KARNER
PSYCHOLOGICAL ASSOCIATES

Patient Name: _____ DOB: _____

Therapist: _____ ☐ Do not know

Late Cancellation Policy

REQUIRES 24 HOUR NOTICE

Insurance Carriers DO NOT PAY for Late Cancellations
Your therapists WILL NOT BE PAID

- Missed Appointments - without 24-hour notice: $50 surcharge
- If you do not want to be charged $50 for missed appointments, please cancel at least 24 hours before your appointment.
- Late Payments: $15.00 surcharge
- **All payments are due at the time of the visit** (unless you make prior payment arrangements at the business office)
- If the Deductible has NOT been met, you will be expected to make payment arrangements with the office. Your deductible must be met before your carrier will pay.
- We will accept your credit card and permission to charge your account when the claim is processed. Please call the office as soon as you receive notice of payment due.
- Non-payment within 45 days of notice may result in termination of care.

☐ **I acknowledge that I have read the above information and understand the above policies and procedures in its entirety and agree to abide by them.**

_____ _____
Signature of Patient or Guardian Date

_____
Relationship to Patient

Main Office: 2280 Western Ave, Guilderland, NY 12084
Clifton Park Office: 634 Plank Rd., Suite 206, Clifton Park, NY 12065
(518) 456-5056 | www.KarnerCare.com

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Client Information and Office Policy Statement

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 a 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 disclosures.**

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, Dr. Frank Doberman 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.

If I am covered by Medicare: I request that payment of authorized benefits be made on my behalf to Karner Psychological Associates for services furnished to me by Karner Psychological Associates. I authorize any holder of medical information about me to release to National Government Services and/or other health plans any information needed to determine these benefits or the benefits payable for related services.

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 therapist, or any office policy, please inform us immediately to discuss the situation.

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.

Payments:
Fees are due at the time of the visit. Contact the office to make payment arrangements if necessary. KPA 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 benefits.

☐ **I acknowledge that I have read the above information and understand the above policies and procedures in its entirety and agree to abide by them.**

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Missed or late appointments will be charged $50 (give at least 24 hours of advance notice to avoid this fee)**.** There is a **$15 service charge** for all co-payments not made at the time of the visit unless otherwise agreed to. **I understand if I receive money from my carrier I will immediately turn it over to KPA. Our therapists are fee-for-service and insurance cannot be billed for missed appointments.**

As such, all missed appointments or those canceled less than 24 hours before the time schedule will incur a $50 fee that must be paid by patient/family.

You may leave messages 24 hours a day at our answering service 518 243-2169 or at our office during regular hours Monday thru Friday 9:30 am to 4:30 pm at 518 456-5056.

☐ **I acknowledge that I have read the above information and understand the above policies and procedures in its entirety and agree to abide by them.**

_____ _____
Patient Name Date

_____ _____
Signature of Patient or Guardian Relationship to Patient

Assignment and Release: I hereby authorize my insurance benefits be paid directly to the physician and acknowledge that I am financially responsible for any and all unpaid balances. I also authorize the therapist to release any information required.

☐ **I understand that I am financially responsible for all charges whether or not covered by my insurance carrier.**

_____ _____
Patient Name Date

_____ _____
Signature of Patient or Guardian Relationship to Patient

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Informed Consent for Treatment

I am aware that the practice of psychotherapy is not an exact science and results cannot be guaranteed. No promises have been made to me about the results of treatment. I understand that I need to provide accurate information about myself so that I can receive effective treatment. I also agree to play an active role in my treatment process.

Telehealth: I understand that telehealth is not 100% secure nor is any electronic device. I understand that KPA has "in person" visit capabilities. I understand that it is my responsibility to secure privacy in my personal surroundings. I understand that I can cancel my "in person" and/or telehealth visits with 24 hour notice

Copays: I understand that there may be a copay and/or deductible due for "in person" or telehealth visits and I will contact my insurance carrier if I have any questions in this regard.

I understand that I may terminate my therapy at any time. My signature below shows that I understand and I agree with all of the above statements. I have had the opportunity to ask questions about the treatment process. If the patient is a minor or has a legal guardian appointed by the court, the patient's parent or legal guardian must sign this consent. We do not accept patients that require court appearances. Please notify us immediately if this applies.

_____ _____

Patient Name Date

_____ _____

Signature of Patient or Guardian Relationship to Patient

Karner Psychological Associates does not discriminate (based on race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of Insurability including conditions arising out of acts of domestic violence, disability, genetic information, or source of payment) in the delivery of health care services and accept for treatment any member in need of health care services they provide.

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Confidential Health Care Information
Mental Health Consultation

☐ **I agree** to allow my therapist to communicate with my ***Primary Care Physician***.
☐ **I *do not* agree** to share this confidential information with my ***Primary Care Physician.***

Primary Care Physician (PCP): _____

Phone: _____ Fax: _____

PCP Office Address: _____

City: _____ State: _____ Zip: _____

_____ _____
Patient Name Date

_____ _____
Signature of Patient or Guardian Relationship to Patient

---------- ***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
☐ Family Therapy
☐ Group Therapy
☐ Couples Therapy
☐ Other: _____
_____

_____

_____

_____
Therapist Printed Name

_____
Therapist Signature

To the party receiving this information: If information is disclosed from alcohol or substance abuse records protected by Federal confidentiality rules (42CFR Part 2), 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/provide 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 consenting to this disclosure.