

Client Information and Office Policy Statement Informed Consent

I. New Client: Welcome!

Thank you for choosing to enter treatment. This is an opportunity to acquaint you with information relevant to treatment, confidentiality and office policies. Your therapist will answer any questions you have regarding any of these policies.

II. Aims and Goals:

The major goal is to help you to identify and cope more effectively with problems in daily living and to deal with inner conflicts that may disrupt your ability to function effectively. This purpose is accomplished by:

1. Increasing personal awareness.
2. Increasing personal responsibility and acceptance to make changes necessary to attain your goals.
3. Identifying personal treatment goals.

You are responsible for providing necessary information to facilitate effective treatment. You are expected to play an active role in your treatment, including working with your therapist to outline your treatment goals and assess your progress. There may also be negative consequences if you do not follow through with recommended treatment(s).

You may be asked to complete questionnaires or to do homework assignments. Your progress in therapy often depends much more on what you do between sessions, than on what happens in the session.

III. Appointments:

Appointments are usually scheduled for 45-50 minutes. Patients are generally seen weekly or more/less frequently, as you and your therapist agree. You may discontinue treatment at any time, but please discuss any decisions with your therapist. In the event of an emergency your therapist may be reached after 5:00 p.m. and on weekends at 243-2169. If you are unable to reach your therapist, contact your primary care physician or go to the local hospital emergency room. For urgent calls, our on-call therapist will assist you

IV. Confidentiality:

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include: 1) suspected abuse or neglect of a child, elderly person or a disabled person, 2) when your therapist believes you are in danger of harming yourself or another person, or you are unable to care for yourself, 3) if you report that you intend to physically injure someone the law requires your therapist to inform that person as well as the legal authorities, 4) if your therapist is ordered by a court to release information as part of a legal involvement in company litigation, etc., 5) when your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc., 6) in natural disasters whereby protected records may become exposed or, 7) when otherwise required by law. You may be asked to sign a Release of Information so that your therapist may speak with other mental health professionals or to family members.

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If you are concerned about some of your information, you have a right to ask KPA, to not use or share some of your information for treatment, payment or administrative purposes. Such request must be made *in writing.* Although KPA will try to respect your wishes, KPA is not required to agree to your requested limitations. However, if KPA does agree, KPA is committed to do as you ask. Your insurance company may refuse to pay if consent is restricted and the patient or guardian will be responsible in that case. Ask your therapist for the form to restrict disclosure.

After you have signed this Consent Form, you have the right to revoke it at any time, by writing a letter to the KPA Privacy Officer, informing KPA that you no longer consent to the use and disclosure of your Personal Health Information. On receipt of your letter, KPA will comply with your wishes about using or sharing your information from that time on; your revocation of consent has no effect on information used or shared prior to its receipt by KPA.

V. Complaints:

You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, your physician, therapist, or any office policy, please inform us immediately to discuss the situation.

VI. Record Keeping:

A clinical chart is maintained describing your condition and your treatment and progress in treatment, dates of and fees for sessions and notes describing each therapy session. Your records will not be released without your written consent, unless in those situations as outlined in the *Confidentiality* section above.

VII. Payments:

Fees are due at the time of visit. Contact the office to make payment arrangements. Your therapist will file your insurance claim, but you are responsible for deductibles, co-insurance, and co-payments. It is your responsibility to familiarize yourself with your insurance benefit.

VIII. Cancellations and Missed Appointments:

You will be billed for all sessions that you cancel with less than 24 hours notice. You may leave messages 24 hours per day. You will be billed \$ _____, not just a co-payment. **Insurance companies do not reimburse for missed appointments.** Your therapist is only compensated for time spent with patients.

Informed Consent for Treatment

I am aware that the practice of psychotherapy is not an exact science and that results cannot be guaranteed. No promises have been made to me about the results of treatment.

