APPLICATION

Name of patient: 1.___________________________________ **Birth date: 1.**_______________ **Marital status:**_________
2. ____ **Birth date: 2.**_______________

Address:____
(street) (town) (zip code)

Phone: (H):______________________ (W): 1.___________________ (W): 2._____________________

(C):1.____________________ (C): 2____________________

Religion:_______________________________________ Email: ___________________________

Occupation: 1.____

2. ____

Last School Attended: 1.____________________________________ **Highest grade: 1.**____________

2.____________ **2.**________________

Social Security #: 1.____________________________________ **2.**_______________________________________
Patient's Birthplace: 1.________________________________ **2.**____

Years residence in MD: 1.___________ **2.**___________________ **This address**_____________

Primary Insurance Company:____
Policy#:________________________________

Insured's Employer:____ Group #:______________________________

Policy holder:____
Relationship:_____________________________

Policy holder's SS#:______________________________________ Policy Holder's DOB:_____________________________

Secondary Insurance: ____

Referral source:____

Family Doctor/Primary Care Physician:___________________+_________________________________

Address:____

Presenting Problem____

When did it begin ____

Military History
Branch____ Dates________________

Combat Location_________________________ Discharge Status _____________________

MEMBERS OF YOUR HOUSEHOLD

Name Age now Relationship

____
____
____
____
____
____

Previous Counseling **yes** **no** Name of therapist ______________________________

Where________________________________When__________________________________

Medication including dosage

Name Dosage Start Date

Current: ____________________ ____________________ ______
____________________ ____________________ ______

Previous ____________________ ____________________ ______

Psychiatric Hospitalization(s) yes no

Where When Attending Physician

______________________________ __________ ____________
______________________________ __________ ____________

Tobacco/Drug/Alcohol/Caffeine Use (also include casual use)

Type Route of administration Date last used

____
____
____

Illness **Date** **Operations** **Dates**

______________________________ ______________________
______________________________ ______________________
______________________________ ______________________

Allergies/Reactions ____

Legal History

Arrested For Age Sentencing Date Probation Officer

____

____

____

In Case of Emergency, Call ____

Phone number______________________________
Relationship____

Please circle any of the following problems which pertain to you.

Alcohol Use	Education	Lack of Interest	Separation
Anger	Energy	Legal Matters	Sexual Problems
Appetite	Fears	Loneliness	Shyness
Being a Parent	Finances	Making Decisions	Sleep
Bowel Troubles	Friends	Marriage	Stomach Troubles
Career Choices	Guilt	Memory	Stress
Children	Headaches	My Thoughts	Suicidal Thoughts
Concentration	Health Problems	Nervousness	Temper
Depression	Inferiority Feelings	Nightmares	Tiredness
Divorce	Insomnia	Past Sexual Abuse	Unhappiness
Drug Use		Relaxation	Work

AUTHORIZATION FOR RELEASE OF INFORMATION

I, and/or We, the undersigned, hereby give permission to Carol A. Deel and Associates, P.A. to disclose information to and receive information from the following regarding any findings and results of any medical, mental health treatment or evaluation, discharge summary or other information concerning me, and/or us, and/or child:

InsuranceCo

____

Address

____

Physician

____

Address

____

I, and/or we, the undersigned, agree to hold Carol A. Deel and Associates, P.A., free and harmless from all responsibility and liability concerning the release of this information; and waive on behalf of myself, and/or ourselves, and any other persons relating to the disclosure of confidential and/or privileged information.

Signed:_________________________________

Signed:_________________________________

Signed:_________________________________

Date:___________

I/We agree to refrain from and protect against disclosure of the requested information which is not authorized by further consent of the patient.

