

GRAVEN & ASSOCIATES

psychology • neuropsychology

Adult New Patient Information Form

PERSONAL INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Address _____ City _____ State _____ Zip _____

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

Preferred Method of Contact Home Phone Cell Phone Work Phone Mail

Employer _____ Education Level _____ Date of Birth ____/____/____ Age _____

DEMOGRAPHIC INFORMATION

Preferred Language: _____ Decline to specify Race: _____ Decline to specify

Ethnicity: Hispanic or Latino Not Hispanic or Latino Decline to specify

REFERRAL INFORMATION

Whom may we thank for referring you to our office? _____

Address _____ Phone (____) _____ - _____ Fax (____) _____ - _____

Signing below indicates that the above information is true and accurate.

Patient Name

Date

Signature

Authorized Representative Relationship/Authority (*CIRCLE ONE*)

Self Guardian Power of Attorney Other: _____

INFORMED CONSENT FOR TREATMENT

Welcome to Graven & Associates, PLLC. This document contains important information about our professional services and business policies. When you sign this document, it will represent an agreement between us. Please read it carefully.

I, _____ (**PRINT PATIENT/PARENT/LEGAL GUARDIAN NAME**), hereby agree and consent to participate in treatment/testing services provided by my Graven & Associates provider. If the patient is under the age of 16 (as per Kentucky law) or unable to consent to treatment, I attest that I have legal custody of this individual and am legally authorized to initiate and consent for treatment on behalf of this individual.

Patient Name

Date

Signature

Authorized Representative Relationship/Authority (*CIRCLE ONE*)

Self Guardian Power of Attorney Other: _____

APPOINTMENTS

Our providers normally conduct a 45- to 60-minute intake evaluation. During this time, you can work with your provider to decide if they are the best person to provide the services you need in order to meet your treatment goals. You can discuss with them the frequency and type of therapy (i.e., individual, couples, family) that would be most beneficial to reduce your symptoms. Once an appointment time is scheduled, you will be expected to pay for it unless you provide 48 hours (2 day) advance notice of cancellation unless you and your provider agree that you were unable to attend due to circumstances beyond your control. Appointments scheduled for Monday must be cancelled by 4:00 PM on Friday. Please do not come to the office sick—this fee is waived in the event of illness or other circumstances at the discretion of Graven & Associates. Work, school and/or social obligations are not considered circumstances beyond your control. Insurance does not pay for missed sessions. In addition, appointment reminders are a courtesy and it is your responsibility to know the date and time of your appointment.

INSURANCE

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. However, it is your responsibility to know what your insurance policy covers and you (not your insurance company) are responsible for full payment of your provider's fees. Further, your provider is not on every insurance panel so it is important that you verify the provider's participation in your network if you will be using your insurance benefits. Ultimately, you are responsible for maintaining coverage through your health insurance. You should also be aware that most insurance companies require you to authorize your provider to provide them with a clinical diagnosis. Sometimes your provider has to provide additional clinical information such as treatment plans, summaries of treatment, copies of an evaluation, or the entire record. By signing this Informed Consent for Treatment you are giving Graven & Associates consent to provide treatment information to your insurance company.

ELECTRONIC COMMUNICATION CONSENT

Electronic communication offers an efficient way to communicate with Graven & Associates. However, this medium is not without its risks. Communication by telephone, cell phone, text, mail, email, websites, fax, and the like are not secure and thus do not guarantee confidentiality. Though your provider takes many steps to protect confidentiality, if you choose to contact your provider via one of these methods, you are accepting the risk that a third party may intercept our communication. Graven & Associates will not be liable for improper disclosure of confidential information that is not caused by our intentional misconduct.

GUIDELINES FOR USE OF ELECTRONIC COMMUNICATION AND APPOINTMENT REMINDER INFORMATION

- Phone calls are NOT appropriate for urgent matters or an emergency situation; instead please call 911 or go to your nearest emergency room.
- Providers typically check messages on a regular basis, however there may be exceptions to this. Most calls are returned within 24 to 48 business hours.
- Graven & Associates is not liable for breach of confidentiality caused by the patient or any third party.
- You are responsible for informing your provider of changes in your contact information including address, email, and phone numbers.
- Please do not request contact or connection with your provider via social media sites such as Facebook or Linked In. This is potentially a violation of your confidentiality and outside the boundaries of the therapeutic relationship.
- Graven & Associates will not email and/or text patients unless it is a means to confirm appointments. The best way to communicate with your provider is via phone, mail, or fax.

Please mark the appropriate selection below.

I **consent** to receive text/email appointment reminders from Graven & Associates at the following cell number and/or email address: _____.

I understand that I may revoke this consent at any time by notifying Graven & Associates in writing of my decision. I understand that this service is a courtesy offered to me and that I am responsible for remembering my scheduled appointment and may be subject to fees if I do not provide a cancellation notice of 48 hours.

I **decline** to receive text/email appointment reminders from Graven & Associates. I understand that I may change this decision at any time by notifying Graven & Associates in writing of my decision. I understand that I am responsible for remembering my scheduled appointment time and may be subject to fees if I do not provide a cancellation notice of 48 hours.

CONTACTING YOUR PROVIDER

Your provider may not be immediately available by telephone, but will make every effort to return your call within 24 to 48 business hours. When they are unavailable, Graven and Associates administrative team will be happy to take a message and give it to your provider or place you in their voicemail. If your provider will be unavailable for an extended time, you will be provided with the name of a colleague to contact, if necessary. If you are unable to reach your provider and feel you can't wait for them to return your call, call 911 or go to the nearest emergency room and ask for the psychologist or psychiatrist on call.

