SPECTRUM PSYCHOLOGICAL AND NEUROTHERAPY, P.C.

NEW PATIENT PACKET

DATE: _____

PATIENT DEMOGRAPHICS

FULL LEGAL NAME (FIRST MIDDLE LAST): _____

PREVIOUS NAME(S): _____ PREFERRED NAME: _____

DATE OF BIRTH: _____ SEX: _____ SSN: _____

RACE: _____ ETHNICITY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

(ADULT CLIENT OR PARENT) MARITAL STATUS: _____ EMPLOYMENT STATUS: _____

(ADULT CLIENT OR PARENT) EMPLOYER: _____

CONTACT INFORMATION

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

ELECTRONIC NOTIFICATIONS: ☐ EMAIL ☐ TEXT MESSAGE

By selecting the checkboxes, the patient agrees to receive text and/or email notifications from the practice.

CLINICAL BACKGROUND INFORMATION

Has the client been in therapy before? (Circle one). YES NO

If yes, where and with whom? _____

_____

Has the client had psychological testing previously? (Circle one). YES NO

If yes, where and when? _____

Primary Care Physician: _____

Please list **ALL current** medications: _____

_____

Please List **ALL past** medications: _____

Who prescribes these (Provider Name & Practice Name? _____

Other treatment contacts (i.e., occupational therapy, speech language therapy, case management):_____

_____

Who referred you to this office? _____

EMERGENCY CONTACT INFORMATION

FULL NAME (FIRST LAST): _____

PHONE NUMBER: _____ RELATIONSHIP:_____ EMAIL:_____

LEGAL GUARDIAN / PARENT CONTACT INFORMATION (OF MINOR CLIENT)

FULL NAME MOTHER (FIRST LAST): _____

PHONE NUMBER: _____ RELATIONSHIP: _____ EMAIL:_____

FULL NAME FATHER (FIRST LAST): _____

PHONE NUMBER: _____ RELATIONSHIP: _____ EMAIL:_____

SPECTRUM PSYCHOLOGICAL AND NEUROTHERAPY, P.C.

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY: _____

MEMBER ID #: _____GROUP #: _____

SUBSCRIBER'S NAME: _____

RELATIONSHIP TO PATIENT: _____ SUBSCRIBER DATE OF BIRTH: _____

SUBSCRIBER'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SUBSCRIBER'S PHONE NUMBER: _____

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY: _____

MEMBER ID #: _____GROUP #: _____

SUBSCRIBER'S NAME: _____

RELATIONSHIP TO PATIENT: _____ SUBSCRIBER DATE OF BIRTH: _____

SUBSCRIBER'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SUBSCRIBER'S PHONE NUMBER: _____

RESPONSIBLE PARTY INFORMATION

RELATIONSHIP TO PATIENT: _____

FULL NAME (FIRST LAST): _____

DATE OF BIRTH: _____ SEX: _____ SSN: _____

RACE: _____ ETHNICITY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYMENT STATUS: _____ EMPLOYER: _____

CELL PHONE: _____ EMAIL: _____

ELECTRONIC NOTIFICATIONS: ☐ EMAIL ☐ TEXT MESSAGE

By selecting the checkboxes, the responsible party agrees to receive text and/or email notifications from the practice.

NAME OF CURRENT PHARMACY: _____

ADDRESS: _____

CITY: _____ ***STATE:*** _____ ***ZIP:*** _____

PHONE NUMBER: _____

SPECTRUM PSYCHOLOGICAL AND NEUROTHERAPY, P.C.