Witness:____

Date:______________

CLIENT INFORMATION

Name: ____

Street Address: ____

City: ______________________ State: _________ Zip: __________

Social Security Number: ___________ - ___________ - ___________

Home Telephone #: ( )__________ Work Telephone #: ( )__________

Birth Date:_______/_______/_________ Sex: M F

Responsible Party (if client is a minor): Name:______________________

Address & Phone: ____

____

Please indicate here if you plan to submit claims to your insurance carrier: Yes No
If yes, please ask your therapist to make a copy of your insurance card for our files

Payment Policy

Answer to some of your questions may be found on the next page titled Policies and Procedures. Please read this information carefully, and we welcome any questions you may have. Your signature at the bottom of this page indicates that you have read, understand and agree to these policies. If we are accepting a co-pay, you may be responsible for more than indicated below. In some cases you must meet a deductible.

The policy for payment is for $ per session, sessions , $ for sessions , and $ for sessions at the time of service, by check or cash. Should you cancel your session without providing at least 24 hours notice, you will be charged a fee of $85.00 unless otherwise indicated by your insurance company.

I HAVE READ AND UNDERSTAND THIS OFFICE AND FINANCIAL POLICY.

Signature: ________________________________ Date: ______________

Witness:__________________________________ Date: ______________

See Next Page

Policies and Procedures

Appointments and Cancellations*:*
Sessions are by appointment and last 50 minutes. You will be expected to pay your office visit fee for any cancellation without a 24 hour notice.

Payment*:*
Any deductible that has not been satisfied for the year is due on your first visit of the year. It is our policy that all services rendered are charged directly to you, the client or guardian, and that you or guardian are ultimately responsible for all payments regardless of whether or not we accept your insurance assignment. The policy is for full fee payment by cash or check at the time of service.

Any outstanding balance over 60 days will be assessed interest at a rate of 2% per month. When payment is received it will be applied to the interest accrued first, then to the past due balance. We reserve the right to take you to court for non-payment. You will be responsible for all court fees. In accordance with state law, we reserve the right to assess a $25.00 fee for checks returned unpaid.

Insurance*:*
Many insurance providers reimburse for some portion of the fee for outpatient psychotherapy. Your insurance is an agreement between you and your insurance company, not your insurance company and Carol A. Deel & Associates. As a courtesy to our clients, our office will complete the necessary forms and reports and file them with your company to help you collect. **It is to be understood and agreed that services rendered are charged to you directly and you are personally responsible.** When all insurance checks have been received we will refund any overpayment to you.

Your insurance plan may require: referral from a medical doctor, precertification, on-going treatment plans, etc. for payment of benefits to be received. Please check your benefit requirements carefully and inform your therapist if we must provide clinical or other information.

The benefits quoted to me by Carol A. Deel & Associates may have been erroneously quoted by my insurance company to Carol A. Deel & Associates. Therefore, I agree to consult with my insurance company to determine my benefits for psychotherapy.

Emergencies:
We use our voice mail service after hours or when in session. If you have an emergency, call 410-879-2470 press 9 leave your message, name and telephone number, and press #911- our beeper will be alerted and we will call you back. In a dire emergency, if you cannot reach us or a therapist taking calls, go to the Upper Chesapeake Hospital or Harford Memorial Hospital, and ask for the psychiatric resident on call.

Confidentiality*:*
Your therapist is ethically bound to guard you confidentiality. No disclosure as to the nature of your treatment will be made without your signed consent. However, the law limits the right of confidentiality under certain conditions. Confidentiality will not be maintained in the following circumstances: child abuse (whether or not the person is still a child), suicidal or homicidal threats, criminal or tort issues. **Client information is also required by insurance companies whenever your benefits are utilized.**

Client's initials

Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name______________________ First Name ________________MI ___
DOB:___ /___ /____
Client Address

____
Home Phone: Cell Phone:

Client Email Address: ___________________________________

Recipient Information

I, ________________________, do hereby authorize _________________________ to release a copy of my mental health information to the person or facility below.
Name :
Phone:
Address:

Date of Authorization: ___/___/______

Authorization to expire on___/___/______ or upon the happening of the following event:

Information to be Released (*Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.*)

My entire mental health record

Only those portions pertaining to:

(Specific provider name and/or dates of treatment)

Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

Other:

