



Dear New Patient,

Thank you for choosing Kent Psychological Associates LLC as your mental health care provider.

If for any reason you are unable to keep your appointment, kindly call 24 hours in advance.

We ask that you please complete the following:

- **Arrive 20 minutes early** for your appointment. There will be additional paperwork to do here.
- Complete the enclosed paperwork prior to your arrival. Please visit our website www.kentpsychological.com to print paperwork if no paperwork accompanies this letter.
- Please be prepared to pay your **co-pay** at the time of each visit.
- Patients with high deductible insurance plans are expected to pay at the time of service.
- Bring a complete list of medications, including dosages.
- Call your insurance, to verify your out-patient mental health coverage including:
 - What is your **annual deductible** (amount that you are required to pay before your benefits start each year)? Deductible amounts almost always start over on Jan. 1 of each new year.
 - What is your **office co-pay** (amount you are required to pay at each office visit)?
 - The **number of visits** allowed per year (out-patient mental health code 90834)
 - If your visits will be covered by an Employee Assistance Program, please contact your Human Resources Dept. for your referral/authorization.
 - Is a referral required from your primary care physician before your first visit?

If you have concerns or questions you can reach our business office Monday through Friday between the hours of 9 a.m. and 4:30 p.m. We look forward to meeting you.

Kent Psychological Associates, LLC

DATE _____

ADULT BACKGROUND INFORMATION

NAME _____ DOB _____ AGE _____ SSN _____
GENDER _____ PRONOUNS: he/him/his she/her/hers they/them/theirs ze/hir/hirs
ADDRESS _____ CITY _____ ZIP _____
PHONE (H) _____ (W) _____
EMERGENCY CONTACT: _____ PHONE _____ RELATION _____
FAMILY PHYSICIAN: _____ PHONE _____
REFERRED BY: _____

HOUSEHOLD INFORMATION: *Who do you live with?*

<u>NAME</u>	<u>RELATIONSHIP</u>	<u>AGE</u>	<u>GENDER</u>	<u>OCCUPATION</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Other important people in your life _____

DEVELOPMENTAL HISTORY:

Please check the following which were problems in the family of origin:

- Frequent moves Alcohol/Drugs Death of family member
- Parents divorce Legal problems Physical abuse/Neglect
- Parents remarriage Parent conflict Sexual abuse
- Parents separated Parent job loss Domestic violence
- Family illness Financial stress Emotional problems
- Other _____
- Other issue (You wish to discuss with counselor in person)

Clarify information about your development up to age 18. *Check those that apply.*

- Premature birth Avoiding others Bedwetting Birth Defect
- Nervous Fidgety/restless Head injury Abuse/neglect
- Eating problems Talking/refusing Picked on Bad dreams
- Learning problems Speech problems Sleepwalking School behavior
- Poor coordination Trouble w/ police Feeling rejected Strong willed
- Visual difficulties Fear leaving home Repeated grade Few friends
- Leaving loved one Behavioral prob. "Worry wart" Overweight
- Small for age Ran away Fighting Shy

How would you rate your present relationship with the following? *If it does not apply put N/A.*

- Spouse/Significant Other/Partner Good Fair Poor Problem for you N/A
- Father Good Fair Poor Problem for you N/A
- Mother Good Fair Poor Problem for you N/A
- Brother Good Fair Poor Problem for you N/A
- Sister Good Fair Poor Problem for you N/A
- Son Good Fair Poor Problem for you N/A
- Daughter Good Fair Poor Problem for you N/A
- In-Laws Good Fair Poor Problem for you N/A
- Employer Good Fair Poor Problem for you N/A

EDUCATIONAL HISTORY

High school attended _____ Highest grade completed _____
College/vocational/technical training yes ___ no ___ #year's ___ Degree ___

OCCUPATIONAL HISTORY

Are you presently employed? ___ yes ___ no Type of work _____ How long? _____
Have you had problems gaining employment? ___ yes ___ no
How many jobs have you held in the last 5 years? _____
Are you a veteran? ___ yes ___ no If yes, what branch of service? _____
Date entered _____ Date discharged _____ Type of discharge _____

