CHILD AND FAMILY THERAPY ASSOCIATES

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's last name:	First:	MI:	Sex: M F	Marital status: Sin Mar Div Sep Wid	
Street address:			Age:	Birth date:	
City:	State:	ZIP Code:	Employer	Occupation	
Mobile Phone	Leave Msg. Yes No	Leave Msg. with Whoever Answers Yes No	May we contact you at work? Yes☐ No☐		
Home Phone	Yes No	Yes No	Employment FT☐ PT☐ Student☐ None☐		
Work Phone	Yes No	Yes No	E-Mail		
PCP			Referred by		

PERSON RESPONSIBLE FOR BILL (IF OTHER THAN PATIENT)

Name	Phone
Address	Relationship
	DOB

EMERGENCY CONTACT

Name	Relationship	
Mobile Phone	Home Phone	Work phone

INSURANCE INFORMATION

Primary

Policy Holder Name	DOB	Relation to Policy Holder	Employer
Insurance Company	Policy Number	Address	
Customer Service Number	Group Number	City/State/Zip	

Secondary

Policy Holder Name	DOB	Relation to Policy Holder	Employer
Insurance Company	Policy Number	Address	
Customer Service Number	Group Number	City/State/Zip	

I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize CAFTA or insurance company to release any information required to process my claims. I agree to notify CAFTA as soon as I am aware of any changes in my health plan coverage. I clearly understand that final responsibility for payment to CAFTA for any and all services rendered due at the time of the visit belongs to me, I also understand that if I suspend or terminate my care and treatment for any reason, any outstanding balance will be immediately due and payable. I fully understand that a 24 hour notice of a cancellation is recommended. If I fail to attend a scheduled appointment, a no-show fee will be charged equal to half of the full session fee.

Patient/Guardian signature	Date

*Deductible, coinsurance, copayments, and no-show fees require a credit card on file

Visa☐ MasterCard☐ American Express☐ Discover☐	Card Number		
Cardholder Name	Exp. Date	CVV Code	Billing Zipcode

The above information is true to the best of my knowledge. I hereby give consent to charge my credit card above for any outstanding balance at the beginning of each month such as deductible, coinsurance, copayments, no-show fees or other amounts my insurance carrier deems payable by me. I fully understand that payment of deductible, coinsurance, copayments, and no-show fees may be paid prior to the end of the month in order to avoid charge to my credit card.

	Patient/Guardian signature		*Date*	

CHILD AND FAMILY THERAPY ASSOCIATES
1121 WESTRAC DRIVE S, SUITE 204
FARGO, ND 58103

Name: _____ Date of Birth: _____ Age:_____ Date:_____
Address: _____

The following information will be helpful to us in determining how to best help you with your concerns. Please fill out this form as completely as you can, and bring it to your first appointment. Use additional space if necessary.

BASIC BACKGROUND INFORMATION:

Education/Vocation:_____
Years of education completed: _____ Highest degree obtained: _____
Current Occupation: _____ Employer: _____

Marital Status:

____ Never married ____ Living together ____ Divorced
____ Married ____ Separated Dates of marriage if divorced:
____ Engaged ____ Widowed _____ to _____

Children:

Name Date of Birth School grade/occupation

_____
_____
_____
_____

PHYSICAL HEALTH:

Please describe any prior or ongoing physical health conditions that you have:

_____
_____
_____
_____

Please provide the following information on any medications that you are currently taking:

Name of medication	Dosage	Reason for medication

LEGAL HISTORY:

Have you ever been convicted of a felony or misdemeanor? YES NO
If yes, please indicate the charge(s) and
dates:_____

_____

CHEMICAL USE HISTORY:

Do you use alcohol? YES NO

If yes, frequency and amount: _____

Do you use tobacco? YES NO

If yes, frequency and amount: _____

Do you use any other street drug: YES NO

If yes, list the type of drug and indicate the frequency and amount:

_____

_____

_____

PRIOR TREATMENT HISTORY:

Have you ever been hospitalized for a psychiatric condition? YES NO

If yes, please indicate the dates and place of hospitalization:

_____

_____

Have you been involved in counseling or psychotherapy previously? YES NO

If yes, please indicate the following:

Reason	Dates of Service	Place of service or provider	Helpful?
			YES NO
			YES NO
			YES NO

FAMILY HISTORY:

Indicate any family history of mental health or addiction history. Leave blank if no relevant history.

