H. DENISE WOOTEN, PsyD, P.A. License #24437

Returning Patient Information

NAME: _____ DOB: _____ AGE: _____ GENDER: _____

ADDRESS _____GRADE _____

CITY, STATE, ZIP _____

(H) PHONE _____(W) PHONE _____(C) PHONE _____

EMAIL_____

FATHER/GUARDIAN if applicable _____ EMAIL _____

OCCUPATION _____ EMPLOYER _____

WORK PHONE _____ CELL PHONE _____

MOTHER/GUARDIAN if applicable _____EMAIL _____

OCCUPATION _____ EMPLOYER _____

WORK PHONE _____ CELL PHONE _____

SELF (*ADULT ONLY*) OCCUPATION_____EMPLOYER _____

ACKNOWLEDGMENT OF OFFICE

OUT OF NETWORK, SELF PAY RATE: $135/UNIT. I ACKNOWLEDGE THIS RATE _____ INITIALS

I HAVE READ THE OFFICE POLICIES AND AGREE WITH THE OFFICE POLICIES: _____ INITIALS

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ACKNOWLEDGEMENTS & CONSENTS

CONSENT FOR TREATMENT OF MINOR/DEPENDENT CHILD

I certify that I am the {father, mother, managing conservator, legal guardian (circle one)} of the above named child, and I hereby give my authorization and informed consent for the above named child to receive psychological or therapeutic outpatient diagnostic and treatment services from H. Denise Wooten, PsyD. I further certify that I have the legal authority to authorize and consent to this treatment.

_____Signature & Date

CONSENT FOR TREATMENT (Adults, 18 years+ only)

I have the legal authority to authorize and give my authorization and informed consent to receive psychological or therapeutic outpatient diagnostic and treatment services from H. Denise Wooten, PsyD

_____Signature & Date

CONSENT TO COMMUNICATE WITH OTHER

If you consent to allow Dr. Wooten to communicate with your physician or other professional regarding your case, please sign below. Your signature will indicate your consent to this communication until you withdraw your consent in writing.

_____ _____

Physician/Professional Name Telephone Number of Professional

_____ Signature & Date

ASSIGNMENT OF INSURANCE BENEFITS

IN-NETWORK INSURED:

If you wish Dr. Wooten's office to file for direct in-network reimbursement by your insurance company, please provide the information requested below.

I hereby assign payment of medical benefits by: (Insurance Company) _____

to H. Denise Wooten, PsyD. I also authorize the release of any medical information requested by the above named insurance or managed health care company. The assignment will remain in effect until revoked by me in writing (a photocopy of this assignment is to be considered as valid as the original). **I understand that I am financially responsible for all charges whether or not paid by said insurance** except to the extent that a contract between the provider and a managed health care company might limit that financial responsibility.

_____Signature & Date

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CHILD AND FAMILY UPDATE

INSTRUCTIONS: Please complete the following information about your child and family. If any questions do not apply to your child, simply write "DNA" (does not apply) in the space provided or leave the space blank. It is best if this form is completed by all parents or primary caretakers. This information will be helpful to your child's doctor or other professional to better understand your child and your family.

I. DESCRIBE WHAT PROMPTED YOUR CONTACT

II. BEHAVIORAL CHANGES TO REPORT

Check the items that describe your child:

	Always on the go, has difficulty staying seated at school, church, meals, etc.		Slow to walk.
	Often doesn't seem to listen.		Delayed development.
	Hard to discipline.		Explosive temper, tantrums.
	Argues excessively.		Destructive (breaks toys, furniture, etc.)
	Socially withdrawn (prefers to be alone)		Fights (adults or children).
	Doesn't like self.		Overly sensitive/fearful.
	Has run away.		Seems unhappy/depressed.
	Has breath-holding spells.		Overly dependent on parents or others.
	Has difficulty keeping his/her attention (concentration) on tasks at school or home.		Lies excessively.
	School reports child often disrupts class, speaks or acts without thinking.		Stealing.
	Speech unclear.		Fire-setting or playful with matches.
	Not talking.		History of physical/sexual abuse (if yes, circle which).
	Other:		

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Developmental – Social - Self Help (indicate approximate age for following)

Has the child had any of the following?

	NO	YES	CURRENTLY?
Convulsions or Seizures			
Vision Problems			
Frequent ear infections			
Ear tubes			
Allergies (if yes, specify):			
Any regularly used medications and/or psychotropic, stimulants, ADHD, mood or anxiety medications(if yes, specify):			
Any unusual reaction or behavior after taking medicine or certain foods (if yes, specify):			
Was child ever hospitalized overnight?			
Concussions or head injuries			

III. FAMILY CHANGES TO REPORT

Have there been any changes in the family dynamic since your last visit to my office?

Mother: divorce and/or remarriage: YES NO If so, when? _____

Do parents/stepparents agree on discipline? YES NO
Is discipline consistent? YES NO

Has there been any sleep disruption recently? YES NO If YES, please describe:

Has there been any disruption in household recently? If YES, please describe:

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IV. SCHOOL UPDATE TO REPORT

What is your child's current grade level? _____

Has the child changed schools? YES NO If yes, what were the circumstances of the change?

_____

Has your child needed to repeat a grade level? YES NO If yes, when: _____

In general, describe your child's performance since your last visit:

List any outstanding strengths or problems.