RELATIONSHIP HISTORY

Sexual Orientation _____

A) In a relationship *If not in a relationship please see section B*

___ Married ___ Significant Other ___ Remarried ___ Other _____

Are you considering separation or divorce? ___ yes ___ no
Are you a divorced custodial parent? ___ yes ___ no
Are you married raising minor children? ___ yes ___ no

Do you and your spouse/significant other/partner:
Agree on the methods of discipline of the children ___ yes ___ no
Share common values in the rearing o the children ___ yes ___ no
Feel the parent/child interaction is positive ___ yes ___ no
Spend quality time as a family ___ yes ___ no

In your present relationship do you:
Enjoy good communication with each other ___ yes ___ no
Feel satisfied with your sexual relations ___ yes ___ no
Spend private couple time with each other ___ yes ___ no
Share similar interests and values ___ yes ___ no

B) Not in a relationship

___ Single ___ Separated ___ Divorced ___ Widowed ___ Other _____

PRIOR MENTAL HEALTH HISTORY

Have you ever had prior mental health treatment? ___ yes ___ no (If no, skip)
Date _____
Was this person a: ___ Psychiatrist ___ Psychologist ___ Clinical social worker ___ Clinical Counselor
___ Minister ___ Other
Have you ever been hospitalized for emotional problems? ___ yes ___ no (If no, skip)
Name of hospital _____ Location _____ Date _____ How long _____
Doctor who treated you _____ Medications given _____
Do you still take any psychotropic medications? ___ yes ___ no Which ones? _____

ALCOHOL/DRUG HISTORY

Do you have a history of alcohol/drug abuse? ___ yes ___ no (If no, skip)
If you are using alcohol or drugs has this resulted in:
___ Marital problems ___ Memory Blackouts ___ Legal problems
___ Problems w/family, friend's ___ Periods of abstinence ___ Physical problems
___ Preoccupation w/alcohol, drugs ___ Financial problems ___ Loss of control
___ DUI or DWI charges ___ Withdrawal symptoms

LEGAL HISTORY ___yes ___no

Check those that apply to you:

___Trouble with law as a juvenile
___Trouble with the law as an adult

___Have legal matter pending
___Have you ever been in jail?

MEDICAL HISTORY

Date of last physical exam _____ Family physician _____

Describe your chief medical/physical complaint(s):

Do you have any special problems with hearing, speech, vision? ___yes ___no
If yes, please explain:

Are you on any medications? ___yes ___no
If so, please list:

Describe any side effects:

Do you have any allergies? ___yes ___no
If yes, please describe:

List any serious illnesses, injuries, or surgeries:

Place an X in the left column if this condition exists. In the right column write self, father, mother, brother, sister, aunt, uncle, etc.

___Alcoholism	_____	___Cancer	_____
___Allergies	_____	___Diabetes	_____
___Developmental	_____	___Epilepsy	_____
Disabilities			
___Obesity	_____	___High blood press.	_____
___Degenerative dis.	_____	___Heart trouble	_____
___Mental health probs.	_____	___Other	_____
___Suicide	_____		

MEDICAL CONDITIONS AND SYMPTOMS

Past/Now

- Arthritis
- Anxiety
- Anger Outbursts
- Asthma
- Backaches
- Binging
- Barbiturates
- Epilepsy
- Cancer
- Chronic Pain
- Chest Pain
- Constipation
- Depression
- Diabetes
- Diarrhea
- Depersonalization
- "Going Crazy" sensations
- Difficulty going to sleep
- Difficulty staying asleep
- Dizziness
- Drug reactions
- Early morning wakening
- Emotional upsets

Past/Now

- Can't work under pressure
- Color Blind
- Exhaustion
- Fainting spells
- Fast pulse
- Heart medicine
- Hormones
- Poor digestion
- Poor appetite
- Treated for a mental cond.
- Other drugs, alcohol
- Shaking
- Smoking packs/day ____
- Craving for sweets
- Fatigue
- Headaches
- Heart trouble
- Hallucinations
- Hearing voices
- Hypertension
- Hand tremors
- Hay fever
- Insulin medication

