PATIENT INFORMATION

Last Name: ________________________________ First Name: _____________________________ M.I.: ____________

Social Security #: ___________________________ Date of Birth: ___________________________ Sex: _____________

Marital Status: _____________________________ Email Address: ____

Home Phone: _______________________ Cell Phone: ________________________ Work Phone: ______________________

Messages may be left at (circle to authorize): Home / Cell / Work / Email

Street Address: ______________________________ City: _________________________ State: _______ Zip: __________

Primary Care Physician: ____ Office Phone: ________________

Emergency Contact: __________________________ Relationship: ___________________ Phone: _____________________

EMPLOYER INFORMATION

Employer Name: ____

Street Address: ______________________________ City: __________________________ State: _______ Zip: __________

PRIMARY INSURANCE INFORMATION

Name of Insured: ____ Relationship to Patient: __________________

Social Security #: ____ Date of Birth: _______________

Street Address: _______________________________ City: _________________________ State: _______ Zip: __________

Insured's Employer: ____ Phone: ______________________

PATIENT AUTHORIZATION (Please initial each statement indicating your understanding)

_______ I acknowledge receipt of the **Notice of Policies and Practices to Protect the Privacy of Your Health Information**

_______ I assume financial responsibility for the services provided.

_______ I request payment to be made directly to the provider.

_______ I am responsible for payment of all appointments cancelled without a minimum of 24 hours notice. My credit card will be charged for these missed appointments (Not applicable for patients with Medicaid). Your card information will be kept confidential and will only be used for this purpose unless authorized for other specified purposes.
____ Expiration Date: ___________ CVV #: ____________

_______ I will be charged $25 for any returned checks due to insufficient funds.

_______ Should the account be sent to collections, I am responsible for any associated fees, including legal.

I have read and understand all of the above:

Name of Patient or Legal Guardian: ____ Date: __________________________

Signature of Patient or Legal Guardian: _______________________________________

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 IT CAREFULLY.

THIS NOTICE DESCRIBES YOUR RIGHTS TO PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA.)

If you have any questions about this notice, please contact Tony Jennings at (317) 762-8084

I. OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information under Federal or Indiana law.
- We must follow the duties and privacy practices described in this notice and give you a copy of this notice.
- We will not use or share your information other than as described here unless you tell us in writing we can. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

II. YOUR RIGHTS:

You may receive a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

You may request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

You may ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

You may choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will take reasonable steps to insure the person has this authority.

You may obtain an electronic or paper copy of your medical record

- You can ask to see or obtain an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

You may request a correction of your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we will tell you why in writing within 60 days.

You may obtain a list of those with whom we shared information

- You can ask for a list (accounting) of the times we have shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

You may file a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

III. CHOICES YOU MAY MAKE ABOUT SHARING CERTAIN HEALTH INFORMATION

For certain health information, you can tell us your choices about what we share. For the situations below, please tell us what you want us to do, and we will follow your instructions.

Situations when you have both the right and choice to tell us your choice about what we share:

- Sharing information with your family, close friends, or others involved in your care
- Sharing information in a disaster relief situation
- Including your information in a hospital directory

(If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.)

Situations when we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

III. HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you. (*Example: A doctor treating you for an injury asks another doctor about your overall health condition.)*

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary. (*Example: We use health information about you to manage your treatment and services.)*

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

(Example: We give information about you to your health insurance plan so it will pay for your services.)

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research.

- We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

We can share health information about you for certain situations that help with public health and safety issues such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you only as required by state or federal laws, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

We can use or share health information to address workers' compensation, law enforcement, and other government requests about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

IV. MISCELLANEOUS

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

This notice is effective as of February 27, 2017

Tony Jennings is the privacy official for any inquiries regarding the information in this Notice. His email address is tjennings@continuummhw.com and his phone number is (317) 762-8084.