The risks, benefits side effects and alternatives of treatment as well as the consequences of non-compliance with treatment have been discussed with me and I have had the opportunity to ask questions.

I understand that I need to provide accurate information about myself to my clinician so that I will receive effective treatment. I also agree to play an active role in my treatment process.

I understand that I may terminate treatment at any time.

My signature below shows that I understand and agree with all of the above statements and give consent for evaluation and treatment. I have had the opportunity to ask questions about the treatment process. If the client is a minor or has a legal guardian appointed by the court, the client's parent or legal guardian must sign this consent.

If you do not sign this Consent form agreeing to the provisions of the KPA Notice of Privacy Practices and Policies and Procedures, KPA cannot treat you. Thank you for your cooperation and welcome to our practice!

Signature of Patient or Parent/Guardian

Date

Printed Name

Relationship to Patient (if applicable)

Witness Signature

Date

Patient Financial Responsibility

I understand that I am responsible for all balances due to Karner Psychological Associates. I give permission for my insurance carrier to be billed on my behalf, if applicable. I agree to the following terms:

1. All payments and/or co-payments are due at the time of the visit.
2. If payment cannot be made I will make arrangements with the billing office. I understand that there is a \$15 surcharge.
3. If I receive payment from the carrier in error I will **immediately** turn it over the KPA.

I would like KPA to keep my credit card on file:

Cardholder's Name: _____

Patient's Name: _____

MasterCard _____ Visa _____ Other (specify) _____

Card Number: _____

Expiration Date: _____ Security Number: _____

IMPORTANT MESSAGE!

- We do **not** have a receptionist at this location.
- Please bring the completed forms with you.
- Choose the file on the wall that corresponds with your insurance and place the papers inside.
- If you are an Empire Plan Patient for NYS or if you are insured by United Behavioral Health please complete the Wellness Questionnaire inside the file.
- Please take a seat.
- Your therapist will come out and greet you.
- If your therapist does not come and get you within 10 minutes and you are at the Guilderland Office, please go to the billing office across the hall for assistance.
- Please keep the billing office informed if your insurance changes or if your personal data needs to be updated.

Thank you for your cooperation.

Confidential Health Care Information (please print)

Mental Health Consultation

PATIENT INSTRUCTIONS: Please check the appropriate box below, and complete this form.

I agree

I do not agree to share this confidential information with my Primary Care Physician

I do not agree to share this confidential information with my Behavioral Health Practitioner

Date: _____

Primary Care Physician: _____

Please Print

First Name

Last Name

Address: _____

Patient Name: _____ **DOB:** _____

Please Print

First Name

Last Name

(For Office Use Only)

I saw your patient for a mental health evaluation. If you have any questions, please feel free to contact me.

Admitting Dx: _____

Treatment Recommendations:

Individual Therapy

Couple Therapy

Family Therapy

Other: _____

Group Therapy

Sincerely,

Therapists Signature

Name (Please Print)

To the party receiving this information: If information is disclosed from alcohol or substance abuse records protected by Federal confidentiality rules (42CFR Part2), those rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by these rules.

Member Consent: I hereby authorize the behavioral health clinician./facility listed above to release the information contained on this form to the practitioner/provider listed above. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will last **one year** from the date signed. I understand that I may revoke my consent in writing at any time, except to the extent that the practitioner or entity which is to make the disclosure has already acted in reliance on it. I understand that my treatment is not conditional in any way on my consent to this disclosure.

Therapist's Name: _____

Patient Information

Date: _____

Patient's Name: _____ Date of Birth: _____ Age: _____
Parent's Name (If patient is under 18): _____

Address: _____ City: _____ State: _____ Zip: _____

SS#: _____ Marital Status: Married Single Divorced Widow

Sex: ___ Male ___ Female

Home Phone Number: () _____ Okay to call: ___ Yes ___ No

Work Phone Number: () _____ Okay to call: ___ Yes ___ No

Employer: _____ Occupation: _____

School: _____ Student Status ___ Full Time ___ Part Time

PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

Name: _____ Relationship: _____ Phone: _____

Who referred you to this office?

