Applied Psychological Services, P.C.
1627 W. 26TH ST
Joplin, MO 64804
Phone# 417-627-9601
Fax# 417-627-9032

Intake Information Sheet

Identifying/Contact Information:

Last Name:_____ First:_____ Middle_____Date_____

Date of Birth:_____ Age:_____ Social Security #:_____

Gender: ☐ Male ☐ Female *Marital Status*: Single Married Divorced Separated Widowed

Race/Ethnic Origin (circle those that apply):

Asian American Indian/Alaskan Native African American/Black Hispanic/Latino Native Hawaiian/Pacific Islander Caucasian/White Other:_____

Contact Information:

Street Address:_____

City: _____ State: _____ Zip Code:_____

Home Telephone #: _____ Alternate Telephone #: _____

Email Address: _____

May we contact you by telephone? ☐ Yes ☐ No Leave a phone message? ☐ Yes ☐ No

Write you at your local address? ☐ Yes ☐ No Have you ever been seen here before? ☐ Yes ☐ No

Health Information: Please list any medical conditions for which you are receiving treatment:_____

_____

_____

_____

Please list any medication, herbs, or supplements you are taking:_____

_____

_____

_____

_____

_____

Insurance Company Name: _____

Insurance Company Phone #:_____ Member ID:_____

CONSENT FOR BEHAVIORAL HEALTH SERVICES

Greetings and welcome to Applied Psychological Services! This document contains important information regarding the professional services you are seeking. Please thoroughly read the following information and sign to indicate your consent to receive services. If you have any questions or if there is something you do not understand, inform a staff member to obtain clarification before signing.

Nature and Anticipated Course of Services

Psychotherapy Counseling: The nature and course of psychotherapy or counseling often varies depending on each clinician and patient, and the particular problems being brought forward. There are many different methods that could be used to deal with the issues presented. For optimal effectiveness, psychotherapy requires active participation on the part of the patient inside and outside of sessions. Psychotherapy could include both benefits and risks. Since it may involve discussing unpleasant aspects of life, the patient may experience uncomfortable feelings such as sadness, guilt, anger, frustration, loneliness, and helplessness. On the contrary, research has suggested most individuals benefit from taking part in psychotherapy. For example, it may lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, no guarantees can be made for probable outcomes. Psychotherapy will often be held on a weekly basis for 45 to 50 minutes, though this depends on individual arrangements made between the clinician and patient.

Assessment/Evaluations: The nature and course of psychological assessment depends on the purpose for the evaluation. It may include multiple meetings and could require the completion of standard psychological procedures (for example, written surveys). These will be administered as deemed necessary and by the mutual consent of patient, authorized representative (if applicable), and clinician. Typically, psychological assessments are scheduled in 2-hour blocks, though this depends on individual arrangements made between the clinician and patient.

Limits of Confidentiality

The limits to the confidentiality for services are thoroughly outlined on the "Notice of Behavioral Health Policies and Practices" document. Potential exceptions occur during group, family, or couple'/marital psychotherapy as the adherence to these policies by other patients is beyond the control of the clinician. Furthermore, if the requested are mandated or authorized by a 3rd party (such as with Probation/Parole, Division of Family Services, or Social Security) it may be required to disclose obtained information (such as attendance, diagnosis, or assessment results). If the services you are seeking fall under such a category, the clinician will notify you of this.

Optimal Consent for Research

Applied Psychological Services is dedicated to the advancement of knowledge in the field of psychology. As a part of this, clinicians may conduct studies on the information obtained from behavioral health services IF permission is granted. Such data may include age, gender, and assessment results. However, the patient's identifying information (such as name, address, or date of birth) would NEVER be used. Allowing this data to be made available for research purposes is completely voluntary, and the acceptance or refusal of this offer will in no way effect the services rendered or respective outcomes. The patient or authorized representative (if applicable) should initial the appropriate statement to indicate his/her preference.

☐ **Yes, my information can be used anonymously for research purposes**

☐ **No, my information cannot be used for research purposes**

Financial Responsibility/Cancellations

Payment is expected for services when rendered, in the form of cash, credit card, or check made payable to Applied Psychological Services. The amount of applicable fees will be established during the initial visit. The patient or authorized representative is ultimately responsible for the balance, regardless of insurance status. If there is an outstanding balance for more than 60 days and arrangements for resolution have not been agreed upon, Applied Psychological Services and its clinicians reserve the option of using legal action to secure payment. This may involve hiring a collection agency or filing suit, and any associated costs will be added to the outstanding balance. The patient or authorized representative is required to give 24-hours notice to cancel a scheduled appointment. If 24-hours notice is not given, or the patient does not show for the appointment, the account will be assessed as a fee.

