NEW CLIENT INFORMATION

A. **Please complete this section if client is 18 years of age or older. If client is under the age of 18, the parent or guardian completes this section, then completes Section B for the child.**

Name: _____ **DOB:** _____
SS# _____ **Marital Status: S __ M__ Div__ Sep__ W___**
Address: _____ **City:**_____ **State:** ___ **Zip:**_____
Hm. Phone: _____ **Wk Phone:**_____ **Cell:** _____
Employer: _____ **How Long:** _____ **Occupation:** _____
Family Physician: _____
Current Medications: _____
Spouse's Name: _____ **DOB:** _____

SS# _____ **Employer:** _____

B. **IF CLIENT IS UNDER AGE 18, PLEASE FILL IN THE FOLLOWING:**
Name: _____ **Age** ___ **DOB:** _____
SS# _____ **School:** _____
Teacher: _____ **School Counselor:** _____

LIST OTHER HOUSEHOLD MEMBERS:

_____

_____

_____

_____

Nearest relative not living with you: _____ **Phone:** _____

In case of emergency, whom do you wish to have contacted?
_____ **Phone:** _____

Are you currently in treatment with, or have you ever been treated by a psychiatrist, psychologist, or psychotherapist? Y___N___. Name of person providing treatment __
_____.

I understand I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information and have completed the New Client Information form. I certify that this information is correct to the best of my knowledge and will notify the office of any changes in information.

Signature:_____ **Date:** _____

Robbie S. Hysong, M.S., LMHC FL MH4332

1000 W 11 St
Panama City Fl 32401

(850) 913-8313
FAX: (850) 913-8314

CONFIDENTIAL COMMUNICATIONS – ALTERNATIVE CONTACT INFORMATION

(This information should be placed in a prominent location in client's record to remind staff to use alternative addresses and/or phone numbers if necessary).

As a courtesy to you and in order to serve you better, our staff will contact you to remind you of your appointment date and time. This form allows you to designate, specifically, whether you wish to be contacted and how. If you do not wish to be contacted, please note that in the section "Requested Accommodations".

Effective date: _____

Client's name: _____ DOB: _____

Requested Accommodations:

_____

_____

Address where we can send information:

_____

Email address: _____

PHONE NUMBERS: (PLEASE LIST *ONLY* THOSE NUMBERS THAT ARE OKAY TO CALL)

IS IT OK TO LEAVE A MESSAGE??

Home: _____ Y N

Work: _____ Y N

Cell: _____ Y N

Other: _____ Y N

Please list billing arrangements:

_____

Signature of Client or Personal Representative: _____

Relationship of Personal Representative: _____ Date: _____

Robbie S. Hysong Email Consent

Many patients prefer to utilize email as a means to confirm or change appointments or to provide information to the office between appointments. Under Florida law, email is not provided the degree of privacy that is permitted other forms of communication, such as telephone calls and letters. While all communications received by email at this office will remain confidential and private, we recommend caution to our patients when using email. I do NOT recommend my patients send very sensitive information by email.

For those who wish to contact Robbie and staff by email, our address is: rcutler@knology.net.
This email is checked daily during the workweek by staff who also respond to all email received at this address. Appropriate uses of this email address might include:

Confirm or cancel an appointment.

DO NOT use this email to communicate an emergency such as:

Suicidal or homicidal thoughts;
Other personal emergencies requiring an immediate response

Email from patients will be printed and made a permanent part of the medical record. Robbie will NOT personally respond. Be sure to include your first and last name and phone number in your email to avoid any confusion. Update our office regarding any changes in your email address.

I consent to email communication with Robbie's office. I understand the risks and limitations of the use of email. I understand that I can withdraw my email consent at any time.

_____ _____

Patient (or Guardian) Name Date

_____ _____

Patient (or Guardian) Signature Email address

Robbie S. Hysong M.S. LMHC
Florida LMHC (MH4332)

1000 W 11 St
Panama City Fl 32401

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Financial Arrangements & Insurance Information

We are committed to providing you with the best possible care. If you have medical insurance, we are here to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance and understanding of our payment policy.

