bills this is a matter between you and your insurance carrier.

PRIMARY INSURANCE

Insured's Name:____
Last First Middle

Relationship to Patient: _________ Insured's DOB: ___________Insured's SSN:_____________________

Insured's Home Phone:______________________ Insured Work Phone:________________________

Name of Insurance Carrier:___________________________ Employer:___________________________

Policy Number: ___________________________________Group Number:______________________

I certify that the information I have reported with regard to my insurance coverage is correct and permit a copy of this authorization to be used in place of the original. This authorization may be revoked either by me or the above name carrier at anytime in writing.

Signature of Subscriber: _______________________________________ **Date:** _________________

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION:

I authorize payment of medical benefits to the Provider named above for professional services. I also authorize the release of any psychiatric, medical or other information including protected health information (PHI) and/or medical records necessary to process claims. I also request payment of government benefits either to myself or to the provider above who accepts assignment.

Signed: ____ **Date:** _________________

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List of Charges

Initial Evaluation: $135
Individual Therapy 45 mn.............................$115
Family Therapy 60/90 mn...........$135/200
Late Cancel/Missed appointment Fee:...........$85
Letter/Form to Physician, Schools, Etc: $120

Cancellation/Rescheduling & Arrival Time Policy

If you are unable to make your scheduled appointment, please contact my office **24** hours in advance. Missed appointments, those without proper notice of cancellation or need for rescheduling, will be assessed a $85 fee. Please be aware that insurance companies will **not** reimburse for missed appointments. Also note that if you arrive late for your appointment, you are forfeiting that time. Your appointment starts at the time on your appointment card, not when you arrive.

In Case of Emergency

If you feel you are at danger to yourself or someone else, call 911 immediately.

If you need to speak with me about an urgent matter and it cannot wait until normal business hours, you may leave a voice mail on my main number and I will return your call promptly. I will also leave a message on my voice mail that will indicate who to contact should I be unavailable. I will make reasonable attempts to inform you ahead of time when I will be unavailable, i.e. emergencies, vacation or attending a workshop.

Court Appearances

Court appearances and custody evaluations are billed to the individual requesting the testimony. The fee for these services is $250/hour with a required minimum fee of $750 paid 24 hours in advance. Payment is expected in Cash or Money Order. There are no refunds. Report writing is billed at $120 per hour and requires one hour be paid in advance. In the event that records or other materials are subpoenaed, a charge of $1 per page will be made for coping and file preparation.

Payment Agreement

- I authorize Haydon-Davis Counseling, Inc to release information to my insurance carrier for the purpose of processing insurance claims for the patient indicated below.
- I understand that all co-pays and deductibles are due at the time of the patient's appointment.
- I understand that I will be charge $25 fee for a returned check. I understand checks may no longer be accepted if a check is returned for insufficient funds - payment will need to be cash or Money Order.
- I understand an account is considered delinquent if the patient has not paid the balance within 30 days following written notification of the balance due. I understand that the unpaid balance will then be subject to a monthly finance charge of 15%. **Any portion of the account balance over 60 days old will be submitted to a collection agency and continue to accrue interest.**
- I am responsible to pay all collection costs on any unpaid balance on my account, generally 50% of balance.
- I understand that for each counseling session, I am responsible for payment of $ ________________.
- **I acknowledge responsibility for my account and guarantee payment of all charges against it.**

Patient's Name: ____
Last First Middle

Responsible Party:____
Last First Middle

Your signature below indicates that you have read, understand and agree to comply with all the terms and conditions explained above.

Signature of Responsible Party: _________________________________Date:_________________

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment: We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law: Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization: Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations. As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the NASW Code of Ethics and HIPAA.

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Notice of Privacy Practices (continued)

Child Abuse or Neglect: We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect. Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients: We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies: We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care: We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight: If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement: We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions: We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health: If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety: We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research: PHI may only be disclosed after a special approval process or with your authorization.

Fundraising: We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

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Notice of Privacy Practices (continued)

Verbal Permission: We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at ________________________:

• **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

• **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

• **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

• **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

• **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

• **Breach Notification**. If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

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• **Right to a Copy of this Notice**. You have the right to a copy of this notice.

Notice of Privacy Practices (continued)

COMPLAINTS If you believe we have violated your privacy rights, you have the right to file a complaint in writing with Wendy H. Davis, LCSW or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint. The effective date of this Notice is September 2013.

Florida Statutes: Florida statutorily grants patients the right of access to medical records maintained by health care practitioners. The disclosure of patient information by providers is generally prohibited without the patient's consent, subject to specified exceptions. Florida has numerous laws protecting the confidentiality of health information held by a variety of entities and government agencies.

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Haydon-Davis Counseling, Inc.'s **Notice of Privacy Practices**. A complete notice with explanations of uses, disclosures, rights and information on how to file a privacy complaint is available at the following: In person at the office or by phone at 904-716-5619.

____

Signature of Patient/Client Date

____

Signature or Parent, Guardian or Personal Representative * Date

____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____ Patient/Client Refuses to Acknowledge Receipt:

____

Signature of Staff Member Date

Patient Name: MR#:

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Authorization for Electronic Communication

As a convenience to me, I hereby request that Haydon-Davis Counseling, Inc. communicate with me regarding my treatment by Haydon-Davis Counseling, Inc. via electronic communications (e-mail or text message). I understand that this means Haydon-Davis Counseling, Inc and/or my treating providers will transmit my protected health information such as information about my appointments, diagnosis, medications, progress and other individually identifiable information about my treatment to me via electronic communications. I understand there are risks inherent in the electronic transmission of information by e-mail, on the internet, via text message, or otherwise, and that such communications may be lost, delayed, intercepted, corrupted or otherwise altered, rendered incomplete or fail to be delivered. I further understand that any protected health information transmitted via electronic communications pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, Haydon-Davis Counseling, Inc. shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information by Haydon-Davis Counseling, Inc. to me.