Past/Now

- Distractibility
- Laxatives used
- Leg Cramps
- Loose bowel/gas often
- Loses temper easily
- Moody often
- Memory problems
- Muscle twitching
- Much sweating
- Moist palms
- Nervous breakdown
- Nervousness
- Nerve Medication
- Overeating
- Overworked
- Pain medication
- Palpitation
- Perfectionist
- Stomach medicine
- Worries, feels insecure
- Reduced sex drive/lack of
- Upset stomach
- Itchy skin

CURRENT SOURCES OF STRESS

Please list your most significant sources of stress or worry:

What is the main goal you wish to attain in seeking services?

How would your life be better if you could manage some of these problems better?

ADDITIONAL INFORMATION: Please add any special information you feel which might be helpful in assisting in your treatment.

Your signature below indicates that you understand the questions and could ask for assistance if needed.

Client signature

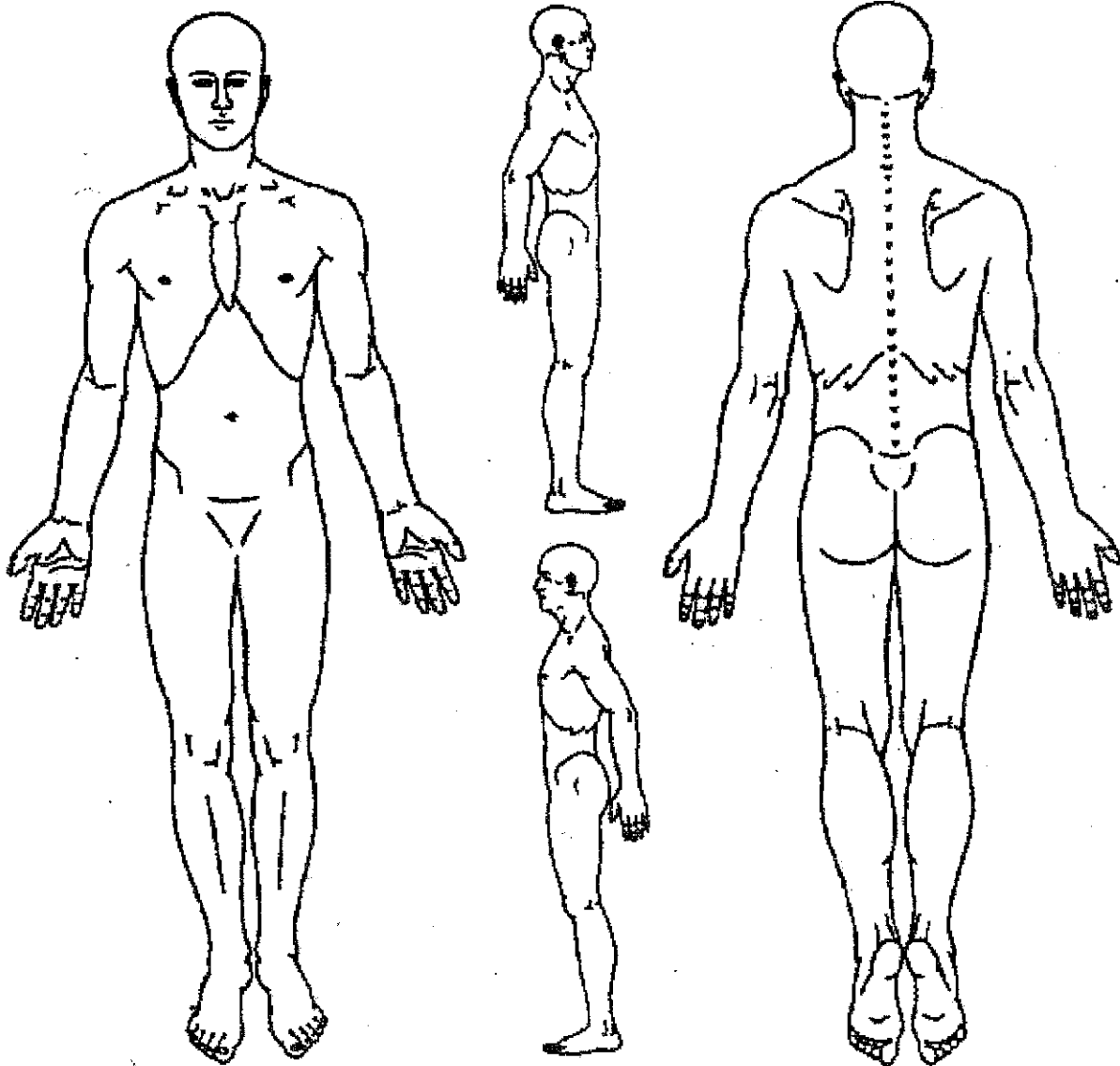
Date

Name: _____ Date: _____

PAIN DIAGRAM

On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

Key: A – ACHE B – BURNING N – NUMBNESS
P – PINS & NEEDLES S – STABBING O – OTHER



PAIN SCALE

Rate the severity of your pain by checking one box on the following scale.

No Pain										Worst Possible Pain
0	1	2	3	4	5	6	7	8	9	10

Name _____

Date _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____
=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all D	Somewhat difficult D	Very difficult D	Extremely difficult D

Name _____

Date _____

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?

(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____=____ + ____ + ____)



Name: _____

DOB: _____

- I give my permission for Kent Psychological Associates to call or if necessary leave a reminder message for an upcoming appointment.

The best number to reach me at is: _____

- I do not want reminder calls.

Reminder calls are a courtesy only. Any missed appointments remain the client's responsibility.

Signature

Date

- Please check if you wish to sign up for reminders by text.

IMPORTANT:

To activate reminders by text you must text: "KPA" to 622622 from the phone where you would like to receive the text reminders.

**Authorization for Release of Health Information Pursuant to HIPAA
Kent Psychological Associates, LLC**