1. Payments of services are due at the time services are rendered unless payment arrangements have been approved in advance by a staff member. We accept cash, checks (with valid I.D.), MasterCard, and Visa. We realize that temporary financial problems may affect timely payment of your account; if such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

2. Returned checks will be subject to additional collections fees. **A full charge of $105 will also be made for appointments at which you 'No Show' or cancel without 24 hrs. advance notice.**

3. This provider does not accept or bill for insurance claims. As such, we are happy to prepare an insurance claim for you to sign and submit to your insurance company for any reimbursements due you. The funds will be sent directly to you. In some cases, your insurance plan may require that you obtain pre-authorization for services before your first appointment; in those cases, it is your responsibility to provide us with that information prior to your first date of service. Failure to do so may result in your insurance company denying some, or all, of your claim.

4. **Not all services are a covered benefit in all contracts.** It is your responsibility to verify that the services for which you are being treated by this office are covered in your particular contract.

5. **You will be billed for any outstanding balance on your account. Negligence to pay could result in the reporting of your account to the Credit Bureau of Bay County.**

If you have any questions about the above-stated information, please do not hesitate to ask us.
We are here to help you.

_____ _____

Signature Date

NOTE: Even though this provider does not bill insurance claims, the information requested below is necessary in order to provide you with an insurance claim form that is correct for your submission to your insurance company for any reimbursement of benefits.

PRIMARY INSURANCE INFORMATION

Name of Insured: _____ DOB: _____

Insured's SSN: _____

Employer of Insured: _____

Name of Insurance Company: _____

Effective date of policy: _____ Policy # _____

If authorization is required for our services, have you called? Y _____ N _____

SECONDARY INSURANCE INFORMATION

Name of Insured: _____ DOB: _____

Insured's SSN: _____

Employer of Insured: _____

Name of Insurance Co. _____

Effective date of policy: _____ Policy # _____

If authorization is required for our services, have you called? Y ____ N _____

MILITARY INSURANCE INFORMATION

Tricare _____ Standard _____ Prime _____ Retired _____ Active _____

VA _____ Champ VA ____ Other _____

Sponsor's SSN: _____ DOB: _____

Sponsor's rank: _____ Branch of Service: _____ Exp. Date: _____

Signature: _____ **Date:** _____

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice is effectively updated as of 06/14/2017.

We are required by law to maintain the privacy of protected health information and must inform you of your privacy practices and legal duties. **You have the right to obtain a paper copy of this notice upon request.**

We are required to abide by the terms of the Notice of Privacy Practices that is currently in effect. We reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that we maintain. The revised Notice will be posted in the waiting room of this office. You may request a copy of the revised Notice at any time.

We have designated a Privacy Officer to answer your questions about our privacy practices and to ensure that we comply with the applicable laws and regulations. The Privacy Officer will take your complaints and give you information about how to file a complaint.

Our Privacy Officer is your therapist, Robbie S. Hysong, M.S., LMHC. You can contact her at 850-913-8313. If you are not receiving services by our office but plan to, please let a member of our office staff know and someone will contact you to assist.

Use and disclosure of your protected health information that we may make to carry out treatment, payment, and health care options:

With your signed consent, we may use information in our record to provide treatment to you. We may not disclose information in your record to help you get health care services from another provider, hospital, etc., unless we have a signed consent from you giving permission to disclose specific health care information to the specific health care provider and for a stated reason. For example, if we want an opinion about your condition from a specialist, we may not disclose information to the specialist to obtain that consultation without written consent from you stating the name of the person with whom we are consulting and for what reason.

_____ _____

Signature Date

Relationship of Personal Representative: _____

We may not make any use of disclosure of information from your record unless you give us written consent. You may revoke consent in writing at any time, but this will not affect any use of disclosure made by us before the revocation. In addition, if the consent was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the consent.

