APEX PSYCHOLOGICAL CARE AND MEMORY CENTER
NEW PATIENT INFORMATION SHEET

Date_______________
Who referred you or how did you hear about the office? _______________

Patient Name______________________________ Birth Date_______________

Age_____ Social Security Number_________________

Single Married Separated Divorced Widowed Partner

Please leave phone numbers and addresses where we can contact you

Home Street Address_______________________________ City_________________
State_______ Zip Code____________
Home Phone________________ May we leave a message at home? Yes No

Cell Phone_________________ May we leave a message on your cell? Yes No

Email______________________ May we contact you via email? Yes No

Emergency Contact Person: Name and Relationship_____________/_____________
Emergency Contact Phone Number__________________________

Employer Name_____________________________
Employer Street Address_______________________________ City_________________

State_______ Zip Code____________

Work Phone______________ May we contact at work? Yes No

Insurance Yes No (if you have your insurance card you can skip this section)
How many insurance policies? _____

Name(s) of Insurance company(ies)_____________________________________

If you are not the policy owner, please fill the information below:

Policy Holder's Name________________ Policy Holder's Birth Date__________

Policy Holder's Social Security Number________________

I authorize payment of insurance benefits to Apex Psychological Care and Memory Center by signing below.

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Patient or Legal Guardian or Power of Attorney Sign Here

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Witness Signature

Rev 6/3/2011

Apex Psychological Care and Memory Center

Consent to Treatment

PSYCHOLOGICAL SERVICES

Psychotherapy uses many different methods to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things your clinician talks about both during your sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness at times. Psychotherapy has also been shown to have benefits for people including: building better relationships, solutions to specific problems, and feeling less distressed. There are no guarantees of what you will experience during psychotherapy.

SESSIONS

Your first session will involve an evaluation of your needs. Your clinician will meet with you for no longer than 50 minutes. During this time, you can decide if your clinician is the best person to provide the services you need. By the end of the evaluation, your clinician should be able to offer you some first impressions of what your work will include and a treatment plan to follow. You should evaluate this information along with your own opinions of whether you feel comfortable working with your clinician. If you have questions about the process, please feel free to ask your clinician whenever they arise. Your clinician will be happy to refer you to another mental health professional for a second opinion or treatment if needed. If you decide to pursue psychotherapy with us, we typically schedule one 45-50 minute session per week on a weekly basis until you start feeling better. Your clinician will taper/space sessions apart after you see improvement in your symptoms.

EMERGENCY SERVICES AFTER HOURS

If a life threatening emergency occurs, please go to the local emergency room and/or call our office at 330-953-1354 (Ohio) or 724-457-0858 (Pennsylvania), where our office staff or answering service will be able to contact your clinician and notify them of your situation. If you are unable to speak with your clinician, then go directly to your local emergency room.

NEUROPSYCHOLOGICAL TESTING

A neuropsychological evaluation is a comprehensive assessment of a person's thinking using various tests. A neuropsychological evaluation consists of an interview and taking many different kinds of tests that a psychologist will administer. The psychologist will use tests that may assess your ability to pay attention, learn and remember information, reason, perceive information, problem solve, use language, organize and plan information, and your motor abilities. The psychologist will score all your tests and then compare your results to individuals

who are similar to you to determine whether or not you have a memory or thinking disorder.

WHEN IS NEUROPSYCHOLOGICAL EVALUATION NEEDED?

A neuropsychological evaluation is recommended for any individual who is experiencing changes in their thinking (e.g., concentration, memory, reasoning ability, language) and/or personality. Neuropsychological testing can determine if you have a neurological disorder such as dementia (e.g., Alzheimer's Disease) or Attention Deficit Disorder.

PROFESSIONAL RECORDS

The laws and standards of your clinician's profession require that they keep mental health treatment records. You are entitled to receive a copy of your record unless your clinician believes that seeing them would be emotionally damaging. Your mental health record can be misinterpreted and/or upsetting to untrained readers. Therefore, it is recommend that you if you choose to view your mental health record that you review them in the presence of your clinician so that he or she can discuss the contents and answer any questions you may have. Patients will be charged an appropriate fee for copying your records and any time spent in preparing information requests (see fee schedule).

MINORS

If you are under eighteen years of age, please be aware that the law states that your parents have the right to examine your treatment records unless a court determines that it is not in their best interest.

BEING DISCHARGED FROM TREATMENT

Your case will be closed and you will have to find another provider if you have several no show or late cancellation appointments and/or if you have significant outstanding balances without making a payment after 60 days. We will gladly assist you in finding another provider if the above situation(s) should arise.