Mother: _____

Father: _____

Sibling(s): _____

Child(ren): _____

Other or extended family members:

_____

_____

CURRENT DIFFICULTIES:

Describe briefly how you have been feeling lately.

_____

_____

_____

Have there been any stressors or events in your life that have impacted your mood lately? If so, what have they been?

_____

Please indicate YES or NO to those statements that reflect how you have been feeling lately. Indicate YES if you have been experiencing these symptoms *nearly every day,* NO if you have not been experiencing these symptoms or if you have been experiencing them less frequently.

Have you been feeling depressed or sad?	YES	NO
Have you found it more difficult to enjoy your usual activities?	YES	NO
Have you had a change in your appetite?	YES	NO
Have you had a change in your weight?	YES	NO
Have you been dieting in an attempt to lose weight?	YES	NO
Have you had difficulties with your sleep?	YES	NO
If yes, have you had difficulties falling asleep?	YES	NO
If yes, have you had difficulties staying asleep?	YES	NO
If yes, have you had difficulties with early morning awakening and being unable to fall back asleep?	YES	NO
Have you felt like you needed more sleep than usual?	YES	NO
Have you been tired or experienced low energy?	YES	NO
Have you had excessive feelings of worthlessness or low self-worth?	YES	NO
Have you had feelings of guilt?	YES	NO
Have you noticed decreased ability to concentrate or pay attention?	YES	NO
Do you notice that you have more difficulties than usual making decisions?	YES	NO
Have you experienced recurrent thoughts about your death?	YES	NO
Have you recently thought about taking your own life?	YES	NO
Have you ever attempted suicide?	YES	NO
Have you noticed a decrease in your interest in sexual activity?	YES	NO
Have you experienced an increase in bodily aches and pains?	YES	NO
Have you had problems with anger or irritability?	YES	NO
Have you felt like you are moving in "slow motion?"	YES	NO
If yes, is it noticeable to others?	YES	NO
Have you felt like you are restless, or that you physically can't sit still?	YES	NO
If yes, is it noticeable to others?	YES	NO

Please note any patterns you may have noticed with respect to changes in your mood:

_____

_____

Have you ever had a period in your life where your mood was extremely elevated, you felt that you had the world "by the tail," went for periods where you went without needing much sleep, or engaged in behaviors that others considered were "over the top?" YES NO

Do you have any fears or phobias? YES NO

If yes, list: _____

Do these ever interfere with your life or ability to do things: YES NO

Do you consider yourself a worrier? YES NO

If yes, what types of things do you worry about?

_____

_____

Do you find it hard to control or stop worrying? YES NO

Is your worrying associated with any of the following?

____ Restlessness or feeling "on edge"
____ Fatigue or tiredness
____ Poor concentration or your mind "going blank"
____ Irritability
____ Physical tension
____ Sleep problems

Do you ever "worry yourself sick?" YES NO

If yes, please explain: _____

Do you have thoughts that pop into you head that you can't control and that bother you? YES NO

If yes, are these thoughts that you think most other people would have ("normal worries")? YES NO

If yes, do you find it hard to ignore these, even if you try? YES NO

Do you have any behaviors that you feel like you have to do, have to repeat, or that you have to do in a certain way? YES NO

If yes, what are these?