PROFESSIONAL RECORDS

The laws and regulations of this profession requires that your provider keeps treatment records. You are entitled to receive a copy of your records, or your provider can prepare a summary for you instead unless precluded from doing so by federal or state law. Because these are professional records, they can be easily misinterpreted and/or upsetting to untrained readers. If you wish to see your records, it is recommended that you review them in your provider's presence so the contents can be discussed. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

OVERVIEW OF CONFIDENTIALITY POLICIES

In general, the privacy of all communications between a patient and a psychologist are protected by law, and your provider can only release information to others with your written permission/authorization. Your provider's general rule, should you see each other outside the office, is to not indicate your provider knows you unless you acknowledge your provider. To prevent a possible breach in confidentiality with awkward introductions, please avoid approaching your provider in public if they are with someone else.

There are a few exceptions to the rule of confidentiality. In most legal proceedings, you have the right to prevent your provider from providing any information about your treatment. Your provider will inform you if they receive a subpoena for your records. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order your provider's testimony if he/she determines that the issues demand it. Additionally, filing insurance claims with your insurance provider, though they contain little clinical information, constitutes confidential protection.

There are some situations in which your provider is legally obligated to take action to protect others from harm, even if your provider has to reveal some information about a patient's treatment. For example, if your provider believes that a child, elderly or disabled person, or another vulnerable adult is being neglected or abused, your provider is required to file a report with the appropriate state agency. By law health care providers **MUST** report these situations, without exception.

If your provider believes that a patient is threatening serious bodily harm to himself/herself or another person or group of persons, your provider is required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, your provider may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. By law health care providers **MUST** report these situations, without exception.

This summary of the confidentiality standards of Graven & Associates is provided to emphasize the important information found in the Graven & Associates Notice of Privacy Practices. ***Please review the Graven & Associates Notice of Privacy Practices carefully for a complete description of your rights concerning your protected health information and how Graven & Associates will use and disclose your protected health information.***

WRITTEN CONSENT TO RELEASE INFORMATION FOR PAYMENT AND HEALTHCARE OPERATIONS

"Protected health information" or "PHI" refers to information about you that may identify you and relates to your past, present or future mental or physical health or condition and related health services.

J Graven

Graven And Associates, PLLC
8007 Lyndon Centre Way, Suite # 101
Louisville, KY 40222

PATIENT INFORMATION

Last Name _____ First _____ MI _____ Marital Status _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Ok to leave message? Yes No

Date of Birth _____ Age _____ Sex _____ Soc Sec Num _____

Email Address _____ Referred By _____

Employer _____ Work Phone _____

GUARANTOR INFORMATION

WHOMEVER BRINGS IN MINOR CHILD MUST COMPLETE THIS SECTION

Last Name _____ First _____ MI _____ Marital Status _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Ok to leave message? Yes No

Date of Birth _____ Age _____ Sex _____ Soc Sec Num _____

Email Address _____

POLICYHOLDER INFORMATION

Last Name _____ First _____ MI _____ Marital Status _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Ok to leave message? Yes No

Date of Birth _____ Age _____ Sex _____ Soc Sec Num _____

	PRIMARY	SECONDARY	OTHER
INS COMPANY NAME			
POLICY HOLDER NAME			
POLICY NUMBER			
RELATIONSHIP TO PATIENT			

All signatures contained herein apply to services rendered at:

GRAVEN AND ASSOCIATES, PLLC

Informed Consent for Treatment:

I hereby agree and consent to participate in treatment/testing services provided by my provider. If the patient is under the age of 16 (as per Kentucky Law) or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature _____ Date _____

Relationship to patient (if applicable) _____

Release of Information to Third Party Payors/Agents & Authorization and Assignment of Benefits Agreement for Payment of Services:

I authorize my provider to disclose portions for the clinical record on the client named below to my insurance company and/or its contracted managed care/utilization review company for the purpose of reimbursement of services rendered at this facility. Such disclosure may include review and release of copies of psychiatric/psychological and/or substance abuse diagnosis, history & physical examinations, intake assessment, treatment plan, progress notes, testing results, discharge summary and any other information or records necessary for the discharge of the legal contractual obligations of the insurance company.

I hereby release my provider and its' officers, agents, employee and any clinician associated with my case from all liability that may arise as a result of the disclosure of information to the insurance company and/or its contracted managed care/utilization review company.

By signing this release, I acknowledge the following:

1. I am aware that I may revoke this authorization at any time except to the extent that action has been taken in reliance hereon.
2. I agree that this authorization will be valid during the pendency of the claim.
3. I further authorize that payment be made to my provider of service on my behalf.
4. I understand that I am financially responsible for all charges not covered by insurance and/or those stated to be patient responsibility by the third party payor.
5. I understand that any expense that is incurred by my provider associated with collecting the balance on my account, such as collection fees and/or attorney's fee will be my responsibility to pay.

Patient Name _____ Date _____

Patient OR Guarantor Signature _____

Medicare Authorization and Assignment of Benefits:

I request that payment of authorized Medicare Benefits be made either to me or on my behalf for any services furnished by or in the office of my provider of service. I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefit of related services.

Signature _____ Date _____

HIPAA Privacy Notice Acknowledgement:

I understand that I have been given an opportunity to read a copy of my provider's Notice of Privacy Practices. I understand that if I have any questions, that I can direct my question to my provider of service.

Signature _____ Date _____