

Registration Information

Date _____

Patient Name _____
Last First

If Minor, Custodial Parent(s)/Guardian Name _____

Parent/Guardian Phone #: _____

Contact Information:

	<i>Preferred method of contact?</i>	<i>Okay to leave msg?</i>
Home Phone: _____	Yes / No	Yes / No
Cell Phone: _____	Yes / No	Yes / No
Email Address: _____	Yes / No	

Social Security #: _____ Sex: M F Age: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Marital Status: Please Circle:

Single Married Widowed Divorced Separated Partner

Employment Status: Please Circle:

Actively Employed Unemployed Retired Disability Student

If Employed, Patient/Parent Employer: _____

Employer Address: _____

Occupation: _____ Work Phone: _____

Spouse's Name: _____ Spouse's Employer: _____
(Or responsible party, if patient is a minor)

Occupation: _____ Bus/Cell Phone: _____

Patient Referred to Practice By: _____

Medical Insurance Information:

Insurance Company Name: _____

Subscriber Name: _____

Subscriber Date of Birth: _____(required)

Policy/Account # _____

Insurance Company Phone Number: _____

In case of an emergency, please contact:

Name: _____ Relationship: _____

Contact Number: _____

Regarding HIPAA Regulations

Stuart J. Nathan, Ph.D. & Associates is required to provide you notification of HIPAA guidelines and your rights under the Privacy Act. **Your signature below indicates you have received the HIPAA terminology definitions and psychotherapy-patient service agreement.**

Please Sign Below.

Signature of Patient/Parent/Guardian

Date

Release of Information

Stuart J. Nathan, Ph.D.

Karen E. West, Ph.D.

Steven S. Callahan, Ph.D.

Michelle Marion Rhodes, Ph.D.

Stephanie Hanks, Ph.D.

Angela Larey, Ph.D.

Sarah Helen Gillis, LMSW

Andrea Estrada, L.P.C.

Sharon Larsen, L.P.C.

Cathy Binstock, LMSW

Kathleen Lanini, LCSW

Stuart J. Nathan, Ph.D. and Associates requires permission from you to discuss your treatment with our clinic. We also need your permission to obtain information from other sources. The following is your agreement to do so if appropriate. **Please list your referring provider, and/or surgeon if applicable**, or any other person you wish our office to disclose information to on your behalf.

The following authorization is regarding _____.
 Patient Name (Print) (Date of birth)

_____ I authorize Stuart J. Nathan, Ph.D. and Associates to release records to
 Initials individuals/entities listed below.

_____ I authorize Stuart J. Nathan, Ph.D. and Associates to obtain records from the
 Initials individuals/entities listed below.

Name	Relationship	Phone	Fax

I authorize release of the following (please check all that apply):

_____ assessment reports _____ treatment summary _____ progress notes
 _____ confirmation of treatment _____ session attendance _____ verbal updates

I authorize this release for the following time period: _____ to _____.
 date date

I understand this authorization can be revoked by me in writing at any time. In addition, I may also add individuals/entities as needed in writing at any time.

 Patient/ Parent/Guardian Signature

 Date

 Witness

 Date

Patient Information Regarding Professional Fees

The purpose of this document is to inform our patients of their personal responsibilities to our office and to allow us to focus on what is most important, which is helping you.

Our Office Policy:

We collect all co-payments or fees for services at the time of the appointment.

We accept all major credit cards, cash or checks (no temporary checks accepted).

Initials I understand that SJN & Associates has the right to charge me **\$140.00** for missed appointments, and/or cancellations with less than 24 hours notification that is not covered by insurance. This amount must be paid in full before making your next appointment.

Initials I am aware that a fee of **\$25.00** will be charged for **non-emergency** calls when a message is received through the **live operator** from our **answering service** during non-business hours.

Initials I am aware that a fee of \$50.00 will be charged to me for returned checks, along with a \$6.50 fee for Return Receipt of Signature and Certified Mail expense. Fees can also be charged to cover copies, bank fees, filing documents to court and for any court appearances, which may be necessary.

Our Office Policy: Claims are processed at the time received by your insurance company and according to your benefits on that date. Quote of benefits by your insurance carrier are not a guarantee of payment.

Initials I understand that I am financially responsible for services provided. Any services which are not covered by my insurance company are my responsibility. I understand that my insurance will be billed directly as a courtesy.

Initials I agree to advise the office when I come in of any change in my address, phone number, marital status, insurance or responsible party that has occurred since my last appointment.