_____

_____

If yes, does doing the behavior make you feel better? YES NO

Do you feel anxious in situations where there are a lot of unfamiliar people or where you think you may be evaluated or that you will do something embarrassing? YES NO

If yes, have you ever avoided situations as a result? YES NO

Would you say that this has caused problems for you? YES NO

Do you ever have periods of intense fear or panic attacks? YES NO

If yes, do these come "out of the blue?" YES NO

If yes, note which symptoms are prominent for you:

____ Heart palpitations	____ Sweating	____ Trembling/Shaking
____ Shortness of breath	____ Smothering sensation	____ Choking sensation
____ Chest pain/discomfort	____ Nausea/upset stomach	____ Dizziness/feeling "faint"
____ Feelings of unreality	____ Fear of going crazy	____ Feeling detached from yourself
____ Fear of losing control	____ Fear of dying	____ Numbness/tingling sensations
____ Hot or cold flushes		

How long do these periods usually last? _____

Have you ever had anxiety about going someplace/doing something because of these symptoms? YES NO

When did these first occur (and what was going on at the time)?

_____

Have you ever been exposed to a situation where you thought you could have been seriously hurt or injured?
YES NO

If yes, describe the situation.

_____

_____

_____

What emotions are associated with this event for you? _____

Do you ever have recurrent or distressing thoughts about the event? YES NO

Do you have recurrent bad dreams about the event? YES NO

Do you ever feel like you are "reliving" the event? YES NO

Are there any "triggers" for your distress? YES NO

If yes, explain what they are: _____

If yes, explain what happens to you when this occurs:

_____

_____

Indicate which of the following are true for you since the event:

____ I avoid thinking or having conversations about the event
____ I avoid activities, people, or places associated with the event
____ I am not really interested in things that I used to be
____ I really can't recall things about the event
____ I don't really feel like I can relate to others
____ I don't experience much emotion
____ I don't think about my future much

Note which of the following are true for you since the event:

____ I am "jumpy" or easily startled
____ I am "on edge" and wary of threats
____ I am more irritable or have anger outbursts
____ I don't concentrate very well
____ I have troubles with my sleep

What are your goals for your involvement in psychotherapy?

_____

_____

_____

_____

Is there anything specifically in addition to the above questions that you want to make sure the psychologist seeing you visits with you about?

_____

_____

_____

_____

Thank you for filling out this form.

CHILD AND FAMILY THERAPY ASSOCIATES
1121 WESTRAC DRIVE S, SUITE 204
FARGO, ND 58103
T: 701.893.3419 F: 701.356.8801

CONSENT FOR CARE AND TREATMENT (INCLUDING MINOR)

I, _____ give my consent to treat:

myself OR minor child _____
Circle one

date of birth _____, by a psychologist/psychology resident/therapist/physician's assistant at Child and Family Therapy Associates. I consent to any treatment considered necessary and proper in treating my/his/her mental condition. I acknowledge that I am responsible for all charges in connection with any care and treatment rendered. I understand that this consent can be terminated at my request.

_____ _____
Signature of parent, legal guardian, or patient Date

_____ _____
Witness Date

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby authorize Carita R. Shawchuck, Ph.D. PC, and Child and Family Therapy Associates to file a claim to my insurance carrier and/or the Social Security Administration and its carriers, and payment to be made directly to them. I certify that I have the same insurance as stated on the registration form.

I authorize release of any medical information necessary to process the claims.

I agree to notify Child and Family Therapy Associates as soon as I am aware of any changes in my health condition or health plan coverage.

I understand that I am responsible for charges not covered by my insurance. I understand that I must have a balance due of zero prior to continuous sessions or testing unless prior formal alternative payment arrangements have been made.

I authorize the release of mental health information to my primary care/referring physician and to other healthcare providers to whom I may be referred for evaluation and treatment. I can revoke my release of medical information at any time.

_____ _____
Signature of parent or legal guardian Date

_____ _____
Witness Date

CHILD AND FAMILY THERAPY ASSOCIATES
1121 WESTRAC DRIVE S, SUITE 204
FARGO, ND 58103

PSYCHOLOGIST/THERAPIST-PATIENT SERVICES AGREEMENT

Welcome to our practice. This document (the Agreement) contains important information about our 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 protection and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payments, and health care operations. HIPAA requires that health care professionals 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 we obtain your signature acknowledging that we 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 your next appointment. Any questions you have about the procedures may be discussed at that time. When you sign this document, it will represent an agreement between you and your psychologist/therapist. You may revoke this Agreement in writing at any time. That revocation will be binding unless we have taken action in reliance on it; if there are obligations imposed on us 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: Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist/therapist and patient, and the particular problems you are experiencing. There are many different methods your psychologist/therapist may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things discussed, both during therapy sessions and at home.

