New Patient Information Sheet

Patient Information

Social Security Number	Title	Last Name	First Name	MI

Street Address	Apartment #

City	State	Zip Code	Date of Birth

Cell Phone	Home Phone	Work Phone

Marital Status	Student	Gender	Employer

Employer's Address

City	State	Zip Code

Emergency Contact Name	Relationship	Phone Number

Financially Responsible Party (If Other Than Patient)

Social Security Number	Title	Last Name	First Name	MI

Street Address	Apartment Number

City	State	Zip Code	Date of Birth

Cell Phone	Home Phone	Work Phone

Marital Status	Student	Gender	Employer

Employer's Address

City	State	Zip Code

Insurance Information

Primary Insurance Company	Policy Number	Group Number
Secondary Insurance Company	Policy Number	Group Number

Referral Information

Referring Physician Name	Practice Name	Phone Number

I, __________________________, hereby assign payment of any medical benefits to which I am entitled to be made to me or, on my behalf, for any services furnished to me by my physician/therapist. I authorize assignee to release any and all medical information necessary to secure payment for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Signature____ **Date**______________________________

I understand that I am financially responsible for all charges, wether or not paid by my insurance carrier. Including, but not limited to, any collection and/or attorney fees incurred in the process of collecting payment for services furnished to me.

Signature____ **Date**______________________________

CONSENT TO EXAMINATIONS AND TREATMENT

Consent and authority is hereby given to ______________________________ to perform or have performed examinations and/or psychotherapy and/or related mental health treatments and to administer medications when deemed necessary or advisable by appropriate member of the professional staff in consultation with me. This statement has been fully explained to me and I understand it.

______________________________	______________________________
Witness	Signature of Patient
______________________________	______________________________
Date	Signature of Parent or Legal Guardian

I have been provided a copy of the HIPAA Notice of Privacy Practices and an opportunity to review it and ask question:

____

(If not signed, staff to state reason on line and initial)

Roni Caw, PHD, LPC
Caw Counseling, LLC

125 Alpine Circle, Columbia, SC 29223 **phone 803-779-3548**

POLICY, FEES, PAYMENT, INSURANCE AND SCHEDULING

The initial fee for services is $180.00 and the follow-up fee is $150.00 for 50-55 minutes. Sliding scale fees may also apply. Please plan to pay the full fee after each session unless otherwise arranged in advance. You will not be billed. However, a copy of your charges and payment record will be made available upon your request. You may pay with cash, credit or debit card, or a check made out to Midlands Psychiatric and TMS Center of Columbia.

Your appointment time is reserved for you alone. Without sufficient prior notice, it cannot be given to anyone else. **You will be charged the full fee of $150.00 for any missed appointments unless our office staff receives a cancellation notice 24 hours in advance or is advised in the event of an emergency.** Appointments will be scheduled after sessions or you can call the office staff at 803-779-3548.

Our office staff will file with insurance companies and they will be glad to provide whatever information your particular plan requires so that you may file for reimbursement. Companies often require that a diagnosis be assigned before they will pay. If you find that this is necessary with your plan, I will advise you of my choice of a diagnosis for insurance purposes.

Insurance companies and policies differ greatly in their choices of what types of providers and mental services are covered. There are sometimes confusing and seemingly arbitrary restrictions on reimbursements. With your permission, our office staff will attempt to provide to you whatever documentation of your services your company requires. If you are relying on your coverage to pay for therapy, you should get direct confirmation from the insurance company that they will pay out-of-network mental health benefits and what percentage they will reimburse. **You are responsible for the full fee at time of service.**

****Please be aware** that using insurance to cover mental health fees is an automatic Release of Information to your insurance company.

I have read and understand this policy

Name____________________________________

Signature____________________________________

Date ______________________________________

General Consent for Communication Guidelines

Roni Caw, PHD, LPC
Caw Counseling, LLC

125 Alpine Circle, Columbia, SC 29223 **Phone 803-779-3548**

Because the nature of communications and technology continues to evolve, it is important that we are clear about how we will and will not communicate with each other in and outside of the therapy hour.

Please initial all statements below with a yes or no answer.

