GRAVEN & ASSOCIATES

psychology • neuropsychology

Child/Adolescent New Patient Information Form

PERSONAL INFORMATION

Last Name _____ First Name _____ Middle Initial _____

School Name _____ Current Grade Level _____ Date of Birth _____ / _____ / _____

Preferred Method of Contact (please select one) □ Home Phone □ Cell Phone □ Work Phone □ Email □ Mail

Parents' Marital Status □ Single □ Married □ Separated □ Divorced □ Widowed □ _____

Is there a legal custody agreement? □ yes □ no □ pending

Who has legal custody and the power to make healthcare decisions? _____

If there is a legal custody agreement, please provide a copy to ensure proper privacy protection of your child.

DEMOGRAPHIC INFORMATION

Preferred Language _____ □ Decline to specify **Race** _____ □ Decline to specify

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

PARENT INFORMATION

PARENT 1	PARENT 2
Name _____	Name _____
Address _____	Address _____
Date of Birth _____ / _____ / _____ Age _____	Date of Birth _____ / _____ / _____ Age _____
Home (_____) _____ - _____ Cell (_____) _____ - _____	Home (_____) _____ - _____ Cell (_____) _____ - _____
Employer _____	Employer _____
Marital Status □ Single □ Married □ Separated □ Divorced	Marital Status □ Single □ Married □ Separated □ Divorced
Stepparent's Name (if applicable) _____	Stepparent's Name (if applicable) _____

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

_____ _____

Patient Name Date

_____

Signature

Authorized Representative Relationship/Authority *(CIRCLE ONE TO CLARIFY YOUR RELATIONSHIP TO THE PATIENT):* Self Guardian Parent Power of Attorney Other:_____

REFERRAL INFORMATION
Whom may we thank for referring you to our office? _____
Address _____
City _____ State _____ Zip _____ Phone (_____) _____ - _____ Fax (_____) _____ - _____

INFORMED CONSENT FOR TREATMENT

Welcome to Graven and 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.

MINORS

If you are under 16 years of age, please be aware that Kentucky law provides your parents the right to examine your treatment records and requires patients age 16 or above to sign all forms in addition to a parent/guardian. If this is a concern, please visit with your provider about this during your first visit. Further, any patient under the age of 16 is required to have a parent/guardian present on the premises during all appointments.

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 and Associates, PLLC. Work, school and/or social obligations are not considered circumstances beyond your control. Insurance does not pay for missed sessions. Any fees accumulated are to be paid before your next appointment. *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 and Associates, PLLC consent to provide treatment information to your insurance company.

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, PLLC 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 that 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 require 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 that 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 and Associates, PLLC is provided to emphasize the important information found in the Graven and Associates, PLLC Notice of Privacy Practices. **Please review the Graven and Associates, PLLC Notice of Privacy Practices carefully for a complete description of your rights concerning your protected health information and how Graven and Associates, PLLC 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.

In an effort to facilitate the payment for services that you receive from Graven and Associates, PLLC and our operations related to your care, Graven and Associates, PLLC seeks your informed written consent for the use and disclosure of your PHI by Graven and Associates, PLLC for the limited purposes of (a) obtaining payment for your psychological and related services from insurers, Medicare, Medicaid and others, as applicable, and (b) supporting the business activities of Graven and Associates, PLLC, including but not limited to, for quality assessment and improvement activities, case management and care coordination, employee review activities, training and supervision of psychological students or psychologists with temporary licensure, and conducting or arranging for other business activities such as audits and administrative services.

Except as provided in the Graven and Associates, PLLC Notice of Privacy Practices and required or permitted by law, all other releases of your PHI will be made only with your specific authorization.

ELECTRONIC COMMUNICATION CONSENT

Electronic communication offers an efficient way to communicate with Graven and Associates, PLLC. 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 and Associates, PLLC 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 INFORMAITON

- Phone calls are NOT appropriate for urgent matters or an emergency situation; instead please call 911 or go to your nearest emergency room.
- Graven and Associates, PLLC 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 and Associates, PLLC 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 and Associates, PLLC 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 and Associates, PLLC. I understand that I may revoke this consent at any time by notifying Graven and Associates in writing of my decision. I understand that this service is a courtesy offered to me by Graven and Associates, PLLC and 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 to Graven and Associates, PLLC.

Cell Number for Appointment Reminders _____

Email Address for Appointment Reminders _____

□ I **decline** to receive text/email appointment reminders from Graven and Associates, PLLC. I understand that I may change this decision at any time by notifying Graven and 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 to Graven and Associates, PLLC.

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 and Associates, PLLC consent to provide treatment information to your insurance company.

Patient Acknowledgement and Consent:

I agree that all communication between this office and the patient is held in strictest confidence pursuant to federal and state laws.

