



Family Psychiatry & Psychology Associates, P.A.

Patient name: _____ D.O.B. _____

Social Security Number: _____

PATIENT ACKNOWLEDGEMENT

I understand that the patient's health information is private and confidential. I understand that Family Psychiatry and Psychology Associates, P. A. works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that Family Psychiatry and Psychology Associates, P.A. may use and disclose the patient's personal health information to help provide health care to the patient, to handle billing and payment, and to take care of other health care operations. (In general, there are not other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. One example would be if a patient threatened to hurt someone.)

Family Psychiatry and Psychology Associates, P. A. has a detailed document called the "Notice of Privacy Practices". It contains more information about the policies and practices protecting the patient's privacy and is attached to this Acknowledgement. I understand that I have the right to read the "Notice of Privacy Practices". If I ask, Family Psychiatry and Psychology Associates, P.A. will provide me with the most current "Notice of Privacy Practices".

Within the Notice of Privacy Practices is contained a complete description of my privacy/confidentiality rights. These rights include, but aren't limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative locations.

Family Psychiatry and Psychology Associates, P.A. has established procedures which help them meet their obligations to patients. Their procedures may include other signature requirements, written acknowledgements information, charges for copies and non-routine information needs, etc. I will assist Family Psychiatry and Psychology Associates, P. A. by following these procedures if I choose to exercise any of my rights described in the "Notice of Privacy Practices".

My signature below indicates that I have been given the chance to review a current copy of Family Psychiatry and Psychology Associates, P.A. "Notice of Privacy Practices".

Patient or legally authorized individual signature

Date

Time

Relationship to patient if signed by anyone other than the patient



Family Psychiatry & Psychology Associates, P.A.

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act 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.

We may use and disclosed your medical records only for each of the following purposes:

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Healthcare operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer services. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

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.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- 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 friend, 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 reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- 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



Family Psychiatry & Psychology Associates, P.A.

with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and 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. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that our privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information at the address listed at the bottom of the page.

For more information about HIPPA or to file a complaint:

The U.S. Dept. of Health & Human Services
Office of Civil Right
200 Independence Avenue, S.W.
Washington, D.C. 20201



Family Psychiatry & Psychology Associates, P.A.

INTAKE FORM

(confidential)

Patient Information:

date: _____

Last Name: _____ First: _____ MI: _____

Date of Birth: _____ Age: ____ Sex: () M () F SSN: _____

Mailing Address: _____

City/State: _____ Zip: _____

Home: (____) ____ - _____ Work: (____) ____ - _____ Marital Status: _____

Name of Person(s) Financially Responsible: _____

Relationship to Patient: _____

Address (if different than patient's): _____

City/State: _____ Zip: _____

Employer/School Information:

Name: _____ Occupation: _____

Address: _____

City/State: _____ Zip: _____

Education/Degrees: _____ Grade: _____

Parent/Spouse's Information:

Name: _____ number: (____) ____ - _____

Relationship to patient: _____

Employer Name: _____ number: (____) ____ - _____

Address: _____ City/State: _____ Zip: _____

Emergency Contact Information:

name: _____

Home: (____) ____ - _____ Work: (____) ____ - _____ other: (____) ____ - _____



Family Psychiatry & Psychology Associates, P.A.

Medical History

Primary Care Physician

Name of Practice: _____ Doctor: _____

Address: _____ number: (____) ____ - _____

Past Diagnosis (please give the year)

1) _____

2) _____

3) _____

Current Medications (Include dosage and frequency)

1) _____ 2) _____

3) _____ 4) _____

Known Allergies: _____

Severe Illness (childhood to present): _____

Previous Out/Inpatient Therapy (please specify which) _____

Stressors affecting you or your family in the past 1-2 years:

Deaths

Job Change

Sexual Abuse

Births

School

Broken Relationship

Marriage

Step-Children

Unwanted Pregnancy

Divorce

Separation

Substance Abuse

Moving

Physical Abuse

Medical

Chronic Illness

Presenting Problem/Reason for Visit: _____



Family Psychiatry & Psychology Associates, P.A.

FINANCIAL POLICY

APPOINTMENTS

The keeping of regular appointments is the most effective means of successful therapy. As schedule permits, we will work out a most convenient time for you for these appointments. The scheduling of an appointment constitutes an agreement to pay for the professional time reserved exclusively for you. We will charge for telephone and/or communication consultations with your provider, which are longer than five minutes, at the usual and customary rate should your provider deem it appropriate. Our policy is to charge for missed appointments or appointments canceled with less than 24 hours notice at the rate of the reserved session. You will be billed directly for this time.

PAYMENT OF FEES

Payment is to be made in full at the time of service. We accept cash, check, and MasterCard/Visa. Payment of any unpaid balance on an account must be received in full before the close of the month. Payments are non-refundable. You will be charged a \$25 service charge for all returned checks. Unpaid balances older than 90 days will be subject to collections proceedings. Service may be interrupted until payment is made.

CONSENT TO RELEASE OF INFORMATION

Patient agrees that his individual provider may share information with other providers at Family Psychiatry and Psychology Associates, P.A. (FPPA) with regard to his/her case in order to better provide quality treatment. This information will be kept strictly confidential and remain in the confines of FPPA only.

REPORTS, CONSULTATIONS AND OTHER CLERICAL MATTERS

Any reports, professional consultations, or clerical tasks involving time beyond that of the regular scheduled session will be a pro-rated charge for the professional or clerical time involved.

READ CAREFULLY AND SIGN

I have read, understand, and agree to comply fully with the above policies. I recognize and accept full financial responsibility for all professional services rendered.

Signature of Patient/Responsible Party

Date

Signature of Office Staffer Doctor