Dear Client: Your health insurance requires us to request consent to coordinate care with your primary care provider. We consider coordination of care an important part of providing high quality care. Please complete the following authorization that allows us to exchange information with your primary care provider. If you are uncomfortable with such exchange of information, please check the box below indicating your refusal to allow us to exchange information with your primary care provider.

- I prefer NOT to allow exchange of information between Kent Psychological Assoc. and my primary care provider.
 I do not have a primary care provider.

CLIENT _____ DOB _____ Last four SSN # _____

I THE UNDERSIGNED AUTHORIZE THE EXCHANGE OF INFORMATION BETWEEN:

My Behavioral Health Provider:
Kent Psychological Assoc. LLC
190 Currie Hall Parkway, Suite A
Kent, Ohio 44240
Phone: 330-673-5812 Fax: 330-673-7162



My Primary Care Provider:
Name: _____
Street: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

INFORMATION TO BE RELEASED BY KENT PSYCHOLOGICAL ASSOCIATES INCLUDES THE FOLLOWING:

Diagnostic Assessment	Service/Treatment Plan
Recommendations	Summary of Treatment
Discharge Summary	Progress Notes

REQUESTED INFORMATION FROM PRIMARY CARE PROVIDER INCLUDES THE FOLLOWING:

History and Physical	Medical Evaluation
Service/Treatment Plan	Current Medications/Medication History
Treatment/Office Visit Notes	

THE EXCHANGE OF INFORMATION IS FOR THE SPECIFIC PURPOSE OF:

Ensuring proper coordination of care with your primary care provider.

I UNDERSTAND:

1. This authorization will expire on _____ (date, event, or condition not to exceed 1 year). If not dated, then this authorization will automatically expire 1 year from the date of signing.
2. I may revoke this authorization at any time by signing the "Revocation of Authorization" portion of this form, below, and providing a copy to the releasing party or by providing any other form of written revocation to the releasing party. I understand that I may revoke this authorization except to the extent that action has already been taken in reliance on this authorization.
3. Signing this authorization is voluntary. My treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon whether I sign this authorization.
4. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA upon its release to the recipient.