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.

The first few sessions will involve an evaluation of your needs. By the end of the evaluation, your psychologist/therapist will be able to offer you some first impressions of what your 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 your psychologist/therapist. Therapy involves a large commitment of time, money, and energy so you should be very careful about the psychologist/therapist you select. If your doubts persist, your psychologist/therapist will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS: An evaluation is normally conducted over the course of 2 to 4 sessions. During this time, the psychologist/therapist and patient both decide if said psychologist/therapist is the best person to provide the services needed in order to meet treatment goals. If psychotherapy is begun, one session of 45 to 50 minutes duration per week is generally scheduled at an agreed upon time, although some sessions may be longer, shorter or more frequent. **Once an appointment is scheduled you will be expected to pay for it unless you provide notice of cancellation.** Exceptions will be made for emergencies or inclement weather. If you fail to give at least 24 hour notice or simply do not appear for a scheduled appointment, you may be charged **up to 50%** of the total fee for the day's visit. **It is important to note that insurance companies do not provide reimbursement for cancelled sessions.** In addition, it is our policy that **after 3 failed appointments and/or late cancellations, therapy will be considered to be terminated** unless you and your psychologist/therapist specifically contract differently.

PROFESSIONAL FEES: As of the date notified on the signature page of this document, professional fees are as follows. These fees are subject to change.

Fee Category	Psychologist	LPCC/LICSW
Initial intake per hour	$250.00	$230.00
30 minute therapy session	$125.00	$110.00
45 minute therapy session	$170.00	$160.00
60 minute therapy session	$215.00	$180.00
Interactive Therapy Add-on	$ 30.00	$ 20.00
60 minute crisis session	$215.00	$175.00
30 minute crisis session add-on	$125.00	$110.00
Family therapy	$200.00	$185.00
Psychological testing	$180.00	NA

CANCELLATION POLICY: Once an appointment is scheduled you will be expected to pay for it unless you provide notice of cancellation. Exceptions will be made for emergencies or inclement weather. If you do not appear for a scheduled appointment, you will be charged up to 50% of the total fee for the day's visit. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

In addition to weekly appointments you may be charged for other professional services that you request at the rate of $185 per hour (costs will be prorated for periods of less than one hour). Other services may include psychological testing, test scoring, test interpretation, report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, time attending school meetings or meetings with other agencies or locations, and other services you may request of your psychologist. *Rating forms used in the initial packet of information and registration and any other rating forms sent to others, including teachers and school personnel are billed as Psychological Testing.* If you become involved in legal proceedings that require the participation of your psychologist/therapist, **YOU WILL BE BILLED FOR ALL PROFESSIONAL TIME**, including preparation and transportation costs and attorney fees incurred by your psychologist/therapist, **EVEN IF YOUR PSYCHOLOGIST/THERAPIST IS CALLED TO TESTIFY BY ANOTHER PARTY**. Because of the complexities of legal involvement, $375 per hour will be charged for preparation and attendance at any legal proceeding.

CONTACTING YOUR PSYCHOLOGIST/THERAPIST: Due to work schedules, your psychologist is often not immediately available by telephone. During regular offices hours of 9 AM and 5 PM, Monday through Thursday and AM to noon on Friday, your telephone call will be answered by voice mail or support staff if your psychologist is with another client. Your psychologist/therapist will make every effort to return your call on the same day, with the exception of weekends and holidays. If you are difficult to reach, please include in your message the times when you will be available. If you are unable to reach your psychologist/therapist and feel that you cannot wait for him/her to return your call, contact your family physician or the nearest emergency room and ask for the psychologist/therapist or psychiatrist on call or call 911 for emergency response.