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INFORMED CONSENT FOR MENTAL HEALTH AND WELLNESS TREATMENT

This document contains important information about our professional services and business policies. Please read it carefully and list any questions you might have so that we can discuss them at our next appointment. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL AND PSYCHIATRIC SERVICES
Mental health treatment varies depending on the personalities of the provider and patient, and the particular problems you bring forward. There are many different methods that may be used to deal with the problems that you hope to address. Psychotherapy, psychiatric consultation and medication management, and psychological testing can have benefits and risks. Since treatment often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to benefit people who do the work, including improved relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, your provider will be able to offer you some first impressions of what the work will include and a treatment plan to follow, if you decide to continue with treatment. You should evaluate this information along with your own opinions of whether you feel comfortable working with your provider. Treatment involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about any procedures, these should be discussed whenever they arise. If your doubts persist, a second opinion or referral can be made.

APPOINTMENTS
A psychotherapy visit typically lasts between 45 and 55 minutes on a weekly basis, although some sessions may be longer or more frequent. Follow-up psychiatry appointments may last 20 to 30 minutes and occur with less frequency, which will be discussed with your psychiatrist. Once an appointment is scheduled, you will be expected to pay your responsibility for that service. If you do not show for your appointment or you cancel your scheduled appointment with less than 24 hours notification, you will be charged a cancellation fee, which may vary per provider but is often $100. Exceptions can be made for illness and emergencies.

PROFESSIONAL FEES
Each provider has a fee schedule for each service provided. Not all providers at our practice accept insurance nor do all providers accept the same insurances. If you wish to use your insurance and your provider is in-network, a claim will be submitted to insurance and you will be responsible for your portion of the payment for services, if any, at the time of service. If your provider is out of network, the claim may be eligible to be submitted for out of network benefits, and you will still be responsible for your portion of the payment for services at the time of the service.

Other non-covered services include letter writing, preparation of records or treatment summaries, and performance of any other non-treatment service(s) you may request. These will be billed at your provider's hourly rate.

If you become involved in legal proceedings that require your provider's participation, you will be expected to pay for your provider's professional time at your provider's forensic rate. If your provider is called to testify at a deposition or a hearing, a refundable retainer set by the provider will be required to be paid before the provider's participation. You also agree not to subpoena or have your attorney subpoena your provider without first paying the retainer.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held in the manner noted above, unless your provider agrees otherwise or unless you have insurance coverage which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, your provider may be willing to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, your provider has the option of using legal means to secure the payment, which may involve hiring a collection agency or pursuing payment through court. If legal action is necessary, you will be responsible for all such costs, including reasonable attorney fees.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. Your provider will fill out forms and provide you with assistance to help you receive the benefits to which you are entitled. However, you are ultimately responsible for full payment of the fees. It is very important that you find out exactly what mental health services your insurance policy covers. If insurance has not made payment within 45 days of your service, then you will be responsible for the full payment of such services. If the practice thereafter receives payment from any insurance for such services, such money will be paid to you within 30 days without interest.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Your provider will also try to help you understand the information you receive from your insurance company.

You should also be aware that most insurance companies require you to allow your provider to submit a clinical diagnosis to them. Sometimes, additional clinical information such as treatment plans or summaries, or in rare cases, copies of the entire record will be requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, your provider has no control over what they do with it once it is in their hands.

CONTACTING YOUR PROVIDER

Your provider is often not immediately available by telephone. When your provider is unavailable, a message will be taken either by the front office staff or by our voicemail service. Your provider will make every effort to return your call promptly, with the exception of weekends and holidays. If it is an emergency, please call 911, go to the nearest emergency room, or call the local Crisis and Suicide Hotline at 317-251-7575.

PROFESSIONAL RECORDS

The laws and standards of our professions require that we keep treatment records. By signing a release of information, however, your records can be shared with another mental health professional of your choice. Because these are professional records, they can be misinterpreted or misunderstood, and therefore it is recommended that you review them with your provider so the contents can be discussed. Patients will be charged an appropriate fee for any time spent in preparing information requests.

ELECTRONIC COMMUNICATION

The following is intended to address our use of electronic modes of communication during your treatment. Many of these modes of communication, while now very common, put your privacy at risk and can be inconsistent with the law and with the standards of our profession.

Email Communications

Email communication messaging will only be used with your permission and only for administrative purposes. This means that email exchanges with the office should be limited to administrative tasks like setting and changing appointments, billing matters, and other related issues. Please do not email about clinical matters as this is a less secure way to share information. If you need to discuss a clinical matter, please call your provider or wait until your next appointment.