Has your child ever received special education services? If so, what grades?

Does your child currently have an IEP from his/her school? YES NO

Does your child currently have a 504 Plan at school? YES NO

If applicable, describe the main focus of your child's IEP or 504 Plan and note any accommodations your child is currently receiving.

Describe any problems your child may have in school with learning:

Describe any problems your child may have with homework (e.g. forgets, does not return it to school, etc.)

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ADULT PATIENT INFORMATION

Name of Patient: _____ Date: _____

Please describe the problem and its onset for which you are seeking help.

How would you describe the severity of the effects of the problem on you?

A Little Bit Moderately Quite Extremely

Please describe any prior counseling, therapy, or evaluation services received, including dates of service.

Please list any medications you are presently take and the amounts prescribed. Also, list any nonprescription medicine regularly taken.

Please identify which of the following you use and the frequency and quantity.

		Frequency	Quantity
Nicotine	No/Yes		
Caffeine	No/Yes		
Alcohol	No/Yes		
Other Drugs	No/Yes		

Please describe any medical conditions for which you are being treated.

Signature: _____ Date: _____

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HIPPA, OFFICE SERVICES AND POLICIES AGREEMENT (Revised 1-1-2019)

This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA). The law requires that I obtain your signature acknowledging that I have provided you with this information. Please read it carefully before signing. You may revoke this right in writing at any time.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- Consultation with a referring health or mental health professionals about a case.
- Disclosures required by health insurers or to collect overdue fees
- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law.
- If a government agency is requesting the information for health oversight.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim, I must, upon appropriate request, provide records relating to treatment or hospitalization for which compensation is being sought.
- If I have cause to believe that a child under 18 has been or may be abused or neglected (including physical injury, substantial threat of harm, mental or emotional injury, or any kind of sexual contact or conduct), or that a child is a victim of a sexual offense, or that an elderly or disabled person is in a state of abuse, neglect or exploitation.
- If I determine that there is a probability that the patient will inflict imminent physical injury on another, or that the patient will inflict imminent physical, mental or emotional harm upon him/herself, or others.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in a professional record. We have transitioned to electronically stored records and administration processes using the professional tool, www.Therapyappointment.com.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. However, if the treatment is for suicide prevention, chemical addiction or dependency, or sexual, physical or emotional abuse, the law provides that parents may not access their child's records. For children between 16 and 18, because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, I may request an agreement from the patient and his/her parents that the parents' consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

PSYCHOLOGICAL SERVICES

Services include psychological evaluations and/or cognitive-behavioral therapy for children, adolescents and adults. Therapy is a joint effort between the therapist and patient. Progress depends on many factors including motivation, effort, and other life circumstances such as interactions with family, friends, and other associates. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. On the other hand, there are potential negative effects, which include, but are not limited to, increased stress in relationships and increased emotional distress. Implications or potential negative effects of a particular therapeutic technique may be discussed at any time with your therapist.

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APPOINTMENTS

If there is need to cancel or reschedule this appointment, I respectfully request **24 hours advanced notification** to reallocate my time as deemed necessary. An infraction of this policy will result in a fee payable by the client prior to any future scheduled appointments. Failure to comply with the office policy can result in cancellation of pre-scheduled appointments.

FEE SCHEDULE

$135/unit	Therapy and assessment are based on a 45 or 60 minute session, depending on the insurance plan. For in-network, we bill the insurance company. Phone consultations are not covered by insurance. If requested, time is scheduled as an appointment and regular fee is charged.
$135/unit	Scheduled Psychological testing, scoring time, interpretation of tests and summary report preparation. (Varies: 5-10 units) For each hour of scheduled face-to-face time, one hour is billed for scoring and interpretation plus one hour for summary report preparation. Exceptions may occur based on the complexity of the evaluation.
$50-75	Fee for non-covered materials and testing protocols deemed necessary to the diagnostic evaluation process
$50	Fee for letters, form preparations, patient record copies, and full reports prepared outside of scheduled appointments. This time allocation is not reimbursable by insurance plans.
$30	Returned checks are subject to a $30 charge.
$100	**Fail to Show Fee** payable by the client. Each scheduled appointment time is appropriated to only one client; therefore, courtesy for my professional time and other clients is expected and appreciated. Fee will be automatically applied to the patient's account and no future appointments will be permitted until account has been satisfied.
$75	**Late Cancellation Fee** within 24 hours of appointment, payable by the client. This fee is automatically applied to the client's account at the time of the missed appointment.

Assignment of insurance benefits accepted from: Blue Cross/Blue Shield PPO, Traditional Medicaid and Medicare.

BILLING, PAYMENTS, AND INSURANCE REIMBURSEMENT

Payments for each session are paid at the time of visit. If I am an in-network provider, I will file insurance claims electronically via www.OfficeAlly.com with your insurance carrier. If considered an out-of-network provider, I will give you the necessary information to submit for any out-of-network benefits. We use Cayan merchant services to process payments made by credit/debit card, and for your convenience, we offer to keep the card number on record if you allow.

Collection policy: If your account has not been paid for more than 60 days, we will debit the card on file to resolve the outstanding balance on your account. As a last resort, we may need to involve a collection agency, which may require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ, UNDERSTAND AND AGREE TO THE OFFICE POLICIES, ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE. ***Please print an additional copy for your records.***

Date: _____ Signature: _____