THERAPY

Phone Sessions:

I am only able to conduct therapy sessions via phone in states where I am licensed, which currently is only in South Carolina. Insurance will not pay for telephone calls. My general rule is that all therapy is done in person unless we have a clear contract that indicates we will talk on the phone. I understand: yes _____ no_____

Skype Sessions:

Skype or other video telecommunication methods such as Face Time are not considered a confidential form of therapy. Therefore I do not conduct therapy session via the internet. I understand: yes_____ no _______

COMMUNICATIONS:

May my office staff and I call you at home? yes ______ no _____. May we leave a message at this number? yes ______ no _____.

May my office staff and I call you at work? yes ______ no _____. May we leave a message at this number? yes ______ no _____.

May my office staff and I call you on your cell phone? yes ______ no _____. May we leave a message at this number? yes ______ no _____.

Please note that if I call you after hours on my cell phone, I cannot guarantee that the phone line is secure and confidential. The same is true if you call me on your cell phone at my office. I understand: yes _______no_____.

Texting:

As our office uses landlines for the sake of your security and confidentiality, we do not use texting as a form of communication. Texting, like email, is not secure. I understand: yes_____ no _____

<u>General Consent for Communication Guidelines</u> page 2

Facebook:

I will not accept Facebook Friend Requests from you or send them to you while you are an active client. I have a Facebook page, but I will not communicate with you as a client on the Wall of that page or via Facebook messaging.

I understand: yes _____ no _____

Email:

Email is to be used only for the purposes of sending psychosocial educational information. I may take as long as 24 hours to respond. **Regarding canceling an appointment, 24 working hours' notice is required for notification in person or by PHONE.** ***Please call our office at 779-3548 between 9 AM and 12 PM, or between 2 PM and 4:30 PM, Monday to Friday to speak to our office staff. Calls outside of those times will be recorded by an answering service.*** **Email is not to be used for appointments or to communicate emergency or therapeutic information.** If you do send me information via email, know that all communication via the internet is not considered secure and I will not respond to personal information related to your care.
I understand: yes _____ no_____

Audio/Video Taping Sessions:
I do not allow audio/video taping of sessions.
I understand: yes _____ no_____

Payment Methods:
I accept cash, checks and credit cards. If you pay me by check, your check will be deposited into my account. My contracted account for billing purposes is Midlands Psychiatric Services and by nature of payments traveling to the bank and being handled by bank professionals, I cannot guarantee your confidentiality. If you have concerns about this method of payment, you may pay me by cash or credit card. My credit card contracted account for business is also Midlands Psychiatric Services.
I understand: yes _____ no _____

If we are taking a credit card payment over the phone, our office staff will call you each time a transaction will be made. I understand: yes_____ no _____

I have read and understand all of the above guidelines for communication and consent to follow them in my therapeutic relationship with Roni Caw, PHD, LPC:

Signature____ Date: ________________

GENERAL INFORMATION AND CONSENT FOR THERAPY

Roni Caw, PhD, LPC
Caw Counseling, LLC

125 Alpine Circle, Columbia, SC 29223 **phone 803-779-3548**

For best results and your own welfare, it is important that you understand what it means to be in psychotherapy. Please read the brief description below. If you have any questions or concerns, you are urged to talk about them. If you understand it and you chose to be in psychotherapy as described here, initial each point and sign and date this form. Your signature represents an agreement between us.

1. Psychotherapy is a special kind of health care service. The goals of psychotherapy are to help you better understand yourself and others, to help you solve problems that may be limiting your life satisfaction, and to help you better cope with the feelings and challenges that you encounter in your daily life.
I understand: ____yes ___no

2. The most common form of psychotherapy involves your talking about your feelings, your problems or concerns, and your experience of yourself and your situation. Other common methods involve using your imagination, keeping personal records of your experiences, and trying new or different ways of thinking, acting, or feeling. These methods may be used within treatment sessions or you may be asked to do them at home. **I understand: ____yes ___no**

3. To better understand you, many psychotherapists use a variety of tests or measures of your current abilities and styles of experiencing. These measures are important in choosing the treatment methods best suited to you, and they are also helpful in estimating your progress.
I understand: ____yes ___no

4. The length of psychotherapy often depends upon your individual needs and the rate of your progress. Many therapists use periodic reviews as a means of evaluating your needs, progress, and satisfaction.
I understand: ____yes ___no