CLIENT FINANCIAL STATEMENT OF AGREEMENT

As your therapist, I believe in providing comprehensive, confidential services to assist you; therefore, I wish to clarify the following policies which are important to understand before you enter into contractual agreement with Spectrum Psychological and Neurotherapy, P.C., of which the terms and conditions are as follows:

- I understand my financial responsibility to total charges and insurance benefits are part of my financial resources and do not waive my personal responsibility. **Initial: _____**
- I authorize Spectrum Psychological and Neurotherapy, P.C. to release to my insurance company or representatives any information regarding my treatment, including diagnosis, that is necessary to process my insurance claims. I authorize and request my insurance company to pay my benefits directly to Spectrum Psychological & Neurotherapy, P.C. All insurance information has been listed correctly. I understand that if any charges are not covered by the listed insurance will be my responsibility. I understand my co-payment, deductible, and co-insurance are due at the time services are rendered. I understand that if my insurance denies the claim, I will be responsible for the full amount of the charges. **Initial: _____**
- I will provide any change in name, address, or phone number and will provide correct and updated insurance information, as necessary. **Initial: _____**
- Should I or my dependent request a Spectrum Psychological and Neurotherapy, P.C. clinician to make a court appearance (or such appearance is subpoenaed by the court), I understand that I will be charged for such appearance(s), document preparation, travel, consultation with court officers and waiting time, at the current fee schedule rate. Court appearances are NOT covered by insurance. **Initial: _____**
- I understand that self-pay services must be paid prior to services being rendered. **Initial: _____**
- A fee agreement can be made only with Dr. C. Rick Ellis, Ed.D. If not adhered to and/or if delinquent for sixty (60) days, the agreement becomes null and void and full payment of the balance will be due immediately. **Initial: _____**
- I agree to pay all costs of collection, which includes but is not limited to, interest on any unpaid balance, court costs, collection fees and I agree to be responsible for any reasonable attorney fees incurred by Spectrum Psychological & Neurotherapy, P.C. **Initial: _____**
- **LATE CANCEL AND NO-SHOW APPOINTMENTS**

  If I do not provide sufficient notice (24 hours/one business day) to cancel an appointment reserved for me, I understand I may be charged up to $100.00. This charge must be paid before I can schedule my next appointment. I have been informed and acknowledge that my insurance company **DOES NOT** pay this charge. If I have missed three or more appointments without a 24-hour notice, I may be prohibited from making any future appointments.

My signature acknowledges that I have read and understand the above contract and agree to comply with its terms.

_____ _____

Name of Client or Legal Guardian Relationship

_____ _____

Signature of Client or Legal Guardian Date

_____ _____

Witness Date

SPECTRUM PSYCHOLOGICAL AND NEUROTHERAPY, P.C.

CONSENT FOR USE OF ELECTRONIC HEALTH RECORDS

I understand that Spectrum Psychological & Neurotherapy, P.C. uses Electronic Health Records. All of my records will be kept electronically. My Electronic Health Records will be kept in accordance to federal, state and local laws. These records are available to me, with a request in writing. I understand that the release of medical records does take up to 14 calendar days.

_____ _____

Name of Client or Legal Guardian Relationship

_____ _____

Signature of Client or Legal Guardian Date

_____ _____

Witness Date

SPECTRUM PSYCHOLOGICAL AND NEUROTHERAPY, P.C.

CONSENT TO TREAT MINOR CHILD

I, _____, as the legal parent/guardian of _____,

give permission for my child to be evaluated and treated by Spectrum Psychological & Neurotherapy, P.C.

I understand that this authorization is valid for the duration of the evaluation and treatment provided and that I may retract this permission/consent in writing at any time.

_____ _____
Name of Client Relationship

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Witness Date

MEDICAL AUTHORIZATION FORM

ONLY complete this form if you would like someone other than the legal guardian to bring your child to their appointments.

I, the undersigned, parent/guardian of _____, hereby authorize _____,

_____ (relationship to child), to authorize any and all medical treatment they in their discretion see fit.

This authorization shall remain in effect for 12 months, unless revoked.

_____ _____
Name of Client Relationship

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Witness Date

SPECTRUM PSYCHOLOGICAL AND NEUROTHERAPY, P.C.

