

### CONFIDENTIAL INFORMATION SHEET

Please fill it out as completely as you can. All information will be held in strict confidence.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

#### **PATIENT INFORMATION:**

Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Sex:  M  F Marital Status:  M  S  W  D E-mail: \_\_\_\_\_

Reason for visit:  Individual  Couples  Family-Problems to Address: \_\_\_\_\_

Referred by: \_\_\_\_\_

#### **INSURANCE INFORMATION:**

Insurance Carrier: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

#### **RESPONSIBLE PARTY INFORMATION:**

Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

Relationship to patient:  Self  Spouse  Other (please indicate): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

\*Legal Guardian if patient is a minor: \_\_\_\_\_

Signature gives consent to treat

1. I, the undersigned, accept financial responsibility for payment of all fees at the time of the session.
2. **AUTHORIZATION FOR RELEASE OF INFORMATION:** I hereby authorize the release of any information regarding me/my child's condition or treatment to my insurance company, if applicable.
3. **AUTHORIZATION TO PAY INSURANCE BENEFITS TO THE PROVIDER:** I hereby authorize the payment of insurance benefits from my insurance company to my provider, if applicable.

\_\_\_\_\_  
Patient's (or responsible party) Signature

\_\_\_\_\_  
Date

## Policies and Procedures

**Fee Structure:** The patient is financially responsible for payment of fees, which will be collected prior to the time of service. If you are using your healthcare insurance or other third-party payor, you are responsible for the co-payment stipulated in the payor's contract with the clinician. The patient will also be responsible for any portion of fees not reimbursed or covered by health insurance within 90 days of the session. In the event of an accrued balance when submitting claims to an insurance company, the patient and therapist can negotiate a payment schedule if necessary. You will be charged for cancelled appointments unless notice is received at least **\*24 hours** prior to the appointment time so that the time may be scheduled for another patient.

**\*NOTE:** Insurance will **NOT** pay for "no-shows" or appointments cancelled without sufficient notice (i.e., 24 hours). You are responsible for paying **\$30.00** for your missed appointment in this event. Except in emergencies, cancellations must be made 24 hours in advance to avoid being charged or termination of the therapeutic relationship. Medicaid patients are excluded, but 3 missed appointments may result in termination of the therapeutic relationship.

**Confidentiality:** Information shared in session is held in strictest confidence according to federal law (Regulation 42 CFT Part 2). Exceptions include: legal obligations (such as child abuse, elder abuse, testimony requires by a judge, personal danger to self or an identifiable victim); information provided to parents if the patient is a minor; and consultation with supervising professionals. Advice may be elicited from professional peers in regard to your case, without revealing identity. Release of information to another professional may be done only with your written consent.

**Patient Privacy:** Laws have been enacted for patient privacy. It is important to know that emails and phone conversations/texts are not secure or guaranteed of privacy because they can potentially be intercepted. Therefore, by signing this document you understand that if we have correspondence by email or phone, there is a potential for confidentiality to be compromised.

**Length of Sessions:** Sessions are scheduled for approximately 50 minutes.

I understand and accept the policies concerning both the cancellations of appointments and payment for services. I will be responsible for the agreed upon payment due of \$ 30.00 (        ) per session.  
Initials

\_\_\_\_\_  
Patient's (or responsible party) Signature

\_\_\_\_\_  
Date

17510 Huffmeister Road, #103  
Cypress, TX 77429  
281-373-5200 ofc. 281-373-5202 fax

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly with appropriate authorization to share information.
- Obtain payment from third-party payers, if applicable.
- Conduct normal healthcare operations such as quality assessments and record keeping.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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### OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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17510 Huffmeister Road, #103  
Cypress, TX 77429  
281-373-5200 ofc. 281-373-5202 fax

**Pre-Authorized Charge Form**

I authorize H.O.P.E. Psychotherapy of Houston, PLLC to keep my signature on file and to automatically charge my Credit Card listed below without prior notice for:

Session fee of \$ 30.00 (        ) for missed appointments and late cancellations.  
Initials

**If you do not agree to these terms you will be subject to termination of the therapeutic relationship.**

I understand that this form is valid indefinitely unless I cancel the authorization through written notice to the service provider.

Patient's Name: \_\_\_\_\_

Cardholder's Name: \_\_\_\_\_  
As it appears on the card

Card Type:

Visa                       MasterCard                       Discover                       American Express

Account Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Card Verification Number: \_\_\_\_\_ Billing Zip Code: \_\_\_\_\_

Billing Address: \_\_\_\_\_

\_\_\_\_\_

Cardholder's Signature: \_\_\_\_\_ Date: \_\_\_\_\_