5. Most people benefit from psychotherapy. The most common benefits include improvements in self-awareness, self-esteem, self-confidence, hope, feeling understood, relationships with other people, emotional expressiveness, and taking an active and responsible role in one's life. There are also some risks to being in psychotherapy. The most common risks are temporary periods of emotional distress related to changes in your life situation and your relationship with yourself and others (including your therapist). Psychological damage caused by psychotherapy is rare, but you should be aware that it could happen. The most common causes of such damage are poor communication or unethical conduct. If you feel that you are not making reasonable progress or that you are being harmed by your involvement in psychotherapy, you should discuss this with your therapist. If you feel that your therapist has attempted to violate you in any way -- financially, physically, sexually, or otherwise -- you should so inform the state agency responsible for professional licensing.
I understand: ____yes ___no

6. You always have the right to choose whether or not to continue in psychotherapy. If you feel that you might work better with a different therapist, your present therapist should be able to offer you information on possible referrals. Local mental health agencies are listed in the phone book and they may also offer helpful information. The most common alternatives to psychotherapy are self-help and support groups, bibliotherapy (therapeutic reading), and different forms of religious counseling.
I understand: ____yes ___no

7. The information communicated in therapy must be kept confidential by your therapist unless you grant permission to release it. The only exceptions to this protection of your privacy are dictated by state laws.

GENERAL INFORMATION AND CONSENT page 2

Roni Caw, PhD, LPC
Caw Counseling, LLC

125 Alpine Circle, Columbia, SC 29223 **phone 803-779-3548**

Confidential information may be released WITHOUT your permission if:

- You threaten to harm yourself or someone else and your threat is believed to be serious your therapist is ethically and in some instances legally obligated to take whatever action seem necessary to protect you or others from harm.
- There is suspected child abuse or neglect. Therapists are obligated by law to report this to the appropriate state agency. This law also applies if you report that you have reason to believe another person is abusing or neglecting a child.
- You are in court-ordered therapy and the court wishes to receive some type of report or evaluation.
- You are involved in litigation of any kind and inform the court of the services you receive here (MAKING YOUR MENTAL HEALTH AN ISSUE BEFORE THE COURT), you may be waiving your right to keep your records confidential.
- You lodge a formal complaint against me or make me a party to a legal action.
- You use insurance to reimburse for fees (please see Release of information Form for Insurance Purposes).
- You do not pay your bill and billing information is forwarded to a collection agent.

I understand: ____yes ____no

8. I understand that my therapeutic relationship is with Roni Caw, PhD, LPC. Although the location is at 125 Alpine Circle and other independent therapists practice at this location, I agree to hold harmless any other service provider at this location. **I understand: ___yes ___no**

9. On occasion, a client will request that I release client record information under circumstances that I feel may be harmful to them. Confidentiality laws do not allow me to do so without a court order. This will also apply to a personal request from you or your attorney. **I understand: ___yes ___no**

Your signature below indicates that you have read and understood the above description of psychotherapy. Your signature also indicates that you are now consenting to be in psychotherapy with the understanding that you retain the right to review and revise this decision at later points in time.

____________________________________ ________________________

Signature of Client or Parent/Guardian Date

South Carolina provides the consumer the opportunity to file inquiries with its Board of Examiners for Licensure of Professional Counselors, Marriage and Family Therapists and Psycho-Educational Specialists. Board offices may be reached at: **South Carolina Board of Examiners, P.O. Box 11329, Columbia, SC 29211-1329.**

GENERAL INFORMATION AND CONSENT page 3

Roni Caw, PhD, LPC
Caw Counseling, LLC

125 Alpine Circle, Columbia, SC 29223 **phone 803-779-3548**

FMLA, Short-Term Disability, Long-Term Disability, Military Compensation Forms

As I am not a medical doctor or a psychiatrist, I do not complete paperwork for FMLA, short-term disability, or long-term disability.

In order to assist military personnel with military compensation forms, all paperwork will be completed in session as a part of treatment.

Your signature below indicates that you have read and understood the aforementioned information concerning requests to complete FMLA, Short-Term Disability, Long-Term Disability, and Military Compensation Forms.