Patient/Parent/Guardian Signature

Date

Patients Exempt From Professional Fee Policies

For Workers' Compensation Patients Only

Our Office Policy: Anyone covered by Workers' Compensation is exempt from responsibility for the fees associated with services provided to them. This office will bill the insurance company directly for all services provided. You will not receive a bill and are not considered personally responsible for any charges incurred. However, if the injury is not accepted by the insurance company or DWC/TDI (Division of Workers' Comp-Texas Department of Insurance) the responsibility becomes the patient's as per Texas State Law.

However, we reserve the right to charge for late cancellations, or no show appointments, which is not covered by the workers' compensation insurance carrier.

Initials I understand that I may be charged \$140.00 for late cancellations, and/or missed appointments less than 24 hours. I understand that this fee is not covered by my workers' compensation carrier.

For VAMC/QTC Patients Only

Our Office Policy: Any veteran being referred for evaluation by QTC related to compensation and benefits review is exempt from responsibility for the fees associated with services provided to them. This office will bill QTC directly for all services provided.

Records for all services provided are sent on to QTC, and are property of the Department of Veterans Affairs. As a result, Release of Information is considered implicit back to QTC and the Department of Veterans Affairs. This office does not maintain those records or provide follow up intervention related to the mental condition being evaluated.

Initials I understand that the Department of Veterans Affairs has access to all records related to my evaluation. If I need a copy of my records, I will notify my case manager with the VA and understand that this office is not authorized to release records back to me.

Patient/Parent/Guardian Signature

Date

Patient Request for Accounting of Disclosures of Their Health Information/Medical Records

Please Read: Complete Areas Highlighted Below

- I have been made aware that I may request a copy of my medical records within the first year of my initial visit at no charge. Any subsequent years following, there will be a charge of \$5.00 for the request of medical records. I also understand records can only be retrieved for up to 7 years after the initial date of service.
- I understand that I may receive an accounting of disclosures (copies of my records sent) for a period of up to 6 years from the date of the request for disclosures or the date of my initial visit.
- I understand that Stuart J. Nathan and Associates will notify me if a request for release of records is made by/for:
 - A physician's office, hospital or healthcare entity requesting my treatment, payment or health care operations,
 - Department of Homeland Security for national security of intelligence purposes (as specified in the Notice of Privacy Practices), or
 - Correctional institutes and/or law enforcement officials under certain circumstances.
- A response to your request for the accounting of disclosures/copy of your medical records will be made within 30 days.

Given the aforementioned conditions, I (*Patient Name*) _____, hereby give permission for disclosures of my protected health information/medical records.

Patient/ Guardian Signature

Date

For Office Use Only

Date: _____

Records related to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Purpose: _____

Confidentiality in Psychotherapy:

All aspects of your participation in services at Stuart J. Nathan, Ph.D. & Associates, including the scheduling of appointments, contents of assessments and therapy or counseling sessions, outcomes of services, and all contents of your records are confidential by state law. A confidential record of the services provided to you will be maintained as required by state law. Only the specific individual may have access to his or her file with the exception of records of a minor as defined by state law. Your record consists of both paper files and electronic record components. All parts of your record are highly secured, physically and/or electronically, and are protected by the same confidentiality and privacy laws.

Stuart J. Nathan, Ph.D. & Associates operates as a single entity, which means that psychologists and other clinicians within may share your information in order to consult with each other in order to provide you the most effective services. Only professional clinicians may access clinical progress notes, test data, or other clinical information in your file. Support staff may have access only to contact and demographic information, diagnostic codes, and funding information for billing and office management purposes. Stuart J. Nathan, Ph.D. & Associates, retains ownership of all physical records and is responsible for establishing policies regarding retention of records. No information may be released without your written permission, with the following exceptions.

Exceptions to Confidentiality:

Stuart J. Nathan, Ph.D. & Associates staff may use or disclose personal health information (PHI) without your consent or authorization in the following circumstances:

- If a clinician learns of or has strong suspicions of abuse or neglect of a child, an elderly person, or person with a disability each as defined by Texas state law. Clinicians must file a report with the appropriate protective service agencies.
- If a clinician assesses that you pose an imminent danger to yourself or others. Clinicians may do what is necessary to protect life within the limits of the law.
- In the case of a court-ordered subpoena. Such orders may require the release of records or a clinician testimony at a court hearing.
- We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials. By law we cannot reveal when we have disclosed such information to the government.
- If a clinician learns of client abuse or sexual exploitation by a previous therapist. While client anonymity may be protected, clinicians must report such instances to the appropriate county district attorney and licensing board.

My signature below indicates that I have read and understand the above-mentioned policies regarding confidentiality.

Signature

Date