Name: _____ Phone: _____

Insurance Information:

1. *Primary Insurance Company:* _____

Policy/MemberNumber# _____ Group# _____

PolicyHolder'sEmployer: _____

Policy Holder's Address: _____ City: _____ State: _____ Zip: _____

Who is the policyholder? Self Spouse Parent Name: _____ Date of Birth: _____

2. *Second Insurance Company:* _____

Policy / Member Number # _____ Group # _____

Policy Holder's Employer: _____

Policy Holder's Address: _____ City: _____ State: _____ Zip: _____

Who is the policyholder? Self Spouse Parent Name: _____ Date of Birth: _____

Who is responsible for paying your bill? Client Spouse Patient Relative Employer

Is this a Workers' Compensation Case? Yes No (If yes, please complete a Workers' Comp Info Form so that we can bill this claim for you.)

**Karner Psychological Associates Child/Adolescent Form
(To be completed by parent/guardian)**

Did anything concern you regarding your child's:

Prenatal development Y N

Birth Y N

Early Infancy Y N

Achievement of early milestones (walking, talking, toileting, etc.) Y N

Please describe: _____

Has your child had:

Physical Issues

Psychological Problems

Social Problems

Learning Problems (Academic Intellectual)

Please Describe: _____

Others Concerns: _____

Karner Psychological Associates Patient Self Report

Date: ____/____/____ Patient: _____

Name of Person completing form: _____

Relationship to patient: _____ Why is patient seeking counseling at this time:

Check all problems as apply to identified patient:

Depressed Mood		Decreased Energy		Delusions	
Hopelessness		Guilt		Paranoia	
Irritability		Medical Problems		Hyperactivity	
Obsessions/Compulsions		Grief		Hallucinations	
Panic Attacks		Anxiousness		Elevated Moods	
Financial Problems		Eating Disorders		Sleep Problems	
Problems with Friends		Legal Problems		Difficulty Concentrating	
Problems at Work		Problems at School		Learning Problems	
Self Care Problems		Not Controlling Temper		Probs with Relationship	
Sexual Problems		Not Thinking Clearly		Family Issues	

Please Describe Supports (spiritual/religious, social, community, etc.) _____

Are there supports needed: Y N: _____

Patient identifies as: (religious, cultural, etc.) _____

School/grade: _____ workplace: _____

Do you wish to change work/school situation: Y N

Patient's strengths: _____

Patient's weaknesses: _____

_____ makes the patient angry. When angry I/(s)he _____

To calm down I/(s)he _____

Current Behavioral Health Meds: _____

Prescribed by: Primary MD Psychiatrist Psychiatric Nurse Practitioner; Name _____

Other Medications/health conditions Y N (please share details include surgeries/treatments, on back of form)

In agreement with current medication plan Y N

Past Inpatient Outpatient Mental Health Treatment Substance Abuse Treatment

(please use back of form to give details of places/practitioners and dates)

Allergies (include medication and foods): _____

Please list adverse reactions to meds: _____

Used in past year Cigarettes (#/day____) Caffeine (#/day____) Alcohol(#/day____)

Marijuana Cocaine/Crack Narcotics (not prescribed to you) _____

Family History of Mental Health Issues Substance Abuse Issues (please share person's relationship to patient and type of treatment on back of this form)

If the identified patient is a **child/adolescent** then a **GUARDIAN** should complete the **Child/Adolescent Form. Thank you.**



YES! Please add me to your e-mail list.
I would like to receive your free newsletter.

YES! I would like to receive correspondence
on new products that may help me.

[Please PRINT carefully to ensure correct entry to our e-mailing list.]

My e-mail address is:

E-mail address (PRINT)

Patient's Name (PRINT)

Parent or Guardian Name (PRINT)