I expressly consent to the release of information designated above. I understand and acknowledge that this authorization extends to all or any part of records designation above, which may include treatment for mental illness (ORC5122.31), alcohol/drug abuse (42 CRF Part 2), and/or Human Immune Deficiency Virus (HIV) Acquired Immune Deficiency Syndrome (AIDS) test results or diagnoses (ORC3701.24.3).

Signature of Client/Parent/Guardian

Date

Relationship to Client

REVOCAION OF CONSENT:

I hereby withdraw my consent for any further release of information as of the date indicated below:

Signature of Client/Parent/Guardian

Date

Relationship to Client

TO THE RECIPIENT: This information has been disclosed to you from confidential records protected by Federal Law. You are prohibited from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. If you have received this information in error please notify Kent Psychological Associates, LLC immediately.



CRISIS RESOURCES

24 HOUR CRISIS HOTLINES

- Crisis Intervention Services – Coleman Behavioral Health - (330) 296-3555
- Town Hall II- (330) 678-HELP
- Akron Children’s Hospital Psychiatric Intake Response Center (PIRC) (330) 543-7472
- Crisis Text Line: Text “4HOPE” to 741741 within Ohio. Free and confidential.
- National Suicide Prevention Hotline 1-800-273-TALK (8255)

EMERGENCY:

- 911

PSYCHIATRIC EMERGENCY SERVICES (WALK-IN):

Portage County:

- Crisis Intervention Services – Coleman Behavioral Health - (330) 296-3555

Summit County:

- Summa Akron City Hospital Emergency Room- (330) 375-3361
- Akron General Medical Center Emergency Room- (330) 344-6611
- Akron Children’s Hospital Behavioral Health Emergency Service - (330) 543-7472

ANSWERING SERVICE:

- Kent Psychological Associates- (330) 376-6801

(Answering service will take your information for one of our clinicians to call you back.)



Permission to Treat and Acknowledgment of Policies
Kent Psychological Associates, LLC

Please initial next to the following provisions to certify that you have read, understand, and agree to each point. If the patient is a minor or has an appointed legal guardian, then the parent of the minor or the legal guardian, respectively, must initial:

_____ **Permission to Treat/Informed Consent:** I understand that my treating professional may use any and all customary procedures and treatments employed by psychological outpatient or clinic facilities. I understand that there are risks involved in all treatment modalities and that my therapist can offer **no guarantee regarding the outcome of the therapeutic measures** in a specific case. I understand that my therapist will be using techniques and procedures consistent with prevailing standards and that I will be informed and will be asked for specific written consent for any high risk or “hazardous practice” procedures. I understand that I have **the right to refuse any specific treatment** procedures, but that if I refuse treatment that is in accord with professional standards, my therapist has the right to terminate treatment upon reasonable notice. My treatment professional will answer any and all questions I may have about my treatment plan or services.

_____ **Notice of Patient Rights and Responsibilities:** I have received my copy of the Kent Psychological Associates, LLC’s Notice of Patient Rights and Responsibilities, and I agree to and understand its terms regarding my rights and responsibilities as a patient and the grievance procedure that I may utilize if I feel that my rights are being violated.

_____ **Notice of Privacy Practices Policy:** I have received a copy of the Notice of Privacy Practices followed by Kent Psychological Associates, LLC, and I agree to and understand its terms regarding how my personal health information may be used. I understand that I can ask any questions that I may have about these policies at any time.

_____ **Confidentiality:** I understand that my discussions in treatment will remain confidential as afforded by ethical practice and by Ohio and Federal law, and my consent is required to release my records. I understand that **there are legally mandated exceptions to confidentiality** such as mandatory reporting of suspected abuse or neglect of a child or older adult, reporting of specific threats to harm another or oneself. A licensed therapist must also obey a court order to produce or discuss records.

