Cheryl A Kilpatrick, Ph.D.
4870 S Lewis Ave, Suite 230
Tulsa, OK 74105
(918) 749-6935

(PLEASE PRINT)

Personal Information

Name_____ Home Phone_____
Last Name First Name Initial

Address _____Soc. Sec. # _____

City_____ State_____ Zip_____

Gender ___ M ___ F Age_____ Birthdate_____ Single____ Married____ Widowed____ Separated____ Divorced___

Patient Employed by_____ Occupation_____

Business Address_____ Business Phone_____ Cell Phone_____

Have you sought previous counseling?_____

What prompted you to call at this time?_____

Whom may we thank for referring you?_____

In case of emergency whom should we notify?_____ Relationship _____Phone_____

Family History

Fill in information about your family

Name of Each Family Member	Relationship to Client	Birthdate	Place of Employment/Position or School/Grade

Medications

Are you currently taking any medications? ___ Yes ___ No

Name of Medication Prescribing Physician Length of Time Taken

_____
_____
_____
_____

I understand that the standard charge for consultation is $125 per counseling hour and that payment is expected following each session. Appointments not cancelled 24 hours in advance are subject to charge since appointments consist of time especially reserved for me. Charges for evaluation vary and will be discussed prior to evaluation.

SIGNATURE:_____ DATE:_____

Consent for Treatment

Cheryl A. Kilpatrick, Ph.D.
4870 S Lewis Ave, Suite 230
Tulsa, Oklahoma 74105

Clinical Psychologist
Tel: 918-749-6935
Fax: 918-749-7611

Re:_____ Date of Birth:_____

I request and authorize Cheryl A. Kilpatrick, Ph.D. to provide professional psychological services to myself and/or specified family members. These services may include assessment or evaluation via clinical interview, psychological testing (intellectual and/or personality assessment via formal test instruments), psychotherapy in individual, family (marital), or group formats, behavioral intervention, professional consultation, and any additional services or procedures listed below.

I understand that the fees for service by Dr. Kilpatrick are currently $125 for a 45 to 60 minute "hour" for services provided in the office. This fee may be prorated for periods of less than an hour. Fees for psychological assessment may apply not only to test administration, but also to time required for scoring, interpretation, and preparation of written summaries or reports.

I understand that I will assume financial responsibility for all fees or charges arising from the services provided, whether requested by me or necessitated by other circumstances, including but not limited to, subpoena or other court process. I understand that I will pay any charges which are not covered by insurance or other third party payers including but not limited to deductibles, exclusions, copayments, etc.

I understand that I may be charged for appointments I miss unless I notify the office at least 24 hours in advance that I will be unable to keep a scheduled appointment. Furthermore, I understand that such charges are not typically covered by insurance or other third party payers and that I will be personally liable for the charges.

I acknowledge having received an explanation of the limits to confidentiality. I authorize Cheryl A. Kilpatrick, Ph.D. to furnish confidential information including but not limited to diagnoses and financial information to any insurer, third party payer, or welfare agency providing financial assistance for the services rendered. I assign and authorize payment directly to Dr. Kilpatrick of any insurance or health plan benefits otherwise payable to me. A photocopy of this authorization and assignment is to be considered as valid as the original.

I certify that I have legal standing to authorize these professional psychological services.

_____ _____

Signature Date

Primary Insurance

Subscriber_____
Last Name First Name Initial

Relation to Patient_____ Birth date_____ Soc. Sec #_____

Address (If different from patient's)_____ Phone_____

Subscriber Employed by_____ Occupation_____

Business Address_____ Business Phone_____

Name of other dependents covered under this plan _____

Authorization Number (if applicable)_____ # of visits_____

Additional Insurance

Is patient covered by additional insurance? ____ Yes ____ No

Subscriber Name_____ Relation to Patient_____ Birth date_____

Address (If different from patient's)_____ Phone_____

Subscriber Employed by_____ Business Phone _____

Names of other dependents covered under this plan _____

Authorization Number (if applicable)_____ # of visits_____

SIGNATURE ON FILE

I authorize use of this form on **all** my insurance submissions.