My signature below signifies that I voluntary consent to evaluation and treatment by Apex Psychological Care and Memory Center. I acknowledge that no guarantees have been made to me as to the result of this evaluation or subsequent treatments. My signature below also indicates that I have read the information in this document and agree to abide by its terms during our professional relationship.

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Patient or Legal Guardian or Power of Attorney Sign Here **Date**

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Witness Sign Here **Date**

Apex Psychological Care and Memory Center

Confidentiality

In general, the privacy of all communications between a patient and a mental health professional is protected by law, and we can only release information about the content of your sessions/evaluations to others with your written permission. **However, there are a few exceptions below:**

1) If you threaten to harm yourself, we are obligated to seek hospitalization for you or to contact your family members or others who can help provide protection.

2) If you threaten serious bodily harm to another individual(s), we are required to take protective actions. These actions may include: notifying the potential victim(s), contacting the police, or seeking hospitalization for you.

3) If you are under the age of 18 (or under the age of 21 if you are mentally retarded, developmentally disabled, or physically impaired), we are required to report if you are being abused (emotionally, physically, or being neglected) or you are facing the threat of being abused to authorities.

4) If the court orders (not subpoenas) your medical record, we will have to relinquish your records to the court. However, we will attempt to discourage the court from doing this.

Email and text communications to the office or clinician are not secure means of communication and confidentiality cannot be guaranteed.

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Patient or Legal Guardian or Power of Attorney Sign Here **Date**

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Witness Sign Here **Date**

Apex Psychological Care and Memory Center

FINANCIAL POLICY

Thank you for choosing Apex Psychological Care and Memory Center as your health care provider. We are committed to providing you the highest quality of service available. To continue this service excellence, it is important that you follow our Financial Policy, which included prompt payment of your bill. The following is a summary of this Policy, which we require all patients to read and sign prior to treatment.

INSURANCE PLANS ACCEPTED

We accept most insurance plans. However, it is your responsibility to check with your insurance company prior to treatment to determine if your policy covers our services. In many cases, insurance companies require pre-authorization prior to seeking treatment. We will get the authorization for you; however, some insurance companies require that you obtain your own authorization.

PROFESSIONAL FEES

Fees listed below are private pay. Insurances will be billed and paid at the contracted rate with your insurance company. You are responsible for all balances.

Initial Evaluation	186.00
45 to 50 minute psychotherapy session	120.00
20 to 30 minute psychotherapy session	80.00
Neuropsychological Testing	147.00 per hour*
Medical Forms to Complete	25.00 each
Copying of medical records	25.00 for total record
Narrative Reports	150.00 each

Other Fees: These services will be charged $80.00 for 20 to 44 minutes of time, $120.00 for 45-60 minutes of time: report writing, telephone conversations lasting longer than 19 minutes, and attendance at meetings with other professionals you have authorized.

*Neuropsychological Testing includes: testing time, scoring, and report writing

A 25% cash/check discount will be given to private pay patients if you pay on your appointment date. A $20.00 fee will be assessed for all returned checks. Cash or credit card payment will be required for all patients who have had checks returned.

Legal proceedings that require your clinician's participation:

You will be expected to pay for my professional time even if we are called to testify by another party. Because of the difficulty of legal involvement, we charge 300.00 for the first hour (one hour minimum) and 150.00 for each hour thereafter for preparation and attendance at any legal proceeding.

Apex Psychological Care and Memory Center

FINANCIAL POLICY

BILLING AND PAYMENTS

You will be expected to pay for each session or pay your copay/deductible on the appointment date. Payment schedules for other professional services not listed above will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided and the amount due.

INSURANCE BENEFIT INTERPRETATION

We will do the best to help you interpret your health care benefits, but it is ultimately your responsibility to understand which services are covered and which are not covered under your plan.

BILLING YOUR INSURANCE

We will bill your insurance company for you through our billing office, DM medical billing services company. You should also be aware that most insurance companies require you to authorize us to provide them with a clinical diagnosis. Sometimes we have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it.

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Patient or Legal Guardian or Power of Attorney Sign Here **Date**

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Witness Sign Here **Date**

Apex Psychological Care and Memory Center

I have read and understand the ways in which my protected health information (the privacy act) can and will be used. I have been given the opportunity to ask questions. I have been offered a copy of this form.

_____________________________	_______________
Name	Date

Witness:

_____________________________	_______________
Name	Date

NOTICE OF PRIVACY PRACTICES

Our Legal Duties
We are committed to protecting the privacy of your protected health information. "Protected Health Information" is your individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, or clearing house that relates to: 1) your past, present, or future physical or mental health condition; 2) the provision of health care to you; or 3) past, present, or future payment for the provision of health care to you.