_____ **Authorization for Release of Information:** I understand that treatment information such as diagnosis will be requested by my insurance company for claims processing and that information such as presenting complaints, previous treatment history, special risk factors, and treatment goals may be requested by my managed care organization if I have managed care rather than traditional health insurance. I have the right to refuse my insurance company and/or managed care organization to access to my treatment information; however, if I exercise this right, I will be fully responsible for the cost of services I incur. Furthermore, I grant my permission for dates of service to be submitted electronically, if available, through my insurance carrier. From time to time my therapist may consult with colleagues at Kent Psychological Associates, LLC regarding clinical or

ethical issues of concern in my case in order to provide the highest quality care. I understand that my full identity will not be divulged in such a discussion, and that all professionals and staff at Kent Psychological Associates, LLC will respect my right to confidential communications.

I hereby authorize Kent Psychological Associates, LLC to release any information in connection to my treatment to the following insurance company(ies) for the purpose of processing the insurance claim:

Insurance company: _____

_____ ***Guarantee of Account:*** I understand I am financially responsible for charges not covered by my insurance company. **If any payment is due, it is expected at the time that services are rendered.**

_____ ***Assignment of Insurance Benefits:*** I hereby authorize payment of the benefits otherwise payable to me by the designated insurance company(ies) directly to Kent Psychological Associates, LLC, the amount not to exceed regular charges.

Your signature below indicates that you have read and understand this form and agree to its terms. Additionally, your signature indicates that you give your treating professional(s) permission to treat you and that you consent to such treatment.

Signature of Patient or Representative

Date

Printed Name of Patient or Representative

Representative's Relationship to Patient (If Applicable)



Payment Policy

Thank you for choosing us to be a partner in your mental health treatment. We are committed to providing you with the highest quality professional services. We have developed this payment policy to clarify some of the common questions we receive regarding client and insurance responsibility. Please read it, ask us any questions you have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans. If we do not participate with your insurance, payment in full is expected at each visit. If we do participate with your insurance, but you do not have your most current insurance card, payment in full is expected at each visit until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Preauthorization. If your insurance plan requires preauthorization before your first visit from you or your family doctor (PCP), this is your responsibility to secure as a member of your insurance plan. Such requirements will usually be stated on your health insurance identification card, with a special phone number listed to receive such authorization for mental health or substance abuse services.

3. Co-payments. **All co-payments must be paid at the time of service.** Unpaid copays must be paid in full prior to your next appointment or your appointment may be rescheduled. Your copay is part of your contract with your insurance company. Failure on our part to collect co-payments from clients can be considered insurance fraud. Please help us in upholding the law by paying your co-payment at each visit.

4. Co-Insurance. Your co-insurance balance will be billed to you once we receive the explanation of benefits (EOB) from your insurance company. This balance is due within eighteen (18) days of when we issue your statement. We are able to assist you with an estimate of the per visit co-insurance cost if needed.

5. Deductibles. If you have a high deductible plan we will contact your insurance company to confirm eligibility and obtain an estimate of your out-of-pocket cost for each visit. All insurance company contracts are different. If your insurance company allows for upfront collection of deductibles, **you will be required to pay in full for your estimated out-of-pocket cost at each visit.** Any remaining balance is due within eighteen (18) days of when we issue your statement. In the event that a credit balance is due to you, the amount will be refunded within thirty (30) days of our receipt of payment from your insurance company. If your insurance company prohibits upfront collection of deductibles we recommend you consider making at least a partial payment at each visit. This will help you avoid a large payment suddenly becoming due once your visits process through your insurance. This full balance will be due within eighteen (18) days of when we issue your statement.

6. Non-covered services. Please be aware that some – and perhaps all if your condition is not covered under your policy – of the services you receive may be noncovered or not considered medically necessary by your insurer. Payment is required for these services in full at the time of visit. Other fees that may not be covered by your insurance include letters, extended phone calls, completion of forms, etc. that are beyond standard coordination of care. Please ask your clinician if you have a question about non-covered services.

- Single page letter or form fee: \$20
- Multi page letter or form fee: \$40
- Phone calls: \$20 for each up-to-15-minute block (no charge first 15 minutes)
- Fees associated with testifying in court or participating in a deposition: billed for preparation, travel time, wait time, and testifying or deposition. \$175 per hour. Three-hour minimum. Minimum must be paid prior to court/deposition date.