I authorize release of my information to all my **Insurance Companies**.

I authorize my therapist to act as **my** agent in helping me obtain payment from my Insurance Companies.

I authorize payment direct to my therapist.

I permit a copy of this authorization to be used in place of the original.

Signature _____ Date_____

Patient Name (Please Print)_____

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between behavioral health providers and your primary care physicians is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary. I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified.

I, _____ , _____ _____ , for the purpose of
(Patient Name - Print) (Patient d.o.b) (Patient Social Security #)

coordinating care, authorize Cheryl A Kilpatrick, Ph.D. , to release information indicated in the "Consent" portion of this form to:

Primary Care Physician Name: _____

Primary Care Physician Phone: _____ **Fax:** _____

Primary Care Physician Address: _____
(Street) (City) (State) (Zip)

Information for Primary Care Physician:

The patient was seen by me on (date): _____ For (Diagnosis): _____

Treatment Plan:_____

_____ Cheryl A. Kilpatrick, Ph.D. Psychologist_____
(Provider Signature) (Provider Printed Name) (Licensure)

CONSENT

I, the undersigned, understand that I may revoke this consent through writing at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date Is specified. I have read and understand the above information and give my consent:

Patient please check <u>one</u>:

( ) To release any applicable mental health/substance abuse information to my primary care physician.
( ) I <u>do not</u> give my consent to releasing any information to my primary care physician.

_____ _____
Patient Signature (Patients over 18) (Date) Parent/Guardian Signature (Patients under 18) (Date)

_____
Witness (Date)

Notice To Recipient Of This Information: This information has been disclosed to you from records which are protected by federal (42 CFR Part 2) and state laws regarding confidentiality. Such laws prohibit you from making any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.

Notice of Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- **"PHI"** refers to information in your health record that could identify you.
- **"Treatment, Payment and Health Care Operations"**
  - **-Treatment** is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - **-Payment** is when I obtain reimbursement for your health care. I may disclose your PHI to your health insurer for payment activities such as: determining eligibility and coverage under a health-care plan, reviewing services to determine medical necessity, and participating in utilization review activities.
  - **-Health Care Operations** are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, case management and care coordination, and providing reminders of appointment times.
- **"Use"** applies only to activities within my office such as sharing, examining, and analyzing information that identifies you.
- **"Disclosure"** applies to activities outside my office such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

- I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain an authorization from you before releasing this information.
- I will also need to obtain an authorization before releasing your psychotherapy notes in the event that I determine releasing those notes is appropriate and consistent with Oklahoma statutes governing mental health records. "Psychotherapy notes" are notes I have made about our conversations during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.
- I will also obtain an authorization from you before using or disclosing PHI in a way that is not described in this Notice.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reason to believe that a child under the age of 18 years is the victim of abuse or neglect, the law requires that I report to the appropriate government agency, usually, the Oklahoma Department of Human Services. Once this report is filed, I may be required to provide additional information.
- **Adult and Domestic Abuse:** If I have reason to believe that a vulnerable adult (defined below) is suffering from abuse, neglect, or exploitation, I am required by law to make a report either to the Oklahoma Department of Human Services, the district attorney's office or the municipal police department as soon as I become aware of the situation. Once a report is filed, I may be required to provide additional information.

  A "vulnerable adult" means an individual who is an incapacitated person or who because of physical or mental-disability, incapability, or other disability, is substantially impaired in the ability to provide adequately for the care or custody of him or herself, or is unable to manage his or her property and financial affairs effectively, or to meet essential requirements for mental or physical health or safety, or to protect him or herself from abuse, neglect, or exploitation without assistance from others.

