

PSYCHOLOGY ASSOCIATES
INITIAL INTAKE

PLEASE PRINT

DATE _____ THERAPIST Dr. Jann

PATIENT NAME _____

ADDRESS (street) _____

(town) _____ (state) _____ (zip) _____

TELEPHONE (H) _____ (W) _____ (C) _____

PATIENT SS# _____ D.O.B. _____

PATIENT EMPLOYER (if a student, give school name) _____ EAP ___ Yes ___ No

PATIENT MARITAL STATUS: Single ___ Married ___ Widowed ___ Divorced ___

Emergency Contact Name _____ Phone: _____

Responsible Party Name _____ Relationship to patient _____

Address _____

Telephone (H) _____ (W) _____

Responsible Party SS# _____ D.O.B. _____

Responsible Party Employer: _____ EAP ___ Yes ___ No

INSURANCE _____

POLICY HOLDER _____

POLICY HOLDER SS# _____ Policy Holder D.O.B. _____

POLICY I.D.# _____ GROUP # _____

Relationship to patient _____ CO-PAY _____

PATIENT AGREES TO TREATMENT

SIGNATURE _____

OVER

OFFICE USE:

Diagnosis Code _____ Description _____

Date patient called _____ First appointment offered _____

Routine ___ Urgent ___ Emergency ___

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

(Please Read Carefully)

HIPAA (Health Insurance Portability and Accountability Act) requires our office to obtain your permission to use or disclose your health information.. We create paper and electronic medical records about your health and the services that we provide to you as out patient. We understand that your out patient mental information is personal to you, and we are committed to protecting that information for you. Your signature on this consent gives our office permission to perform the following:

	<u>Yes</u>	<u>No</u>
Bill your insurance company	___	___
Communicate with your primary care physician	___	___
Communicate and disclose information to your insurance company	___	___
Contact you via phone to remind you of appointments	___	___
Communicate with anyone identifying themselves as a family member	___	___

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

This consent authorizes Psychology Associates to use and disclose health information about you for treatment, payment, and health care operations. Psychology Associates has a Notice of Privacy Practices, which describes how we use and disclose protected health information about you and how you can access your protected health information. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain. You have the right to request that we restrict how your protected health information is used or disclosed to carry out treatment, payment, or health care operations. We are not required to agree to any requested restrictions. However, if we agree to a requested restriction, we are bound by that restriction. You have the right to revoke this consent, except to the extent that we have taken action in reliance on the consent. To revoke this consent, you must submit a written revocation to our administrative office at 301 Oxford Valley Road, Suite 301B, Yardley PA 19067

CONSENT

I have read and understand the above Explanation of Rights and have been provided the opportunity to review the Notice of Privacy Practices for Psychology Associates prior to signing this consent. Psychology Associates is authorized to use and disclose health information about:

_____ (patient name) for treatment, payment, and health care operations in accord with its Notice of Privacy Practices.

Signature of Patient or Patient's representative (patient or representative be 18 or older)

Date

Name of Patient Representative

Relationship to Patient