Purpose of Information Release:

Further mental health care
Applying for insurance
At the request of the individual
Payment of insurance claim
Vocational rehab, evaluation
Other (specify): ___________________________________
Legal investigation
Disability determination

Authorization and Signature
I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature ______________________ Date

If signed by a personal representative:

(a) Print your name: ____

(b) Indicate your relationship to the client and/or reason and legal authority for signing: Patient is: minor incompetent deceased disabled

(c) Legal authority: parent legal guardian representative of deceased

Consent for Treatment
and Limits of Liability

Limits of Services and Assumption of Risks:

Therapy sessions carry both benefits and risks. Therapy sessions can significantly reduce the amount of distress someone is feeling, improve relationships, and/or resolve other specific issues. However, these improvements and any “cures” cannot be guaranteed for any condition due to the many variables that affect these therapy sessions. Experiencing uncomfortable feelings, discussing unpleasant situations and/or aspects of your life are considered risks of therapy sessions.

Limits of Confidentiality:

What you discuss during your therapy session is kept confidential. No contents of the therapy sessions, whether verbal or written may be shared with another party without your written consent or the written consent of your legal guardian. The following is a list of exceptions:

Duty to Warn and Protect
If you disclose a plan or threat to harm yourself, the therapist must attempt to notify your family and notify legal authorities. In addition, if you disclose a plan to threat or harm another person, the therapist is required to warn the possible victim and notify legal authorities.

Abuse of Children and Vulnerable Adults
If you disclose, or it is suspected, that there is abuse or harmful neglect of children or vulnerable adults (i.e. the elderly, disabled/incompetent), the therapist must report this information to the appropriate state agency and/or legal authorities.

Prenatal Exposure to Controlled Substances
Therapists must report any admitted prenatal exposure to controlled substances that could be harmful to the mother or the child.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients’ records.

Insurance Providers
Insurance companies and other third-party payers are given information that they request regarding services to the clients.

The type of information that may be requested includes: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, summaries, etc.

By signing below, I agree to the above assumption of risk and limits of confidentiality and understand their meanings and ramifications.

____
Client Signature (Client’s Parent/Guardian if under 18)

____
Date

Cancellation Policy

If you are unable to attend an appointment, we request that you provide at least 24 hours advanced notice to our office. Since we are unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency.

For cancellations made with less than 24 hour notice (unless due to illness or an emergency) or a scheduled appointment that is completely missed, you will be mailed a bill directly for the full session fee.

We appreciate your help in keeping the office schedule running timely and efficiently.

____ ____________________

Client Signature (Client's Parent/Guardian if under 18) Date

NOTICE OF PRIVACY PRACTICES

Carol A. Deel & Associates, P.A.

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

Our Duties

We are required by law to maintain the privacy of your mental health information and to provide you with notice of our legal duties and privacy practices. We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change those terms and any changes made will be effective for all mental health information we maintain. You may request a copy of a revised notice at our office, or from our Privacy Coordinator by calling (410) 879-2470 or writing to Carol A. Deel & Associates, Attention: Privacy Coordinator, 101 South Main Street, Suite 307 Bel Air, Maryland 21014. You may also address questions regarding our privacy practices, your privacy rights, or requests for additional information regarding your privacy to the Privacy Coordinator.

Permitted Uses

We may use and disclose your mental health information for specific reasons:

- Treatment: We will provide your doctor or other health care provider with the results of an evaluation or treatment. We may contact you before an appointment to remind you of your appointment or to talk with you about your appointment.

- Payment: We will bill your insurance company, you directly, or another person that may be responsible for payment of your account. We may need to contact your health plan to see if they will pay for your mental health treatment.

- Health Care Operations: We routinely review past treatment records to maintain quality assurance goals. That means that we may select your records for a review by another therapist. We may also select your billing information for review by our internal financial department or by external auditors.

Disclosures without Authorization

We may use and disclose mental health information about you, without your specific authorization:

- Disclosures Required by Law: We may be required by federal, state, or local law to disclose your mental health information.