My signature below indicates I have read and understand this information, and give my consent to receive services.

_____ _____

PRINT Patient's Name Date

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Witness Signature Date

Offer to receive a copy of this form: (please initial) _____**ACCEPTED** _____**DECLINED**

Notice of Behavioral Health Policies to Protect the Privacy of Patient's Health Information

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

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

Applied Psychological services and its practitioners/employees (hereafter APS) may *use* or *disclose* the patient's *protected health information (PHI) for treatment, payment, and health care operations* purposes with the patient's consent. Associated definitions:

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

II. Uses and Disclosures Requiring Authorization

APS may use or disclose PHI for purposes outside of treatment, payment, or health care operations when the patient's appropriate authorization is obtained. An *"authorization"* is written permission about and beyond the general consent that permits only specific disclosures. In those instances, when the practitioner is asked for informational purposed outside of treatment, payment, or health care operations, and authorization will obtained from the patient before releasing the information. The practitioner will also need to obtain an authorization before releasing the patient's psychotherapy notes. *"Psychotherapy Notes"* are notes the practitioner has made about conversations during a private, group, joint, or family counseling session, which the practitioner keeps separate from the rest of the patient's medical record. These notes are given a greater degree of protection then PHI.

The patient may revoke all such authorization (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. The patient may not revoke an authorization to the extent that (1) the practitioner has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining payment from a third party, such as for insurance coverage (law provides the insurer the right to contest the claim under certain policies).

III. Uses and Disclosures with Neither Consent nor Authorization

APS and its practitioners/employees may use or disclose PHI without your consent or authorization in the following circumstances:
* *"Child Abuse":* If there is reasonable cause to suspect that a child has been or may be subjected to abuse or neglect, or if the practitioner observes a child being subjected to conditions that would reasonably result in abuse or neglect, the practitioner must immediately report such information to the Missouri Division of Family Services. The practitioner may also report child abuse or neglect to a law enforcement agency or juvenile office.
* *"Adult and Domestic Abuse":* If there is reasonable cause to suspect that an eligible adult "defined below" present a likelihood of suffering physical harm or is in need of protective services, the practitioner must report such information to the Missouri Department of Social Services. *"Eligible Adult"* means any person 60 years of age or older, or an adult with a handicap "substantially limiting mental or physical impairment" between the ages of 18 and 59, who is unable to protect his/her own interest or adequately perform or obtain services which are necessary to meet his/her essential human needs.
* *"Health Oversight Activities":* The Missouri's Attorney General's Office may subpoena records from the practitioner relevant to disciplinary proceedings and investigations conducted by the Missouri State Committee or Psychologists, the Missouri State Committee of Counselors, or other relevant licensing entity.
** "Judicial and Administrative Proceedings":* If the patient is involved in a court proceeding and a request is made for information about diagnosis or treatment and the records thereof, such information is privileged under state law, and the practitioner will not release information without written authorization from him/her or his/hers personal or legally appointed representative, or a court order. The privilege does not apply when the patient is being evaluated for a third party or when the evaluation is court ordered. The practitioner will inform you in advance if this is the case.
* *"Serious Threat to Health or Safety":* When the practitioner judges that disclosure is necessary to protect against a clear and substantial risk if imminent serious harm being inflicted by the patient on him/herself or another person, the practitioner must disclose relevant, confidential information to the appropriate workers, public authorities, the potential victim, his/her family, or the patient's family.
* *"Worker's Compensation":* If the patient files a worker's compensation claim, the practitioner must permit your record to be copied by the Missouri Labor and Industrial Commission or the Division of Worker's Compensation of the Missouri Department of Labor and Industrial Relations, the patient's employer, the patient and any other party to the proceedings.
* *"Feedback":* Feedback to referring physician or other entity who suggested the patient comes to APS is important to treatment coordination and will be provided in minimum necessary form. The patient may elect that this not be done, simply by oral request.

IV. Patient's Rights and Therapists Duties

Patient's Rights

* *Right to request restrictions:* the patient has the right to request restrictions on certain used and disclosures of protected health information, e.g., asking that a certain clerical person not type notes about you. However, the practitioner is not required to agree to a restriction the patient requests.

* Right to *Receive Confidential Communications by Alternative Means and at Alternative Locations:* The patient has the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, the patient may not want a family member to know he/she is receiving services. On the patient's request, bills will be sent to another address.)