Uses and Disclosures of Protected Health Information
In order to administer our services effectively, we will collect, use and disclose protected health information for certain activities, including payment for health care services.
The following description of how we may use and/or disclose protected health information about you for payment and health care operations:

- For example, we may use your protected health information to submit for payment of claims from doctors, hospitals, health plans, and other for services delivered to you that are covered by your health plan and may be to determine eligibility for benefits, coordinate benefits, and/or examine medical necessity.
- For example, we may use your protected health information to conduct quality assessments and improvement activities, or to engage in care coordination and case management to manage our business.

We may also use and disclose protected health information to other covered entities, business associates, or other individuals (as permitted by HIPAA) who assist us in administering our programs and delivering services to you.

Business associates
In connection with health care services our claims and health care operation activities, we contract with individuals and business associates to perform various functions to provide certain types of services (such as claims processing, verification of insurance plans, and demographics). To perform these functions or to provide services, business associates will receive, create, maintain, use or disclose protected health information, but only after we require the business associates to agree in writing to contract and safeguard your information.

Other covered entities
In addition, we may use or disclose your protected health information to assist other health care providers in connection with treatment or payment activities, or to assist other health care entities in connection with other health care operations. We may disclose your protected health information to another provider to render treatment to you.

Plan sponsors
We may disclose your health information to a plan sponsor or group health plan. For example, a plan may contact us regarding a member question, concern or issue regarding claims, benefits, service or treatment, etc.

Required by Law/Public Health Activities
We may use or disclose your health information to the full extent that public health activities are permitted by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability.

Abuse or Neglect
We may disclose your protected health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence.

Legal Proceedings
We may disclose your protected health information: 1) in the course of any judicial or administrative proceeding; 2) in response to an order of a court or administrative tribunal; and 3) in response to a subpoena, a discovery request, or other lawful process.

We may disclose your protected health information to: 1) any law enforcement required for legal process; or 2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person.

Serious Health Threats
Consistent with applicable federal and state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

Worker's Compensation
We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries, illnesses, or payment for such services.

Others Involved in your Health Care
Unless you object, we may disclose your protected health information to a friend, family member, or responsible party (guardian or parent) that you have identified as being involved in your health care. We may disclose information to an entity in a disaster relief effort so that your family or guardian can be notified about your condition, status, or location. If you are not present or able to agree to these disclosures then we may, use our professional judgment to determine whether the disclosure is in your best interest.

Right to Access

You have the right to look at or get copies of your protected health information in a designated record set. Generally, a record set contains psychological, medical, and billing records, as well as records of decisions made about your health care. ***The actual test forms used in neuropsychological testing will not be released.*** Any request must be made in writing to obtain protected health information.

We may deny your request to inspect and copy your protected health information in certain limited circumstances. If you are denied, you have the right to a review. A licensed professional health care provider, chosen by us, will review your request and the denial. Under certain circumstances, our denial will not be reviewable. If this event occurs, we will inform you that our denial is not reviewable.

Right to Restriction
You have the right to request a restriction on the protected health information we use or disclose about you for treatment, payment, or other health care operations. We are not required to agree with these restrictions, but if we do, we will abide by our agreement unless the information is needed to provide emergency treatment to you. Any agreement of restrictions will be in writing and signed by you or a person on your behalf.

Right to Request Confidential Communications
If you believe that a disclosure or all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information by alternative means or to an alternative location. For example, you may ask that we contact you only at your work address or via your work email.

You must make your request in writing and you must state why you believe that your health information may be at risk. You must also give alternative ways of communication of confidential health information.

Information We Collect and Maintain
We collect information from the member, client, parent, guardian, or responsible party either directly or through a chosen party or administrator. This information includes personal data provided on applications, history forms, surveys or other forms such as name address, social security number, date of birth, marital

status, dependent information, and employment information. It may also include other health care information and/or information submitted to us in writing, in person, by telephone, or electronically.

We collect and create information about our clients. Examples include information to submit claims for payments; including names, a diagnoses code, services provided, charges, amounts paid and if necessary, payment history, utilization review, appeals, and grievances.

We may also submit your protected health information to a claims billing service for processing and payment of your health care services. This third party will have a written associate of health care privacy notice signed and on file. This third party will cooperate and administer only information that we provide to them for insurance products or services. All contracts with others will require them to protect the confidentiality of our members'/clients' personal information.

How Do We Protect Information
We restrict access to our members'/clients' personal information to those employees, agents, third party billing services, consultants, or other health care providers or health care services. We maintain physical, electronic, and procedural safeguards that comply with state and federal regulations to guard personal financial information from unauthorized access, use and disclosure.

For questions about this Privacy Notice, please contact your provider.