I, _____ **(PRINT PATIENT NAME)** agree and consent to participate in mental health services offered and provided by a mental health provider through Graven and Associates, PLLC.

I,_____**(PRINT PATIENT NAME)** hereby permit Graven and Associates, PLLC and the psychologists or other healthcare professionals involved in my care to use and disclose my protected health information for the payment and healthcare operations activities described above and in more detail in the Graven and Associates, PLLC Notice of Privacy Practices.

Further, I specifically acknowledge and agree that my Graven and Associates, PLLC provider may use and disclose my PHI to employees of Graven and Associates, PLLC under the supervision of my provider where such employee becomes involved in my care by virtue of assisting my provider with healthcare diagnosis or treatment at the request of my provider.

I also acknowledge that I have read the information in this document and agree to abide by its terms during the professional relationship. **Additionally, I acknowledge that I was provided the opportunity to review and/or obtain a copy of the Graven and Associates, PLLC Notice of Privacy Practices.**

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

_____ _____

Patient Name Date

_____ Authorized Representative Relationship/Authority *(CIRCLE ONE TO CLARIFY YOUR RELATIONSHIP TO THE PATIENT):* Self Guardian

Signature Parent Power of Attorney Other:_____

PROFESSIONAL FEE POLICY

Charges for services are due and payable in full at the time the services are rendered. If you have health insurance coverage, a claim form will be filed on your behalf. In the event the insurance rejects your claim, the amount paid is based on Graven and Associates, PLLC regular fee schedule. You are responsible for paying the balance owed on your account immediately. Your account can be settled using cash, check or credit card.
If a statement remains unpaid after sixty (60) days and no satisfactory arrangements have been made, the account will be sent to collections or small claims court. The cost of these proceedings will be included in the claim.

Your appointment time is reserved especially for you and you must cancel with 48-hours' notice to avoid a cancellation charge. Regarding *therapy appointments*, if you cancel without 48-hours' notice or miss an appointment, you will be charged $75. However, regarding *testing appointments*, if you cancel without 48-hours' notice or miss an appointment, you will be charged $75 per hour you were scheduled to be in the office. 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 and Associates, PLLC. Work, school and/or social obligations are not considered circumstances beyond your control.

There is a $55.00 charge for each fifteen (15) minutes of a telephone consultation lasting longer than five (5) minutes. There is a minimum $50.00 charge for each fifteen (15) minutes of the provider's time required for filling out paperwork related to disability claims, etc. Patients requesting a second copy of their record may be expected to pay $1.00 per page. Insurance companies will not pay for these fees. (Paperwork required by your insurance company for services rendered is *not* subject to this fee.) Additional copies of any evaluation conducted are $20.00. Once a proper written request for medical records has been received records will be produced within thirty (30) days. However, if they are needed within two (2) weeks, then you have the option of paying an expedited processing fee of $250.00.

If you become involved in legal proceedings that require your provider's participation, you will be responsible for their professional time. Because of the difficulty of legal involvement, you are expected to pay a flat fee of $1200.00, which covers the first two hours of court or deposition appearance and one hour of preparation time/phone calls. An administrative fee of $250.00 is also required. Additional time will be billed at $400.00 per hour for preparation work and $500.00 per hour for attendance at any legal proceedings. Insurance companies will not pay for this fee. All legal fees are non-refundable.

In the event that an overpayment is made, the patient will be contacted as soon as all claims have been processed. Reimbursements will be issued in the form of a check from Graven & Associates, PLLC. There are two options available to patients in order to receive their reimbursement. One, patients may come by the office during business hours to receive the check. Two, patients can choose to have the check sent to them via certified mail. The patient will be responsible for a processing fee of $10.00, which will be deducted from the reimbursement amount.

In the event that a patient loses or misplaces the check, the check will be re-issued to the patient. A $50.00 processing fee will be deducted from the reimbursement and the check will be sent to the patient via certified mail.

If the patient's reimbursement is less than $50.00, they will be required to come into the office during normal business hours to receive the check.

A $50 processing fee will be charged for checks returned by the bank due to nonsufficient funds. Further, we reserve the right to request to have patients pay for future sessions by credit card or cash if a check has been returned.

By signing below, I attest that I understand and agree to the professional fee policy. I am aware that I am ultimately responsible for any charges incurred for services rendered. It is my responsibility to inform this office of any changes to my insurance or billing information.

_____ _____

Authorized Representative Signature Date

MEDICATION LIST

Please complete this form regarding any medications that you are currently taking, including prescription medications, over-the-counter medications, vitamins, supplements, etc.

If there are no current medications please write "none" on the top line and sign and date below.

Please note that it is YOUR responsibility to inform your provider of any changes to this list as soon as they occur.

Medication Name	Dosage	Reason Prescribed	Prescribing Doctor

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

Authorized Representative Signature

Date

☐ 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_____