- Public Health Activities: We may disclose your mental health information to a public agency if mandated by the courts.

- Victims of Abuse, Neglect, or Domestic Violence: We are required to disclose your mental health information if we feel that you have been abused or neglected OR if you tell us that you have abused someone else.

- Risk to Yourself or Others: We are required by law to report, to the proper authorities, if we feel that you are at risk to harming yourself or others.

- Mental Health Oversight Activities: We may be required to disclose your mental health information to your insurance company or a related agency if they select your case for a mental health review.

- Judicial and Administrative Proceedings: We may have to disclose your mental health information if we receive a subpoena from a judge or administrative tribunal.

- Law Enforcement: We may have to disclose your mental health information in conjunction with a criminal investigation by a federal, state, or law enforcement agency.

- Serious Threats to Health or Safety: We may be required to disclose your mental health information if, in our opinion, doing so will help avert a serious threat to the public.

- Military Personnel: We may disclose your mental health information to the appropriate command authorities.

- Worker's Compensation: We may disclose your mental health information to comply with laws regarding workers' compensation.

Patient Rights

You have certain rights with respect to your mental health information.

Requesting Restrictions: You may ask us to limit our use or disclosure of your protected mental health information. We are not required to agree to your request, but if we agree to it, we will abide by your request except as required by law, in emergencies, or when the information is necessary to treat you. Your request must: 1) be in writing, 2) describe the information that you want restricted, 3) state if the restriction is to limit our use or disclosure, and 4) state to whom the restriction applies.

Confidential Communications: You may ask that we communicate with you in a particular way, or at a certain location, to maintain your confidentiality. Your request must be in writing and must tell us how you intend to satisfy your financial responsibility and specify an alternate way that we can contact you confidentially. You do not have to give a reason for your request.

Inspect and Copy: You may request access to inspect and copy your mental health information maintained in our records, including mental health and billing records. Your request must be in writing. We will act on your request within 21 days after we get it. If we must deny your request, we will send you a written denial. If this happens, you may request a review of the denial. We may charge you a fee for this service.

Amendment: You may ask us to amend your health information if you believe that it is incorrect or incomplete. Your request must be in writing and must include a reason to support the amendment. Your request may be denied if we believe that the information is complete and accurate, if the information is not part of the mental health information that you would be permitted to inspect or copy, or if we did not create the information.

Accounting of Disclosures: You may request a list of disclosures that we have made of your mental health information over the previous six (6) years. You may not request an accounting for dates of service prior to April 14, 2003. Your first request within a 12-month period is free, but we may charge for additional lists within the same 12-month period.

Paper Copy of This Notice: You are entitled to receive a paper copy of our Notice of Privacy Practices by using the contact information supplied on the first page.

File a Complaint: If you believe that we have violated your privacy rights, you may file a complaint directly with us using the contact information on the first page. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for complaining.

Provide an Authorization for Other Uses and Disclosures: We will request your written authorization for uses and disclosures of your mental health information that are not identified in this notice or permitted by law. You may revoke your authorization at any time in writing.

Carol A. Deel & Associates

Signature Form Regarding Privacy Practices

I, ____ have received a copy of the Notice of Privacy Practices for Protected Health Information to read. This provides a complete description of patient rights and disclosures, supplied to me by Carol A. Deel & Associates, P.A.

I understand that if I have any questions about this form, I may contact Carol A. Deel & Associates, P.A. at 410-879-2470.

____ ____________________

Client Date

____ ______________________

Witness Date

SIGNATURE ON FILE

Please initial each line, sign at the bottom and date

- I authorize use of this form on all insurance claims. __________
- I am ultimately responsible for my bill. __________
- I authorize payment direct to the above provider of services.__________
- I allow a copy of this authorization to be used in place of the original ________

NAME____

SIGNATURE____

WITNESS____

DATE____

101 South Main Street • Suite 307 • Bel Air, Maryland 21014 • 410-879-2470 • cadeel@gmail.com