Use of disclosure of your protected health information that we are required to make without your permission:

In certain circumstances, we are required by law to make a disclosure of your health information. For example, **state law requires us to report suspected child or elderly abuse or neglect.**

When there is clear and immediate probability of physical harm to you, other individuals, or to society, your "licensed psychotherapist" may communicate this information only to the potential victims, appropriate family members, and law enforcement or to other appropriate authorities.

When your "licensed psychotherapist" is a party defendant to a civil, criminal, or disciplinary action arising from a complaint filed by you, health information shall be disclosed that is pertinent and required to that action.

Use or disclosure of your protected health information that we are allowed to make without your permission:

When you receive mental health care including treatment for substance abuse, information related to that care must be more protected than other forms of health information. Communications between a psychotherapist and patient in treatment are privileged and may not be disclosed without your permission, except as required by law. For example, psychotherapists still must report suspected child abuse and may have to breach confidentiality if you appear to post an immediate danger to yourself or others, in order to reduce the likelihood of harm to you or others.

We may disclose information from your record if ordered to do so by a judge.

If you tell us that you have committed a violent crime that caused serious physical harm to the victim, we may not disclose that information to law-enforcement officials. Information of this sort, if revealed in a counseling or psychotherapist session or in the course of treatment for this sort of behavior, may not be disclosed to law enforcement without your consent, and unless it pertains to the specific conditions stated above, such as abuse of a child or the elderly.

With your informed consent, your provider (or office staff) may contact you to provide appointment reminders **as a courtesy. However, it is your responsibility to remember your appointment. Missed appointments may be subject to a fee.** If you do not want to be contacted or have special circumstances regarding how or where you wish to be contacted, the office staff will provide you with the necessary paperwork to keep us informed of those conditions.

Signature: _____ **Date:** _____

Relationship of Personal Representative: _____

We may not use or disclose information from your record to allow "health care operations", without your written consent. These operations include activities like reviewing records to see how care can be improved; contacting you with information about treatment alternatives, and coordinating care with other providers. For example, we may not use information in your record to train our staff about your condition and its treatment without specific written consent.

Your Rights:

You may ask to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment or health care operations. Since your records are confidential under state law, we must honor those restrictions. However, if after reviewing the requirement for information to process your claims you decline to consent, then you will be personally responsible for payment of services provided.

You have the right to inspect the information in your record and may obtain a copy of it. This may be subject to certain limitations and fees. Your request must be in writing to the "licensed psychotherapist" who provided services and not to the office personnel. Your request will be acted upon within thirty (30) days. If this time frame cannot be honored by your psychotherapist and an extension is necessary, you will be given the reason for the delay in writing.

If you believe information in your record is inaccurate or incomplete, you may request amendment for the information. You must submit sufficient information to support your request for amendment. Your request will be acted upon within sixty (60) days, with conditions for a delay for thirty (30) days, if necessary, which will be provided to you in writing.

You have the right to request an accounting of all disclosures made by us with your consent. This includes incidental disclosures made in the course of correcting hardware or software problems about account information used to bill or schedule appointments.

You have the right to complain to us about privacy practices (including the actions of our staff with respect to the privacy of your protected health information). You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. You will not face retaliation from us for making complaints.

Signature: _____ **Date:** _____

Relationship of Personal Representative: _____

Robbie S. Hysong, M.S., LMHC
Florida LMHC (MH4332)

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Receipt of Privacy Practices

Given to client on: _____ Version/Effective date: _____

_____
Signature of Client or Personal Representative

Relationship of Personal Representative to Client: _____

****

Given to client on: _____Version/Effective Date: _____

_____
Signature of Client or Personal Representative

Relationship of Personal Representative to Client: _____

****

Given to client on: _____ Version/Effective Date: _____

_____
Signature of Client or Personal Representative

Relationship of Personal Representative to Client: _____

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Given to client on: _____ Version/Effective Date: _____

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Signature of Client or Personal Representative

Relationship of Personal Representative to Client: _____

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