7. Proof of insurance. All clients must provide photo identification and a current, valid insurance card before being seen by the clinician. If you fail to provide us with the correct insurance information at the time of your first visit, or at any point at which you obtain new insurance coverage, you may be responsible for the balance of your claim.

8. Claims submission. We will submit your claims and assist you in any way reasonably possible to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with your insurance company's request as well as to comply within the given time specified by your insurance company. Please be aware that the balance of your claim is your responsibility. If your insurance company has not responded within forty-five (45) days, we will require you to contact them and at that point your claim balance will become your responsibility.

9. Coverage changes. **If your insurance changes, please notify us before your next visit** so we can make the appropriate changes to help you receive your maximum benefits. We will need to verify your benefits and verify that your clinician is on panel with your new insurance.

10. Nonpayment. **If your account is over thirty (30) days past due we will be unable to schedule additional appointments except for a clinical emergency.** An exception may be made if you contact us and make a payment plan arrangement with terms agreed upon by our office. If your account lapses to ninety (90) days past due, you will receive a letter stating that you have twenty (20) days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this occurs, you will be notified by regular and certified mail that you have thirty (30) days to find alternative care. During that 30-day period, our clinician will assist you with a referral to another agency.

11. Missed appointments. **There is a \$75 fee for missed appointments and \$60 fee for appointments cancelled without sufficient prior notice.** This fee will be your responsibility and cannot be billed to your insurance company. This fee must be paid in full prior to your next scheduled appointment or your appointment may be rescheduled. Please help us to serve you better by keeping your regularly scheduled appointment. Clients who develop a pattern of frequent missed or cancelled appointments may be discharged from the practice.

12. Financial Hardship: If you experience temporary financial difficulties that affect timely payment of your account, please discuss this issue with your therapist or our billing staff at your earliest possible convenience, before any misunderstandings can develop. If your treatment has concluded and such questions or problems rise, contact your therapist or our billing department.

13. Uninsured Clients: We offer a reduced fee for uninsured clients who demonstrate financial hardship based on Federal Poverty Guidelines. If you feel you qualify, an application will be provided. You will be required to produce documentation of income. Eligibility for reduced fee must be updated every 6 months. For clients who do not qualify for reduced fee, a prompt pay discount is available.

14. Non-sufficient Funds: There is a \$25 fee for returned checks.

If you have difficulty understanding your account or billing statements please contact our office and ask to speak with a member of our billing staff.

Thank you for understanding. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party

Date



Appointment Cancellation Policy Agreement:

Kent Psychological Associates is committed to providing all of our clients with exceptional care. When a client cancels without giving enough notice, this prevents another client from being seen.

Please call our front desk at 330-673-5812 by 4:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call by 4:00 p.m. on Sunday and leave a message on our voicemail.

If you miss an appointment without giving any notification (no-show), you will be charged \$75 for the missed appointment. This fee must be paid prior to your next scheduled appointment.

If you cancel an appointment without giving prior day notification (late-cancel), you will be charged \$60 for the missed appointment.

We do waive these fees for cases of true emergency or sudden onset impairing/contagious illness. Please speak with your clinician in this circumstance and your clinician will forward your request to the Clinical Directory.

Please sign below to consent to these terms.

Client Signature (Client's Parent/Guardian if under 18)

Date



Notice of Patient Rights and Responsibilities for Kent Psychological Associates, LLC

Kent Psychological Associates, LLC recognizes that all patients have basic individual rights and responsibilities. To protect these rights, we have adopted specific guidelines to ensure the support and respect each patient's basic human dignity, as well as each patient's civil, constitutional, and statutory rights. We respect each patient's right to participate in decisions about his or her care, treatment, and services, and to give or withhold informed consent.

As a patient, you have the following rights and responsibilities. If you have any questions about these rights and responsibilities, please contact us at (330) 673-5812.