____________________________________ __________________________
Signature of Client or Parent/Guardian Date

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: ____
Social Security #: ____________________ Date of Birth: ______________

I hereby authorize: ____
To Release to: ____
Address: ______________________ Phone: ____________________
______________________________ Fax: ______________________

Type of information to be released from medical record – (SPECIFY)

____
____

For the purpose of:

- ___ Continuation of medical treatment and care
- ___ Aftercare follow-up treatment and management
- ___ Psychological, Vocational or Social Evaluation
- ___ Obtaining insurance benefits
- ___ Other (specify)

This consent is given freely and voluntarily. Any information obtained shall not be released by the above-named person or organization to any other persons or organizations unless I so authorized, except as mandated by state and federal law. In the event that information is released by a third party to other unauthorized persons, the under signed here by releases Dr. ______________________ from any and all liability for such unauthorized release or information. This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. I further understand that my records may contain information regarding psychiatric treatment and alcohol & drug treatment.

______________________________ ______________
Patient's Signature Date

______________________________ ______________
Signature of legal Guardian Date

______________________________ ______________
Signatures of Witness Date

THIS RELEASE EXPIRES ON ______________

Consent is invalid if signature is not witnessed and dated*

Office use only: Copies of ______________________ were sent to
______________ on ____________ by ____________.

Revised July 2014

CONSENT FOR RELEASE OF IMFORMATION

Patient Name: ______________________________

SS#: ____________________ Date of Birth: ____________________

I hereby authorize: (Dr. Name) ______________________________
To Release To: Med Voice (appointment reminder service)

Type of information to be released: Name, phone number, doctor's name, and appointment time ONLY.

The purpose of this information is only to remind the patient of their appointment.

This consent is given freely and voluntarily. Any information obtained shall not be released by the above named person or organization to any other persons or organizations unless I so authorize, except as mandated by state and federal law. In the event that information is released by a third party to other unauthorized persons, the undersigned hereby releases (Dr. Name) ________________________ from any and all liability for such unauthorized release of information. This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon.

______________________________ ____________________
Patient's Signature Date

______________________________ ____________________
Signature of Legal Guardian Date

______________________________ ____________________
Signature of Witness Date

This release expires on ____________
(consent invalid if not witnessed and dated)

MIDLANDS PSYCHIATRIC SERVICES, LLC
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Midlands Psychiatric Services, LLC is required, by law, to maintain the privacy and confidentiality of your protected health information. Also we are required to provide our patients with a notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

> *"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Midlands Psychiatric Associates."*
>
> *"It is our policy to provide a substitute health care provider authorized by Midlands Psychiatric Services, LLC to provide assessment and/or treatment to our patients without advanced notice. In the event of your primary health care providers absence due to vacation, sickness or other emergency situation."*

Payment
We may disclose your health information to your insurance provider for the purpose of payment on health care compensations.

> *"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Midlands Psychiatric Services, LLC for health care services rendered. The billing statement contains medical information, including diagnosis, date of injury or condition and codes which describe the health care services rendered."*

Worker's Compensation
We may disclose your health care information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the even of an emergency or your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury or disability, reporting child abuse or neglect, responding to domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications as well as reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

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Law Enforcement
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

Deceased Persons
We may disclose your health information to coroners or medical examiners.

Organ Donations
We may disclose your health information to organizations involved in procuring, banking or transplanting organs or tissues.

Research
It may be necessary to disclose your health information to researchers conducting researchers conducting research that has been approved by an Institutional Review Board

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious or imminent threat to the health and safety of a particular person or to the general public.

Specialized Government Agencies
We may disclose your health care information for military, national security, prisoner and government benefits purposes.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Midlands Psychiatric Associates is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon request.
- You have the right to inspect and copy your health information.
- You have the right to request that Midlands Psychiatric Services, LLC amend your protected health information. Please be advised, however, that Midlands Psychiatric Services, LLC is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Midlands Psychiatric Services, LLC.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
Midlands Psychiatric Services, LLC reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all information that it maintains. Until such amendment is made. Until such amendment is made, Midlands Psychiatric Services, LLC is required by law to comply with this Notice.

Midlands Psychiatric Services, LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information.

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