NEWTOWN SPORT

PERFORMANCE | PSYCHOLOGY

CLIENT REGISTRATION

Client Name: _____ Today's Date: _____

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

Email Address: _____

Date of Birth: _____Gender_____ Home Phone: _____ Cell: _____

Client's Spouse/Partner (if applicable): _____

(If Client is a Student) Name of School: _____ Grade:_____

Family Physician: _____ Psychiatrist (If applicable): _____

Current medications & dosages: _____

Person to contact in an emergency: _____ Phone: _____

Would you like to receive text reminders for your appointments the day before? Y ☐ N ☐

On what number? _____

FINANCIAL AGREEMENT

I have agreed to pay privately for my sport psychology & general psychology services. The agreed upon charge is $_____ for each session. The initial intake session is 60 minutes. All subsequent sessions are 50 minutes long for adults, and 45 minutes for children and adolescents, unless another arrangement is made. Testing, paperwork and other requests will be a separate cost according to the current Fee Schedule. Payment is due at the time of service. I acknowledge that Newtown Sport & Performance Psychology will not bill my insurance company, but will provide me with a receipt for service. Additionally, I acknowledge that my insurance company may not reimburse me for Newtown Sport & Performance Psychology for services. There is a 24 hour cancellation policy which requires that you cancel or reschedule your appointment 24 hours in advance. Failed appointments (no cancellation) or same-day cancellations will be charged the full fee.

Signature: _____ Date: _____

FOR TREATMENT OF A MINOR

As the parent or legal guardian of _____, I authorize his/her evaluation and treatment by Newtown Sport & Performance Psychology. As parent or legal guardian, I have the right to request information concerning the above minor's evaluation and treatment.

Signature: _____ Date: _____

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HIPAA POLICY NOTICE

NOTICE OF PSYCHOLOGISTS' POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

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

I may use or disclose your protected health care information (PHI) for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment, Payment, and Health Care Operations"
  - Treatment is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - Payment is when I obtain reimbursement from your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care and/or to determine eligibility or coverage.
  - Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my practice such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosure. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. "Psychotherapy notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent and Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse*: If I know, or have reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that I report such knowledge or suspicion to the Pennsylvania Department of Child and Family Services.

- *Adult and Domestic Abuse***:** If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.

- *Health Oversight***:** If a complaint is filed against me with the Pennsylvania Department of Health on behalf of the Board of Psychology, The Department has the authority to subpoena confidential mental health information from me relevant to that complaint.

- *Judicial or Administrative Proceedings:* If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without the written authorization or you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance in this case.

- *Serious Threat to Health or Safety***:** When you present a clear and immediate probability or physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

- *Worker's Compensation***:** If you file a worker's compensation claim, I must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

1. Right to Request Restrictions – You have the right to restrictions on certain uses and Disclosures or protected health information about you. However, I am not required to agree to a restriction you requested.

2. Right to Receive Confidential Communications by Alternative Means and at Alternative Means and at Alternative Locations – you have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a psychologist. Upon your request, I shall send any mailings to another address.)

3. Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the request process.

4. Right to Amend – You have the right to request an Amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I shall discuss with you the details of the amendment process.

5. Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I shall discuss with you the details of the accounting process.

6. Right to a Paper Copy – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist Duties:

1. I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

2. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently I effect.
3. If I revise my policies and procedures, I shall provide individuals with a revised notice during their session or by mail within 60 days, and subsequent to any request made by you when you are no longer in treatment with me pertaining to the release of any information or consultation with an outside person or agency.

V. Business Associates

I may rely, depending on the circumstances, on certain persons or entities, who are not my employees, to provide services on my behalf. These persons might include lawyers, billing services, collection agencies and credit card companies. Where these persons or entities perform services, which require the disclosure of individually identifiable health information, they are considered under the Privacy Rule to be my business associates. I enter into a written agreement with each of my business associates to obtain satisfactory assurance that the business associate will safeguard the privacy of the PHI of my patients I rely on my business associates to abide by the contract, but will take reasonable steps to remedy any breach of the agreement that I become aware of. If my attempt to remedy the breach is not successful, then I will terminate the contract, or if termination is not feasible, I will report the problem to the Department of Health and Human Services.

***VI.* Complaints**

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to me (as above). You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed at the outset can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

I will limit, i.e., deny, the disclosures that I make when your request to access copies of either your or your child's psychotherapy notes may, in my professional opinion, pose harm to you or you child's mental health. Such denials to access may be considered final and not reviewable by another licensed health care professional typically designated as a reviewing official with respect to other conditions (see below). I may also deny access to records when information is compiled in reasonable anticipation of, or for use, in a legal or administration action of proceeding, and when someone other than a health provider provides information about you or your child under a promise of confidentiality and the access to the requested information would be reasonably likely to reveal the source of the information. However, you may request and are entitled to a review of my denial by another licensed health care professional for access to other information contained in your medical records when I deny access if: 1) in the exercise of my professional judgement I determine that access to the record is "reasonably likely to endanger the life or physical safety" of you, the patient, or another person; 2) the requested information makes reference to another person (other than another health care provider) and in the exercise of professional judgement I determine that access is "reasonably likely to cause substantial harm" to this person; or 3) a personal representative for you or the patent has requested access to the record and in the exercise of professional judgement I determine that such access is "reasonably likely to cause substantial harm" to the you, the patient or another person.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by face-to-face verbal explanation and written notice in person or via mail within 60 days.

NEWTOWN SPORT & PERFORMANCE PSYCHOLOGY / HIPAA PRIVACY POLICY

I have read and reviewed the Newtown Sport & Performance Psychology HIPAA Privacy Policy.

Signature Date

NEWTOWN SPORT

PERFORMANCE | PSYCHOLOGY

CREDIT CARD AUTHORIZATION FORM

I _____, authorize Newtown Sport & Performance Psychology to charge my credit card for services rendered.

AMOUNT $_____per session

CREDIT CARD TYPE _____

CREDIT CARD # _____

CARD CV2 # _____

EXPIRATION DATE _____

BILLING ZIP CODE _____

NAME ON CARD _____
(As it appears on card)

_____ _____
SIGNATURE DATE

Credit cards are processed in the evening or during breaks. If you would like an email or text receipt, please provide email address or phone number below:

_____

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RELEASE OF INFORMATION

I, _____ hereby authorize Newtown Sport and Performance Psychology to release and exchange information pertaining to my evaluation and sessions to:

_____

_____

I understand that authorization shall remain valid from the date of my signature below and for 9 months thereafter. I have been informed that I may revoke this authorization by written or oral communication to Newtown Sport and Performance Psychology. I certify that this form has been fully explained to me and that I understand its contents.

_____
Printed Name of Client

_____ _____
Signature / Guardian Signature Date of Authorization

4 Terry Drive, Newtown, PA 18940 • (267) 756-0575