The best way to contact your psychologist/therapist between sessions is by phone. Per federal HIPAA laws, it is our clinic policy to only use email for simple administrative purposes, such as scheduling or changing appointments. Do not email any clinical information to your psychologist/therapist, because we check e-mail only once per day, email is not a secure or confidential means of communication, and copies are kept on internet service providers. Any emails you send to our office will become part of your chart. We will not respond to e-mail.

PROFESSIONAL RECORDS: Professional laws and standards require that Protected Health Information about you is kept in your clinical record. You should be aware that, pursuant to HIPAA, your Protected Health Information is kept in two sets of professional records. One set constitutes your clinic record. It includes information about your reasons for seeking therapy, a description of the ways in which your problems impact on your life, your diagnosis, the goals set forth in treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records which are received from other providers, reports of any professional consultations, your billing records, and any reports that have been set to anyone, including reports to your insurance carrier. In addition, a set of Psychotherapy Notes may be kept. These Notes are for the use of your psychologist/therapist and are designed to assist them in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of conversations, your

psychologist/therapist's analysis of those conversations, and how they impact your therapy. They may also contain particularly sensitive information that you may reveal to your psychologist/therapist that is not required to be included in your Chinic Record. These Psychotherapy Notes are kept separate from your Clinic Record. While insurance companies can request and receive a copy of your Clinic Records, they cannot receive a copy of your Psychotherapy Notes without your signed, written authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of both sets of records, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, it is recommended that you initially review them in the presence of your psychologist/therapist or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, your psychologist/therapist is allowed to charge a copying fee of $35 for the first 25 pages and $.75 per page for any pages beyond 25. This fee includes administrative, document retrieval and postage charges. The exceptions to this policy are contained in the attached Notice Form.

BILLING AND PAYMENTS: As a private practice, it is important for us to manage reimbursements effectively. In that way, we can focus on providing the best services available and prevent payment and billing issues from interfering with the psychotherapeutic process. You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. **If your Insurance policy requires copayment or coinsurance payments, such payments are due at the time of service.** Payment schedules for other professional services will be agreed to when they are requested. **In the event that said psychologist/therapist is seeing a child whose parents are divorced or separated, copayments and coinsurance payments are the responsibility of the parent accompanying the child to the therapy session. As indicated above, such payments are due at the time of the session.**

Payment is due in full after insurance processing is complete. If your account has not been paid for more than 60 days after insurance has paid, and arrangements for payment have not been agreed upon, we 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 require us to disclose otherwise confidential information. In most collection situations, the only information released regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its cost will be included in the claim.

INSURANCE REIMBURSEMENT: In order for realistic treatment goals and priorities to be set, 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. We will provide you with reasonable assistance in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of fees. **It is your responsibility to check with your insurance company to verify coverage.**

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, we will provide you with whatever information we can, based on our 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, we will be willing to call the company on your behalf.

Due to the rising cost of health care, insurance benefits have become increasingly more complex. It is sometimes 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 out specific problems that interfere with a person's usual level of function. 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 they need more services after insurance benefits end. (Some managed care plans do not allow provision of services to you once your benefits end. If this is the case, we will do our best to find another provider who will help you continue your psychotherapy).

Once we have all 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 professional services yourself to avoid the problems described above (unless prohibited by contract).

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist/therapist. In most situations, we 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:

- Your psychologist/therapist may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, they will make every effort to avoid revealing the identity of the patient. The other professionals are also legally bound to keep the information confidential. If you don't object, you will not be told about these consultations unless your psychologist/therapist feels that it is important to your work together. Your psychologist/therapist will note all consultations in your Clinic Records (which is called PHI in the Notice of Policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that your psychologist/therapist employs administrative staff. In most cases it is necessary to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. 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.
- Your psychologist/therapist contracts with various businesses including a cleaning service, accounting firm, collection agency and the company from which our office space is leased. As required by HIPAA, we have formal business associate contracts with these businesses in which they promise to maintain the confidentiality of data, except as specifically allowed in the contract or otherwise required by law.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a patient threatens to seriously harm himself/herself, your psychologist/therapist may take actions to prevent this including seeking hospitalization for him/her, or contacting family members or others who can help provide protection.

