ASC Psychological Services

Client Intake Form

Please Print

Date: ___/___/2014

Name:	Male Female	Date of Birth	Marital Status
Address:	SS#:		
City: State: Zip:	Employer:		
Home Phone:	Spouse: DOB:		
Cell Phone:	SS#: Employer:		
Work Phone:	Spouse Phone:		
Email:	In Case of Emergency:		

Reason for Visit: _____

_____

Previous Treatments for This Condition: _____

Other Doctors Seen for This Condition: _____ **When Did Your Symptoms Begin?** _____

Current Medications: _____

If You Are a Veteran, Please Provide a Copy of Your DD-214 Form

Are You A Veteran? Yes / No **Currently on Active Duty? Yes / No** **Branch of Service:** _____

Military Service Era: _____ **If Global War on Terrorism, Specify Combat Zone: OIF / OEF / OIF - OEF**

Discharge Type: _____ **VA Service Connected? Yes / No** **If Yes, Please Specify:** _____

Primary Insurance: _____

Phone: _____ **Fax:** _____

Name of Insured: _____

Insured SS#: _____ **DOB:** _____

ID#: _____ **Group#:** _____

Relationship to Client: Self Spouse Child Other

Secondary Insurance: _____

Insured ID#: _____ **Group#:** _____

Insurance: If you have medical insurance, we will be glad to process your claims for you as a courtesy of this office.

Pay Arrangements: If you are not covered under insurance, arrangements can be made through our front desk.

Authorized Consent for Treatment of a Minor

_____

SIGNATURE OF PARENT / GUARDIAN

Relationship To Client: _____

To submit a claim for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

I hereby authorize release of information necessary to file a claim with my insurance company and **ASSIGN BENEFITS OTHERWISE PAYABLE TO ME TO THE COUNSELOR OR FACILITY INDICATED ON THE CLAIM.**

I understand that I am financially responsible for any balance not covered by my insurance carrier.

I also direct this office to do all acts necessary to recover all or any part of these sums payable to me.

A copy of this signature is as valid as the original.

I attest that the above information is accurate to the best of my ability. **SIGNED** _____

ASC Psychological Services

CONFIDENTIALITY NOTICE

I, _____ have received a copy of the Confidentiality Notice, and it has been explained to me.

_____

Signature of Client Date

- Or -

_____

Signature of Client's Authorized Representative Date

ASC PSYCHOLOGICAL SERVICES 12 Civic Center Plaza, Suite 1615 | Mankato, MN 56001

P: 507.345.4679 | F: 507.345.8685 | www.ascpsychological.com

Dr. George Komaridis | Dr. Adam Anderson | Julie Melzer | Jean Zenk

CONFIDENTIALITY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL AND DRUG AND ALCOHOL RELATED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

General Information

Information about your treatment and care, including payment for care, is protected by The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under this law, the program may not disclose your identity, information, or involvement in the program to anyone without your permission, except as permitted by the federal laws referenced below.

The program must obtain your written consent before it can disclose information about you for payment purposes. For example, the program must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before the program can share information for treatment purposes or for health care operations. However, federal laws permit the program to disclose information in the following circumstances without your written permission:

1. To program staff for the purpose of providing treatment and maintaining the clinical record;
2. Pursuant to an agreement with a Business Associate (e.g. Clinical laboratories, record storage services, billing services);
3. For research, audit or evaluations (e.g. State licensing review accreditation, program data reporting as required by the State and/or Federal government);
4. To report a crime committed on the program's premises or against program personnel;
5. To medical personnel in a medical/psychiatric emergency;
6. To appropriate authorities to report suspected child abuse or neglect;
7. To report certain infectious illnesses as required by state law;
8. To report any clear threats of harm to self or others, or clear indication of harm to self or others.
9. As allowed by a court order.

Before the program can use or disclose any information about your health in a manner which is not described above, it must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing. (NOTE: Revoking a consent to disclose information to a court, probation department, parole office, etc. may violate an agreement that you have with that organization. Such violation may result in legal consequences for you).

*** 42 U.S.C. § 130d et. Seq., 45 C.F.R. Parts 160 & 164**

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CONFIDENTIALITY NOTICE

Your Rights

- Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health and treatment information. The program is not required to agree to any restrictions that you request, but if it does agree with them, it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency.
- You have the right to request that we communicate with you by alternative means or at an alternative location (e.g. another address). The program will accommodate such requests that are reasonable and will not request an explanation from you.
- Under HIPAA you also have the right to inspect and copy your own health and treatment information maintained by the program, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal, or administrative proceeding, or in other limited circumstances.
- Under HIPAA you also have the right, with some exceptions, to amend health care information maintained in the program's records, and to request and receive an accounting of disclosures of your health related information made by the program during the six (6) years prior to your request.
- If your request to any of the above is denied, you have the right to request a review of the denial by the program Administrator.
- To make any of the above requests, you must fill out the appropriate form that will be provided by the program.
- You also have the right to receive a paper copy of this notice.

The Use of Your Information at the Program

In order to provide you with the best care, the program will use your health and treatment information in the following ways:

- Communication among program staff (including students or other interns) for the purposes of treatment needs, treatment planning, progress reporting and review, staff supervision, incident reporting, medication administration, billing operations, medical record maintenance, discharge planning, and other treatment related processes.
- Communication with Business Associates for billing purposes and agencies that provide in-site services.

The Program's Duties

The program is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. The program is required by law to abide by the terms of this notice. The program reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. The program will provide current patients with an updated notice, and will provide affected former patients with new notices when substantive changes are made in the notice.

In the Event of an Emergency

Staff at ASC in available Monday through Friday 8:30 a.m. to 4:30 p.m. If you find yourself in a situation that calls for immediate attention, and we are unavailable, please dial 911 or go to your local Emergency Room for assistance.

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P: 507.345.4679 | F: 507.345.8685 | www.ascpsychological.com
Dr. George Komaridis | Dr. Julene D. Nolan | Timothy Benesch | Julie Melzer | Jean Zenk

CONSENT FOR EXCHANGE OF CLIENT INFORMATION

Client Name_____ Date of Birth_____

I hereby authorize ASC and _____
Name and address of Agency/Individual

_____

to exchange information from my records when I was a client up to and including _____
Date (valid one year from signature date)

The information shall include the following:

__ Psychological/Psychiatric report or summary
__ Progress Notes
__ Psychological testing results
__ Discharge Summary
__ History and Physical
__ Social or Family History
__ Nursing Assessment
__ Family Assessment
__ Other (Specify) _____
__ School Records
__ Chemical Use Assessment
__ Drug Screens
__ HIV Testing

I do/do not also agree to the verbal exchange of information. The information requested is for the following reasons:

_____

I understand that I may revoke this consent at any time and that this consent will automatically expire one year after the date of my signature.

The document of informed consent has been explained to me and I understand the contents to be released, the need for information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

I acknowledge that information to be released may include material that is protected by federal law applicable to drug/alcohol abuse.

_____
Signature of Client or Client's Authorized Representative

_____
Relationship of Authorized Representative

_____
Witness Signature

_____
Date

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records federal requirements (42 C.F.R. Part 2) prohibit further disclosure without the specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug information.