Text Messaging
Because text messaging is a very unsecure and impersonal mode of communication, this mode will not be used unless you have made other arrangements with your provider.

Social Media
Our providers do not communicate with patients via social media platforms such as Twitter and Facebook.

Websites
Our practice does maintain the websites: www.continuummentalhealthandwellness.com and www.continuummhw.com. Both domain names take you to the same site which is designed for you to learn about our practice, providers, services, and contact information. Registration forms are also available for you to download. The site is not used for direct communication between patients and providers.

Web Searches
Your provider will not use web searches to gather information about you without your permission. We believe that this violates your privacy rights. However, we understand that you might choose to gather information about us in this way. Should you have any concerns or questions based on your search, please discuss this with your provider so that it can be addressed properly in treatment.

MINORS
If you are under eighteen years of age, please be aware that the law may provide your parent(s) or guardian(s) the right to examine your treatment records. It is our policy to discuss privacy with your parents or guardians and that they agree to give up access to your records because of the importance of confidentiality. As discussed with and understood by your parent or guardian, your provider will share with them only general information about the work, unless your provider feels there is a high risk that you will seriously harm yourself or someone else. In this case, your provider will notify them of such concerns. If appropriate in the provider's opinion, before giving them any information, your provider will discuss the matter with you and address any objections you may have regarding the material that is to be discussed. All of this is subject to the rights of parents and guardians to have access to your records under Indiana law.

CONFIDENTIALITY
In general, the privacy of communications between a patient and mental health provider is protected by law and your protected health information can only be released with your written permission, as noted in the **Notice of Policies and Practices to Protect the Privacy of Your Health Information** which you have been provided.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during your professional relationship with your provider.

___________________________________ ___________________________________

Signature of Patient or Legal Representative Date

____

Printed Name

HIPAA AUTHORIZATION FORM TO RELEASE MEDICAL INFORMATION

I, the undersigned, hereby authorize the release of information from my medical records concerning my hospitalizations or treatments, including, but not limited to, information regarding treatment of drug or alcohol abuse, psychological conditions, communicable diseases, HIV testing or an AIDS related condition.

Patient Name: ______________________________________ **Date of Birth:** ____________________________

Continuum: Mental Health and Wellness is to: [ ] Send records to the following: [ ] Request records from the following:
Name of Individual/Group: ____
Address: ____
Phone: ____________________________ Fax: ____________________________

Release records for the following dates of service: [ ] All [ ] Only for dates ____________ to ____________

The Following Information May Be Released (please check all that apply):
[ ] Discharge Summary [ ] Nursing Notes [ ] Doctor's Orders/Progress Notes
[ ] History & Physical [ ] Tests & X-rays [ ] Psychological Records [ ] Intake Notes
[ ] All records written & typed [ ] Medication Records [ ] Psychotherapy Notes [ ] Other: ____________________

Purpose of the Release:
[ ] Coordination of care with another provider [ ] Claims Administration/Payment [ ] Employer Mandated Treatment
[ ] Subpoena or other legal process [ ] Other: ________________________
[ ] At Patient's Request (*check here if you do not wish to specify a reason for the release*)

I understand I have the right to revoke this authorization, in writing, at any time by sending such written notification to Continuum: Mental Health and Wellness at 2620 Kessler Blvd. East Dr., Ste. 235 Indianapolis, IN 46220. I understand the revocation will not apply to information that has already been released in response to this authorization or to information released in reliance upon this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that my provider generally may not condition treatment services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party. I further understand that I may file a complaint against my provider for violations of the Health Insurance Portability and Accountability Act (HIPAA, **45 CFR 164**) without fear of retaliation.

I understand that I (or my legal representative) am entitled to a copy of this authorization, and that I may inspect or copy the information to be used or disclosed, as provided in **45 CFR 164.524**. I understand any disclosure of information carries with it the potential for an unauthorized redisclosure to individuals not subject to the requirements of HIPAA, and that the information may no longer be protected by HIPAA or other state or federal privacy laws.

This consent will expire (*please check one*):
[ ] One year after the signature date (**/ / 20**___)
[ ] By my written revocation only
[ ] On the following date: ______________________

I hereby state that I have read and fully understand the above statements as they apply to me.

____ ____
Signature of Patient or Legal Representative Date

____
Printed Name