CLIENT RIGHTS AND RESPONSIBILITIES

Client Rights:

- I have chosen to receive treatment at Spectrum Psychological & Neurotherapy, P.C. My choice has been voluntary and I understand that I may terminate therapy at any time.
- I understand that confidentiality of record or information collected about me is protected by law and the ethics of the counseling profession. Records will be held or released in accordance with state laws regarding confidentiality of such records and information.
- I understand state and local laws require that my therapist report all cases of abuse or neglect of minors or elderly.
- I understand state and local laws require that my therapist report all cases in which there exists a danger to self or others.
- I understand that I have the right to informed consent, an explanation of my condition and the treatment that I can understand. I have the right to participate in the planning of my treatment, refuse treatment and file complaints or compliments. Treatment often involves addressing concerns that are distressing and I can discontinue at any time, although this is best done in consultation with my provider of care.
- I have the right to receive care that is respectful.
- I have the right to receive care in a safe setting that is appropriate for my needs.

Client Responsibilities:

- I am responsible for providing information about my health, including past diagnoses, illnesses, allergies, hospital stays, medications, advanced directives and any need for special equipment or assistive devices.
- I am responsible to ask questions when I do not understand information and instructions given to me.
- I am responsible to show respect and consideration toward other patients and staff.

Signature below is only acknowledgement that I have received the patient rights and responsibilities.

_____ _____

Name of Client Relationship

_____ _____

Signature of Client or Legal Guardian Date

_____ _____

Witness Date

SPECTRUM PSYCHOLOGICAL AND NEUROTHERAPY, P.C.

HIPAA 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 IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations. Treatment means providing, coordinating, managing health care and /or related services by one or more health care providers. Examples of treatment would include office visits, neurotherapy services, psychological testing, etc. Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance plan for your mental health services. Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone, text, or e-mail) or provide you with information about treatment options or other health-related services, including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected health information when we are required to do so by federal, state or local law. We may disclose your protected health information to public health authorities that are authorized by law to collect information (i.e. the Centers for Disease Control) or to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your protected health information if requested by a law enforcement official for any circumstance required by law. We may release your protected health information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your protected health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your protected health information if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your protected health information to federal officials for intelligence and national security activities authorized by law. We may disclose protected health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your protected health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your protected health information for workers' compensation and similar programs. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to request a copy of your protected health information (charges for the copying are subject to state requirements).

The right to request an amendment to your protected health information. The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.

The right to obtain a paper copy of this notice from us upon request. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

Signature below is only acknowledgment that you have read this Notice of HIPPA Privacy Practices.

_____ _____

Name of Client Relationship

_____ _____

Signature of Client or Legal Guardian Date

_____ _____

Witness Date

SPECTRUM PSYCHOLOGICAL AND NEUROTHERAPY, P.C.

Authorization for Release of Information

Client Name: _____ Date of Birth: _____

I hereby authorize: To:

Spectrum Psychological and NeuroTherapy, P.C. _____Release Information To
3145 Virginia Beach Blvd. Suite 100
Virginia Beach, VA 23452 _____ Obtain Information From
Phone: 757-640-1882
Fax: 757-640-0253

Name/Agency: _____
Address: _____
Phone: _____Fax: _____
For the purpose of: Treatment Planning
Specific Information to be released: Service dates of: _____to_____
_____ Psychiatric Evaluation
_____Oral Communication
_____Psychological Testing/Assessment
_____Progress/Psychotherapy Notes/Labs
_____School Records
_____Other (specify) _____

This authorization may be relied upon when transmitted by FAX ____Yes _____No
I further authorize the information to be sent by FAX ____Yes _____No

1. I understand that this authorization will expire 12 months after the date signed below.
2. I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Spectrum Psychological Services in writing.
3. I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment, or eligibility for benefits (if applicable).
4. I may inspect or copy any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a healthcare provider or plan covered by federal privacy regulations, the information described above may be disclosed and would no longer be protected by these regulations.

_____ _____
Signature of Client Date

_____ _____
Signature of Legal Guardian Witness

_____
Name of Clinician