**Right to Inspect and Copy:* The patient has the right to inspect or obtain a copy (or both) of PHI in the mental health and billing records used to make decisions about the patient for as long as the PHI is maintained in the record. The practitioner may deny the patient's access to PHI under certain circumstances, but in some cases, the patient may have this decision reviewed. On the patient's request, the practitioner will review the details of the request and the denial process.

* *Right to Amend:* The patient has the right to request an amendment of PHI for as long as the PHI is maintained in the record. The practitioner may deny the request. On the patient's request, the practitioner will review the details of the amendment process.

**Right to an Accounting:* The patient generally has the right to receive an accounting of disclosures of PHI. On the patient's request, the practitioner will review the details of the accounting process.

**Right to a Paper Copy:* The patient has the right to obtain a paper copy of the notice from the practitioner upon request, even if the patient has agreed to receive the notice electronically.

Therapist's Duties

*APS is required by law to maintain the privacy of PHI and to provide the patient with a notice of legal duties and privacy practices with respect to PHI.

* APS reserves the right to change the privacy policies and practices describes in this notice. Unless notification is provided, APS is required to abide by the terms currently in effect.

* If APS revises its policies and procedures, the patient will be notified in writing.

V. Complaints

It is the policy of APS to provide services to all persons without regard to race, color, national origin, age, gender, disability, religious, or political beliefs. Patients who believe their privacy rights have been violated, who disagree about what APS has done with regard to records access or who believe they have been denied a benefit or service may file a complaint of discrimination or PHI violation with Dr. Jennifer Alberty or with the Department of Social Services, Office of Civil Rights at 1-800-776-8014 or the Department of Health and Human Services at 1-816-426-7277. Any complain about the nature or quality of service delivered or denied by a professional at APS may be made in writing to Dr. Alberty. Two professionals (excluding the professional involved) will be appointed to review the case and respond to the patient in writing. An interview may then be conducted at the patient's request. If the patient is not satisfied, a referral will be made to the appropriate State of Missouri or federal professional oversight body for further resolution.

VI. Effective Dates, Restrictions, and Changes to Privacy Policy

This notice will go into effect on November 1, 2005. APS reserves the right to change the terms of this notice and to make the new notice previsions effective for all PHI that are maintained.

Agreed so by:

_____ _____

Patient Name Date

_____ _____

Patient's legally authorized representative* Date

_____ _____

Practitioner's Name Date

If the patient refused to sign this form, his/her reasons for preferring not to are noted below and services are provided in the normal manner. If a legally authorized representative of the patient signs the Notice, a description of such representatives' authority to act for the patient must be provided below.

Offer to receive a copy of this document: (please initial) _____**ACCEPTED** _____**DECLINED**

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Name:

_____ _____ _____

Last First M

Phone: ( ) - _____ DOB: ____/____/____ SSN: _____

I authorize the following organization to release the protected information as indicated below.

This authorization covers the time period _____/_____/_____ (date) to _____/_____/____ (date)

Information to be released FROM:

[ ] **Applied Psychological Services, P.C.**

[ ] _____

Organization/Person Name

_____

Street Address

_____

City, State, Zip

_____

Telephone Number

Information to be released TO:

[ ] **Applied Psychological Services, P.C.**

[ ] _____

Organization/Person Name

_____

Street Address

_____

City, State, Zip

_____

Telephone Number

Specific Information being requested:

[ ] Verbal Communication [ ] Records of Psychological Treatment [ ] Medical Treatment

[ ] Diagnosis/Prognosis [ ]Records of Psychological Evaluation [ ] Pharmacological Interventions

[ ] Other _____

Purpose or Need for this information:

[ ] Verbal Communication [ ] Records of Psychological Treatment [ ] Medical Treatment

[ ] Diagnosis/Prognosis [ ]Records of Psychological Evaluation [ ] Pharmacological Interventions

[ ] Other _____

This authorization contains restrictions [ ] YES [ ] NO

If yes, please specify: _____

This authorization will expire one (1) year from the date of signature unless otherwise specified by the following date, event or condition:

_____

I understand I have the right to revoke this authorization, in writing, at any time. The revoking of this authorization shall not cancel any prior action that has already transpired. My signature below indicates I herby agree and authorize the release of confidential information to the above name person and/or organization. I release and discharge the above named organization from any and all liability for action made pursuant to this authorization. Certain information (including alcohol and drug abuse and HIV) may be protected by Federal Laws and Regulations [42 USC 290-3, 42 USC 209 ee-3, 42 CFS Part 2]. I acknowledge I have fully reviewed and understand the contents and nature of this authorization form.

Patient/Guardian Signature:_____ Date: _____

Witness Signature:_____ Date: _____