There are some situations in which your psychologist/therapist is 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 your evaluation, diagnoses and treatment, such information is protected by the psychologist/therapist-patient privilege law. Your psychologist/therapist cannot provide any information without your written authorization or 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 your psychologist/therapist to disclose information.
- If a government agency is requesting the information for health oversight activities, your psychologist/therapist may be required to provide it for them. .
- If a patient files a complaint or lawsuit against your psychologist/therapist, he/she may disclose relevant information regarding that patient in order to defend himself/herself.
- If a patient files a worker's compensation claim, your psychologist/therapist must, upon appropriate request, provide appropriate information including a copy of the patient's record or other information concerning mental health care services to the Worker's Compensation Bureau.

There some situations in which your psychologist/therapist is legally obligated to take actions, which he/she believes are necessary to attempt to protect others from harm and he/she may have to reveal some information about a patient's treatment. These situations are unusual, but do occasionally occur.

- If your psychologist/therapist has reason to suspect that a child is abused or neglected the law requires that he/she file a report with the Department of Human Services. Once such a report is filed, he/she may be required to provide additional information.
- If your psychologist/therapist has knowledge of or reasonable cause to suspect that an adult with developmental disabilities or mental illness is abused or neglected or exploited, the law requires he/she report such information to the Protection and Advocacy Project. Once such a report is filed he/she may be required to provide additional information.
- If a patient threatens serious physical harm to an identifiable victim, your psychologist/therapist may take actions to protect the victim. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

If such a situation arises, your psychologist/therapist will make every effort to fully discuss it with you before taking any action and he/she will limit the 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 any questions or concerns that you may have now or in the future are discussed with your psychologist/therapist. The laws governing confidentiality can be quite complex, and your psychologist/therapist is not an attorney. In situations where specific advice is required, formal legal advice may be needed.

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 your psychologist/therapist amend your record; requesting restrictions on what information from your Clinic Record is disclosed to others; receiving confidential communications by alternative means at alternative locations; 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 policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form and the privacy policies of this practice. Your psychologist/therapist is willing to discuss any of these rights with you.

MINORS & PARENTS: 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 unless the psychologist/therapist decides that such access is likely to injure the child or you both agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is the policy of your psychologist/therapist to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment the psychologist/therapist will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Any other communication will require the children's authorization. The psychologist/therapist will also provide parents with a summary of their child's treatment when it is complete. Before giving parents any information, the psychologist/therapist will discuss the matter with the child, if possible, and do his/her best to handle any objections the patient may have. At any time, should the psychologist/therapist feel that the child is in danger or is a danger to someone else, the psychologist/therapist will notify the child's parents.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE **READ, UNDERSTAND AND AGREE** TO THE TERMS OF THIS PSYCHOLOGIST/THERAPIST-PATIENT SERVICES AGREEMENT.

Patient name (print): _____

_____Date_____
Signature of patient/legal guardian

Relationship to patient, if applicable_____

CHILD AND FAMILY THERAPY ASSOCIATES
1121 WESTRAC DRIVE S, SUITE 204
FARGO, ND 58103

Patient Financial Responsibility Policy

Financial Policies:

- As a private practice, it is important for us to manage reimbursements effectively in order to avoid billing issues from interfering with the psychotherapeutic process. Therefore, payment for each session is due at the time of service.
- Payment is due in full at the time that services are rendered. We will collect your initial estimated portion (deductible, coinsurance and/or copay) and then bill the insurance company for the session. You will be responsible for any outstanding balance following insurance reimbursement. Previously approved financial arrangements can be made for subsequent visits depending on the circumstances. Our office accepts Visa, MasterCard, Discover, Flexible Spending Account debit cards, personal checks, and cash as forms of payment.
- Although information regarding your insurance coverage is provided as a courtesy, we suggest that you confirm your benefits with your insurance company as well. We will work with your insurance company to help you receive the benefits for which you are entitled. However, you, not your insurance company, are ultimately responsible for full payment of fees.
- You will receive a Statement for Services if a balance remains on your account after insurance reimbursement is received by our office. The amount on your monthly statement is due upon receipt of your bill. We will continue to send a statement each month until the balance of your account is paid in full. A finance charge of 1.5% of the balance due will be applied to accounts over 30 days old. If your account has not been paid for more than 60 days after insurance reimbursement has been received by our office, and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment.
- As noted, statement balances are due upon receipt. This means that any outstanding balance at the time of your next appointment must be paid before the session begins.
- **In the case of parents who are divorced or separated, copayments and coinsurance payments are the responsibility of the parent accompanying the child to the therapy session.**
- Cancellation Policy: Once an appointment is scheduled you will be expected to pay for it unless you provide notice of cancellation. Exceptions will be made for emergencies or inclement weather. If you do not appear for a scheduled appointment, you will be charged up to 50% of the total fee for the day's visit. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.
- If you have any questions regarding your account balance, or if you are experiencing circumstances beyond your control, please discuss your concerns with your therapist.

Please Sign Page 2

CHILD AND FAMILY THERAPY ASSOCIATES
1121 WESTRAC DRIVE S, SUITE 204
FARGO, ND 58103

Patient Financial Responsibility Agreement

Welcome to the office of Child and Family Therapy Associates. We are happy to answer any and all questions regarding payment policies.

Our Policy requires payment at the time of service for your visit.

If you are a member of an insurance plan, it is your responsibility to:

- Provide us with information relative to your claim, including insurance card, number, birth date, and address. This information is requested on the Patient Registration form that we ask you to complete at your initial visit.
- Pay your estimated deductible, coinsurance, and copay at the time of service.
- Pay for services not covered by your insurance carrier upon receipt of the Statement of Services.

Insurance claims for your carrier are filed as a courtesy.

- To assist you with your payment, our office accepts Visa, MasterCard, Discover, Flexible Spending Account debit cards, personal checks, or cash.
- In the case of divorced or separated families, the parent bringing in the child for the session is responsible for payment at the time of the appointment.

When your bill is unpaid, a collection agency may be chosen to manage delinquent accounts. Please refer to the Psychologist/Therapist-Patient Services Agreement for our policy on delinquent accounts.

Cancellation Policy: Once an appointment is scheduled you will be expected to pay for it unless you provide notice of cancellation. Exceptions will be made for emergencies or inclement weather. If you do not appear for a scheduled appointment, you will be charged up to 50% of the total fee for the day's visit. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

Your signature below indicates that you have read the Patient Financial Responsibility Policy and the Patient Financial Responsibility Agreement and agree to its terms.

Patient name (print): _____

_____ Date_____
(Signature of patient/legal guardian)

Relationship to patient, if applicable: _____

CHILD AND FAMILY THERAPY ASSOCIATES
1121 WESTRAC DRIVE S, SUITE 204
FARGO, ND 58103

NOTICE OF POLICIES AND PRACTICES TO PROTECT THE
PRIVACY OF YOUR HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND. HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. **Uses and Disclosures for Treatment, Payment, and Health Care Operations**

Your psychologist may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment and Health Care Operations"
  - Treatment is when your psychologist provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when your psychologist consults with another health care provider, such as your family physician or another psychologist.
  - Payment is when your psychologist obtains reimbursement for your healthcare. Examples of payment are when your psychologist discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - Health Care Operations are activities that relate to the performance and operation of this practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within this office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of this office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

Your psychologist may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when your psychologist is asked for information for purposes outside of treatment, payment and health care operations, he/she will obtain an authorization from you before releasing this information. He/she will also need to obtain an authorization before releasing your psychotherapy notes. “Psychotherapy notes” are notes your psychologist has made about the conversation during a private, group, joint, or family counseling session, which he/she has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) your psychologist has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

