Psychology Resource Group, PLLC

DIRECTIONS FOR COMPLETION OF NEW PATIENT FORMS

1. Credit – Billing – Insurance Policy Form
   - ✓ Please note the late cancellation policy
   - ✓ Review, date, sign

2. Informed Consent for Treatment
   - ✓ Fill in Patient Name
   - ✓ Review, date, sign

3. Request for Confidential Handling of Health Information
   - ✓ Complete patient name
   - ✓ Under section A, if we can communicate with you in any form (i.e., mail, email,fax), you may enter 'All Means'. If you want to specify the way we can communicate with you (i.e., mail only, different address, etc.), please indicate that on the form.
   - ✓ Complete section B – all areas
   - ✓ Sign and date form

4. Authorization Form
   - ✓ Complete patient name
   - ✓ In the space provide next to 'to release/receive' – please indicate 'Records'
   - ✓ In the next space provided, indicate the name and address to whom we can release records.
   - ✓ If you do not want records released to anyone, please enter 'No One'.
   - ✓ Review the rest of the form, sign and date

5. Health Insurance Portability and Accountability Act (HIPAA)
   - ✓ Date, sign and print the first two sheets only
   - ✓ Please review the policy which also includes our 'Late Cancellation / No Show' policy. This information is for you to keep

6. Please print all forms and bring with you to your appointment.

Psychology Resource Group, PLLC

BILLING – INSURANCE POLICY

This letter describes our policies concerning fees, billing, and insurance procedures. If you have any questions about this or any other office policy, please discuss it with us.

Charges for services are due and payable in full at the time the services are rendered. If you have health insurance coverage, ***as a courtesy***, a claim form will be filed in your behalf. In the event the insurance company rejects your claim, or the amount paid is less than the charges, you are responsible for paying the balance owing on your account immediately. ***Our office cannot accept responsibility for knowledge of individual or group insurance policy coverage or exclusions. If you have questions concerning your coverage or covered services, please contact your insurance company or your personnel office.***

Unpaid balances will be billed once. All statements are due and payable in full upon receipt. If a statement remains unpaid after sixty (60) days, the account will be sent to collections.

Your appointment time is reserved especially for you. ***You will be charged $50.00 for missed appointments and late cancellations with less than 24 hours notice. Monday appointments must be cancelled by Friday at 4:00 p.m. If you are 15 minutes or more late, you may be asked to reschedule and a late cancellation fee may apply.***

There will be a charge for telephone consultations.

If you have any questions regarding your bill, this policy or any other office policy, please call immediately.

I understand and agree that all communication between this office and the client is held in strictest confidence unless the client authorizes release of information with a signature, or we are ordered by a court to release information, and/or child or elder abuse/neglect are suspected. In the latter two cases, we are required by law to inform legal authorities and/or potential victims.

Signature _____

Date _____

Psychology Resource Group, PLLC

Informed Consent for Treatment

Patient Name_____

I, _____(name of patient), agree and consent to participate in mental health services offered and provided by _____(name of provider), a mental health provider. I understand that I am consenting and agreeing only to those services that the above-named provider is qualified to provide within: 1) the scope of the provider's license, certification, and training; or 2) the scope of the license, certification, and training of these mental health providers directly supervising the services received by the patient. If the patient is under the age of eighteen, I attest that I have legal custody of this child am therefore allowed to initiate and consent for treatment.

Signature_____ Date_____
(includes patients 16 years and older)

Relationship to Patient_____

Psychology Resource Group, PLLC

Request for Confidential Handling of Health Information

I, _____ request that
(Print First and Last Name of patient/recipient)

Psychology Resource Group, PLLC handle my confidential health information in the following way:

A. All reasonable requests to receive communication of your health information by alternative means will be granted. Please indicate below all alternative means (e.g. US mail, telephone call, etc.) by which you prefer to receive your health information.

___ Telephone – I give my permission for Psychology Resource Group, PLLC to leave a detailed message on an answering machine or voice-mail.

___ Mail

___ Email

___ Other (please describe) _____

_____

B. All reasonable requests to receive communication of your health information at alternative locations will be granted. Please complete the following section only if you want communications regarding your health care information sent to an alternate address (other than your residence).

_____
(Street Address)

_____ _____ _____
(City) (State) (Zip Code)

_____ _____
(Signature) (Date)

Psychology Resource Group, PLLC
Authorization Form

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate. It also authorizes me to receive protected information from your clinical records from the person you designate.

I, _____, authorize my psychologist _____
(Please print your name)
to release / receive _____

This information should only be released to or received from:

_____

_____

_____

I am requesting my psychologist to release this information for the following reasons ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

_____

This authorization shall remain in effect for six (6) months.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____
Signature of Patient Date

_____
If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

Psychology Resource Group, PLLC

Health Insurance Portability & Accountability Act (HIPAA)

This practice follows all rules and regulations as mandated by HIPPA. The following are available for your review:

1. Psychologist-Patient Service Agreement
2. Policy and Practices to Protect the Privacy of Your Health Information
3. Patient Record Privacy

Your signature below indicates you have been informed the above information is available. You may obtain copies of the above information upon request.

_____ _____

Patient Signature Date

Psychology Resource Group, PLLC
7400 New LaGrange Road, Suite 301 Louisville, Kentucky 40222
(502) 394-9990