Inland Psychological Professional Corporation

CONFIDENTIAL PATIENT INFORMATION

Patient Name: **Date of Birth:** **Soc. Security No.:**

Address:

Home Phone: **Work Phone:** **Cell Phone:**

Employer/ School: **Occupation/ Grade:**

If child patient: Mother's Name: **Father's Name:**

Contact phone no: **Contact Phone no:**

Patient (or Parents) Marital Status: __ Single __ Engaged __ Married (First? Yes No) (How long?)

__ Separated OR __ Divorced (First? Yes No) (How long?)

Patient Lives with:

INSURANCE INFORMATION

Insured Name: __ same as patient

OR ______________________________ Relationship to Patient:

Insured Date of Birth: **Insured Soc. Security No:**

Insured Address: __ same as patient OR ____

Insured Phone No.: **Work phone:**

Insured Employer:

Insurance Company: **Insur ID Number:**

Plan Name: **Group Number:**

Address:

Member Services Phone: **Provider Phone:**

Did you call someone for authorization or for the referral? ___ YES ___ NO Who?

Name of Managed Care Company: **PhoneNo:**

Authorization Number: **No. visits authorized:** **Copayment:$**

EMERGENCY CONTACTS

Personal contact: Name: **Phone:** **Relationship:**

Medical Doctor: Name: **Phone:**

Psychiatrist: Name: **Phone:**

INLAND PSYCHOLOGICAL PROFESSIONAL CORP.

CONSENT TO TREATMENT
and NOTICE OF PRIVACE PRACTICES

PLEASE READ CAREFULLY
and DISCUSS ANY QUESTIONS WITH YOUR CLINICIAN

I understand that all psychological services have both risks and benefits, and that there may be limitations to the treatment available if I wish to use my managed care health benefits.

I understand that all communications between patient and clinician and records of such communication, (called "Protected Health Information" or PHI) are absolutely confidential, unless I give my written permission, except for the following conditions as required by law: the patient is in danger of harming themselves or others, the clinician suspects that child abuse, child neglect, domestic violence or elder abuse has occurred, the patient has been referred by an employer to evaluation or treatment related to job performance or worker's compensation, the records are legally subpoenaed by a court, the patient has been ordered by the court to undergo psychiatric evaluation or treatment, the patient is in medical danger and needs emergency care, the clinician needs to consult with other mental health professionals to ensure the quality of my care (my identity will not be revealed in this latter case).

I understand that if the patient is a minor, the following conditions on confidentiality will apply: the legal guardian(s) must provide consent for treatment and may examine a minor's treatment record, except if the minor is seeking treatment for child abuse, drug abuse, unwanted pregnancy, or sexually transmitted diseases, or if access to the record would be deemed by the clinician to be harmful to the minor.

I understand that my PHI may be disclosed without my consent in order to perform routine healthcare and office operations, including the following: billing, accounting, benefit verification, claim submission, communication with my insurer to obtain payment or to obtain authorization for treatment, making or changing appointments, and other office procedures, such as being called by name in the waiting room. When required, such PHI will be submitted to my insurance or managed care company by phone, facsimile, mail, e-mail, or through a password-protected Internet provider web site using secure channels.

I understand that the Health Information Portability and Access Act (HIPAA) provides me with many rights with regard to my clinical Records and disclosures of PHI, including the right to have an accounting of disclosures of my PHI and the right to file a grievance, and the right to restrict how my PHI will be disclosed. I understand that all details of HIPAA and how it relates to my treatment can be provided to me at my explicit request, including the procedures for filing a grievance, and that this information can also be found on the Internet.

When anyone from IPPC attempts to contact me, I request the following restrictions in communicating my PHI:

__No restrictions __ Only call cell __ Only call home __ Only call work

__ I give permission to contact me at the following e-mail address: _________________

Other:

I understand that although as a courtesy my insurance will be billed directly, that I am responsible for the total cost of services rendered to me, including all applicable copayments, deductibles, and fees for services not covered by my insurance plan.

I understand that if I do not cancel my appointment by 9am on the previous business day, I will have to pay a cancellation fee up to or equal to the full charge for the appointment, and that my insurance will not be billed for such cancellations.

Terms of Consent and Agreement:
I understand that this consent is valid from the date of signature until treatment is completed and all payments for services rendered are received. I may revoke this Consent and Agreement at any time, which will be binding unless my clinician has already taken action in reliance upon it, and/or there are obligations imposed by my health insurer in order to process or substantiate claims made under my policy. If I revoke this agreement, however, my clinician may no longer provide services to me. My clinician has the right to change the terms of the Agreement, including privacy
policies and practices described in this Agreement, but must notify me of these changes by posting the information in the waiting room and/or giving me a copy of it.

I CONSENT TO RECEIVE TREATMENT FROM INLAND PSYCHOLOGICAL PROF. CORP. AND I AUTHORIZE DISCLOSURE OF MY PHI AS NECESSARY TO AUTHORIZE AND OBTAIN PAYMENT FOR THIS TREATMENT.

__Yes __ No I have questions regarding confidentiality and the disclosure of my PHI:

__Yes __ No I have questions regarding financial policies and procedures:

__ Yes __ No I have other questions: ____________________________________

________________________________ ___________
Patient Name Date

________________________________ ________________________________
Signature of Patient or Guardian Relationship

Patient Name: ___________________________

IPPC: PERSONAL HISTORY CHECKLIST

Please check all items that have ever applied to the patient and/or their family as indicated:

Patient as Child OR Child Patient	Patient as Adult OR Child's Parents	
O	O	Abnormal pregnancy or delivery
O	O	Abnormal milestones/ Developmental Delay
O	O	Difficulties eating
O	O	Difficulties sleeping
O	O	Difficulties with elimination/bowel control
		School Difficulties:
O	O	Poor grades
O	O	Learning Disabilities
O	O	ADD/ADHD
O	O	Behavioral problems
O	O	Difficulty making/keeping friends
O	O	Difficulty with anger or aggression
O	O	Difficulty with anxiety
O	O	Suicidal thoughts, feelings or attempts
O	O	Self-injurious behavior
O	O	Got in trouble with the law
O	O	Difficulty with work
		Experienced Abuse:
O	O	Sexual
O	O	Physical
O	O	Neglect/Abandonment
O	O	Emotional
O	O	Parents separated or divorced
O	O	Parent(s) deceased
O	O	Lived in Foster care
O	O	Adopted
O	O	Experienced other trauma: _______________________________
O	O	Military experience
		Substance Abuse:
O	O	Drug use
O	O	Alcohol use
O	O	By other Family Member
O	O	Previous Psychotherapy
O	O	Previous Psychiatric medications
O	O	Previous Psychiatric Hospitalizations
O	O	Medical condition/Serious illness/Medical Hospitalization
O	O	Allergies: _______________________
O	O	Mental illness in other family member: _______________
		Relationship: ______________________
O	O	Serious medical illness for other family member

Patient Name: ___________________________

Other Medical Information

O Current Medications (Name, dosage, purpose): ____

____

____

O Past Psychiatric Medications Tried: ____

____

O Other Medical Conditions (including Allergies) or significant medical history: __________________

____

____

Presenting Problem

Why are you seeking help at this time?

Date/month the problems started:

Describe any event(s) that made the problem(s) surface, or any recent changes/traumas in the family:

What have you tried to do about this problem up to now?

What help would you like to receive from us? What would you like to accomplish in your treatment?