- **Health Oversight:** If you file a disciplinary complaint against me with the Oklahoma State Board of Examiners of Psychologists, the Board would have the right to view your relevant confidential information as a part of the proceedings.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release the information without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** If you communicate to me an explicit threat to kill or inflict serious bodily injury upon a reasonably identifiable person, and you have the apparent intent and ability to carry out that threat, I have the legal duty to take reasonable precautions. These precautions may include disclosing relevant information from your mental health records, which is essential to protect the rights and safety of others. I also have such a duty if you have a history of physical violence of which I am aware, and I have reason to believe there is a clear and imminent danger that you will attempt to kill or inflict serious bodily injury upon a reasonably identifiable person.
- **Worker's Compensation:** If you file a worker's compensation claim, you will be giving permission for the Administrator of the Worker's Compensation Court, the Oklahoma Insurance Commissioner, the Attorney General, a district attorney (or a designee for any of these individuals) to examine your records relating to the claim.
- **Use and Disclosure Allowed Under Other Sections of Section 164.512:** When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of PHI. However, I am not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address designated by you.
- **Right to Inspect and Copy:** You have the right to inspect and/or obtain a copy of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process. This right does not apply to a very narrow category of medical information referred to as "psychotherapy notes."
- **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- **Right to an Accounting:** You generally have the right to receive an accounting of disclosures of PHI regarding you. You may request one free listing of disclosures every 12 months. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003.
- **Right to Notice:** You have the right to obtain a paper copy of the notice.
- **Right to Restrict Disclosures When You have Paid for Your Care Out-of-Pocket.** You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.
- **Right to Be Notified if There is a Breach of Your Unsecured PHI.** You have a right to be notified if: (a) there is a breach (a use of disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

You must submit a written request to exercise any of these rights. You may request forms to exercise these rights by contacting my privacy office as follows:

Privacy Officer
4870 S Lewis Ave, Suite 230
Tulsa, Oklahoma 74105

Psychologist's Duties:

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
I reserve the right to change the privacy policies and practices described in this notice.
Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
If I revise my policies and procedures, I will provide written notice in the first treatment session following the change or by mail if you are no longer in treatment and if it has been less than six years since the last date of treatment.

V. Complaints

If you are concerned that I may have violated your privacy rights, or you disagree with a decision I have made about access to your records, you may contact my privacy officer as noted above. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The privacy officer will provide you with the appropriate address upon request.

I will not retaliate against you if you file a complaint against me.

This notice takes effect April 14, 2003.

Cheryl A. Kilpatrick, Ph.D.
4870 S Lewis Ave, Suite 230
Tulsa, OK 74105

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGMENT AND CONSENT

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES:

The Notice of Privacy Practices tells you how I may use and disclose your protected health information (PHI). **Please read the notice carefully**.

- I will use and disclose your PHI to treat you and to bill for the services I provide.
- I will use and disclose your PHI to run my business.
- I will use and disclose your PHI as required by law.

All the ways I may use and disclose your PHI are explained in more detail in the Notice of Privacy Practices.

You have the following rights with respect to your PHI:

1. You have the right to look at and receive a copy of your PHI.
2. You have the right to receive a list of individuals or agencies to whom I have given your PHI.
3. You have the right to ask for an amendment in your PHI.
4. You have the right to ask that I not use or disclose your PHI.
5. You have the right to ask that I change the way I contact you.
6. You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.
7. You have a right to be notified if: (a) there is a breach (a use of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) your PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

All of these rights are explained in more detail in the Notice of Privacy Practices.

I have received a copy of Dr. Kilpatrick's Notice of Privacy Practices.

Signature: _____ **Date**: _____
(Of patient or Legal Representative)
Capacity of Legal Representative (if applicable)*: _____

CONSENT:

I **consent** to the use and disclosure of my protected health information (PHI) for treatment payment, and operation purposes as described in the Notice of Privacy Practices.

Oklahoma law (63 OS, Sec, 1-502.2) requires that I advise you that the **information authorized for disclosure may include records which may indicate the presence of a communicable or non-communicable disease. It also may include mental health or other sensitive information.**

Signature: _____ **Date**: _____
(Of Patient or Legal Representative)
Capacity of Legal Representative (if applicable)*: _____

* May be requested to provide verification of representative status.