Your psychologist may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If, in the professional capacity of your psychologist, he/she 1has gained knowledge of or has reasonable cause to suspect that a child is abused or neglected or has died as a result of abuse or neglect, your psychologist is required by law to report the circumstances to the North Dakota Department of Human Services.
- **Adult and Domestic Abuse:** If your psychologist has knowledge or reasonable cause to suspect that an adult with developmental disabilities or mental illness to whom he/she is providing services is being abused, neglected, or exploited, your psychologist is required by law to report the circumstances to the North Dakota Protection and Advocacy Project.
- **Health Oversight:** If the State Board of Psychologist Examiners subpoenas your psychologist, he/she must appear as a witness and bring copies of patient records.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your evaluation, diagnosis and treatment and the records thereof, such information is privileged under state law and your psychologist must not release your information without your written authorization or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. Your psychologist will inform you in advance if this is the case.
- **Serious Threat to Health or Safety:** Your psychologist may disclose your confidential information to protect you or others from a serious threat of harm by you.
- **Worker's Compensation:** If you file a worker's compensation claim, your psychologist may disclose any information, including subsequent prognosis reports, records, bills, and other information concerning mental health care services to the North Dakota Worker's Compensation Bureau.

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IV. <u>Patient's Rights and Psychologist's/Therapist's Duties</u>

<u>Patient's Rights:</u>

- Right to Request Restrictions - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, your psychologist is not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations - You have the right to request and receive confidential communications of PBI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, your psychologist will send your bills to another address.)
- Right to Inspect a Copy - You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, your psychologist will discuss with you the details of the request
- Right to Amend - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. Your psychologist may deny your request. On your request, your psychologist will discuss with you the details of the amendment process.
- Right to an Accounting - You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, your psychologist will discuss with you the details of the accounting process. .
- Right to a Paper Copy - You have the right to obtain a paper copy of the notice from your psychologist upon request, even if you have agreed to receive the notice electronically.

<u>Psychologist's/Therapist's Duties:</u>

- Your psychologist is required by law to maintain the privacy of PHI and to provide you with a notice of his/her legal duties and privacy practices with respect to PHI.
- Your psychologist reserves the right to change the privacy policies and practices described in this notice. Unless he/she notifies you of such changes, however, he/she is required to abide by the terms currently in effect.

- If your psychologist revises privacy policies and procedures, he/she will notify you as described below.

V. Complaints

If you have questions regarding privacy rights described in this notice, if you disagree with a decision made about access to your records, or if you believe that your privacy rights have been violated, you may file a written complaint with the privacy officer, Carita Shawchuck, Ph.D., 1121 Westrac Drive S, Suite 204, Fargo, ND 58103; 701-893-3419. You may also send a written complaint to the Secretary of the US Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

We must follow the privacy practices described in this notice beginning April 24, 2003. We may change our privacy practices and this notice at any time. Any changes will apply to the Protected Health Information we maintain at that time. When such change is made, you will be asked to read the new agreement and resign the form.

I have received a copy of this Notice of Policies and Practices to Protect the Privacy of Your Health Information form. I understand that my signature indicates I have received the notice.

I have received a copy of this Notice of Policies and Practices to Protect the Privacy of Your Health Information form (HIPPA). I understand that my signature indicates I have received the notice.

Patient name (print): _____Signature_____

Relationship to patient, if applicable_____Date_____

CHILD AND FAMILY THERAPY ASSOCIATES
1121 WESTRAC DRIVE S, SUITE 204
FARGO, ND 58103

ACKNOWLEDGEMENT OF RECEIPT OF THERAPIST/PATIENT AGREEMENT AND NOTICE OF PRIVACY PRACTICES

I have read the Psychologist/Therapist-Patient Services Agreement and understand the professional and business policies of Child and Family Therapy Associates, as well as the right to privacy with regard to Protected Health Information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) including:

- The Psychologist/Therapist-Patient Relationship
- Professional Records
- Billing and Payment
- Cancellation Policy
- Insurance Reimbursement
- Use and Disclosures of Protected Health Information
- Patient Rights

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLDEGEMENT THAT YOU HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES INFORMATION DESCRIBED ABOVE.

Patient name (print): _____

_____ Date_____
(Signature of patient/legal guardian)

Relationship to patient, if applicable: _____