After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize Haydon-Davis Counseling, Inc. to communicate electronically with me, which will include the transmission of my protected health information electronically. I understand that in the event I no longer wish to receive electronic communications from Haydon-Davis Counseling, Inc., I may revoke this authorization by providing written notice to Haydon-Davis Counseling, Inc. at P.O. Box 600003 Jacksonville, FL 32260-0003 or fax at 248-751-5913.

I agree that Haydon-Davis Counseling, Inc. may communicate with me electronically unless and until I revoke this authorization by submitting notice to Haydon-Davis Counseling, Inc. in writing. This authorization does not allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties.

I hereby authorize the transmission of my protected health information electronically as described above.

Patient Name ___________________________________

Signature of Patient ______________________________ Date _______________

Signature of Parent for minor ______________________________ Date _______________

Pt Name: ______________________________ MR#: ______________

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Parental Consent and Treatment Agreement For a Child or Adolescent

You or your son or daughter is requesting counseling services at the Haydon-Davis Counseling, Inc. Because (s)he is under 18 years of age, parental consent is necessary for her/him to receive counseling and psychological services. The purpose of this form is to inform you about the counseling process and you and your child's rights and responsibilities regarding clinical services.

The process for arranging counseling involves your child's scheduling an appointment to meet with a counselor. Before the appointment, you and your child will be asked to complete forms. The forms (s)he will be asked to complete are extensive, but provide the counselor with important information about the child's background. However, a counselor-client relationship is not created until your child has visited with a counselor in person.

Your child's first meeting with one of our counselors will be an initial assessment. In the initial assessment, the counselor will help your child clarify her/his concerns and discuss services that are most likely to be helpful. At each session, we ask that the parent participates by meeting with the counselor individually or with the child.

CONFIDENTIALITY

Haydon-Davis, Counseling, Inc. adheres to strict confidentiality standards according to Florida Law. While your child is a minor, you have rights to discuss your child's counseling with her/his counselor. After your child becomes 18, you can have her/him give the counselor written permission to allow two-way communication between yourself and the counselor. If your child does not sign such a release at that time, you can communicate information to the counselor, but the counselor will not be able to confirm whether or not your child is continuing in counseling or talk to you about your child's counseling experience. Please note that although you have rights to your child's counseling information until they become 18, it is often in the best interest of college-aged clients if their parents are only involved when requested by the client and/or counselor

Haydon-Davis Counseling, Inc. will maintain confidentiality about the fact that your child is in counseling, the information your child discloses in counseling, and your child's counseling records. If you or your child wants us to provide information about your child's counseling to your pediatrician or other professional, we will do so with your child's written authorization. Until your child is 18 years old, your written permission is also necessary. There are several instances when information may be released. First, in an effort to provide her/him with the best service, the counselor may share information about her/him with a licensed colleague for the purpose of clinical consultation.

You should be aware that Haydon-Davis Counseling, Inc. staff may be required to disclose client information, even without consent, in the following situations:

1. When doing so is necessary to protect the client or someone else from imminent physical and/or life-threatening harm.
2. When a client lacks the capacity or refuses to care for him/herself and such lack of self care presents substantial threat to his or her well-being.
3. When the abuse, neglect, or exploitation of a child, elder adult, or dependent adult is suspected. Examples of abuse, neglect, or exploitation include, but are not limited to, violence towards a minor, a minor witnessing violence or being in the presence of violence, drug use in front of or while caring for a minor, or financial exploitation of an elder adult. Examples also include incidents of past abuse, including those described above, if the alleged perpetrator of abuse is currently in a caretaker capacity with any minor or is still present in the home of a minor.
4. When a client is involved in a legal proceeding and there is a court order for the release of the client's records.
5. When a release is otherwise required by law (e.g., Patriot Act).

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Informed Consent and Treatment Agreement for a Child or Adolescent (continued)

BENEFITS AND RISKS

Counseling is an active and cooperative effort involving both the patient and the counselor. Counseling may result in better emotional and mental health and positive changes in behaviors and coping ability. However, through the normal process of counseling and discussing your child's personal concerns, your child may experience greater emotional distress at times. Your child also may find that the positive changes that (s)he makes may result in changes in the relationships in her/his life (e.g., gaining relationships, becoming closer in relationships, losing relationships, or relationships feeling more distant). If you or your child has any concerns about your child's progress or the results of her/his counseling, we encourage you or your child to discuss them with her/his counselor at any time.

PATIENT RESPONSIBILITIES

Patients are expected to behave in a respectful manner. Failure to do so may also result in termination of services.

Parental Informed Consent for Child's Counseling Services at Haydon-Davis Counseling, Inc.

I am the parent or legal guardian of ______________________________.
Minor Child's Name

I have full, partial, or rotating custody of the above child/adolescent. I have received a copy of the Haydon-Davis Counseling, Inc. Parental Consent for Counseling form. I have read and fully understand the information contained in this form. I hereby give my permission to Wendy H. Davis, LCSW to engage in counseling/psychotherapy with my daughter/son.

______________________________ ______________________
Student's Name (Print) Student's Date of Birth

______________________________ ______________________
Name of Parent/Legal Guardian (Print) Date

______________________________ ______________________
Parent/Legal Guardian's Signature Date

______________________________ ______________________
Wendy H. Davis, LCSW Date