Patient Rights

As a patient, you have the right to:

- **Access to care.** You have the right to not be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, sexual orientation, gender identity, physical or mental handicap, or developmental disability. This includes the right to a current written, individualized service plan that addresses one's own mental and physical health, and that specifies the provision of appropriate and adequate services, as available, either directly or by referral.
- **Be treated with dignity and respect.** You have the right to be treated with respect for personal dignity, autonomy, and privacy. This includes:
 - the right to be fully informed of all rights;
 - the right to exercise any and all rights without reprisal, including continued uncompromised access to service;
 - the right to be free from all forms of harassment, neglect, exploitation, and verbal, mental, physical, and sexual abuse;
 - the right to service in a humane setting which is the least restrictive feasible, as defined by the treatment;
 - the right to freedom from unnecessary or excessive medication; and
 - the right to freedom from unnecessary restraint or seclusion.
- **Participate in decisions about your care.** You have the right to be reasonably informed about and to participate in decisions made involving your healthcare, including the right of competent adults to refuse treatment. This includes:
 - the right to be informed of your condition, of proposed or current services, or therapies, and of the alternatives;
 - the right to consent or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal;
 - the right to active, informed participation in the establishment, periodic review, and reassessment of the service plan;
 - the right to participate in any appropriate and available organizational service, regardless of refusal of one or more other services, treatment or therapies, or regardless of relapse from earlier treatment in that or another service, unless there is a valid and specific necessity which precludes and/or requires the client's participation in other services. This necessity shall be explained to the client's current service plan;
 - the right to be informed of and refuse any unusual or hazardous treatment procedure;
 - the right to be advised of and to refuse observation by methods such as one-way mirrors, tape recorders, televisions, movies, or photographs;
 - the right to consult with independent treatment specialists or legal counsel at one's own expense;
 - the right to be informed in advance of the reason(s) for discontinuation of service provision, and to be involved in planning for the consequences of that event;
 - the right to receive an explanation of the reason for denial of service; and
 - the right to know the cost of services.

- **Keep your medical records and identity private.** You can expect that any information, images, or recordings with information that could identify you will be kept private. This includes:
 - the right to confidentiality of communications and of all personal identifying information within the limitations and requirement for disclosure of various funding and/or certifying sources, state laws, or federal statutes, unless release of information is specifically authorized by the client or court appointed guardian of the person of an adult child; and
 - The right to have access to one's own psychiatric, medical, or other treatment records, unless access to particular identified items of information is specifically restricted to that individual client for clear treatment reasons in the client's treatment plan. "Clear treatment reasons" shall be understood to mean only severe emotional damage to the client, such that the danger of self-injurious behavior is an imminent risk. The person restricting the information shall explain to the client that factual information about the individual client that necessitates the restriction. The restriction must be renewed annually to retain validity. Any person authorized by the client has unrestricted access to all information. Clients shall be informed in writing agency policies and procedure to viewing or obtaining copies of personal records.
- **File a grievance.** You have the right to report concerns or complaints about your care and safety and receive help to resolve your concerns. This includes the right to have oral and written instructions for filing a grievance.

In order to protect each client's rights, we have adopted the following procedures:

- Each client shall receive this written Notice of Client Rights during the intake procedure;
- Clients will sign the Permission to Treat sheet indicating receipt of the Notice of Client Rights;
- Copies of the Notice of Client Rights are posted within the agency to ensure that the clients as well as staff are well aware of the basic rights.

If you feel that any of these rights have not been respected, then please follow our grievance procedure. We would like to help you get any complaint or concern resolved quickly and to your satisfaction. The grievance procedure will be posted in a highly visible place in each agency location.

Additionally, all Kent Psychological Associates clients and/or guardians shall have the option to register a complaint with any or all, but not exclusively, the following:

- Ohio Department of Mental Health
- Ohio Legal Rights Service
- United States Department of Health & Human Services
- Appropriate professional licensing, regulatory associates, and/or other State Departments. The names, addresses, and phone numbers of the aforementioned will be given to the griever. The relevant addresses and phone numbers about the grievance shall be included along with all relevant information about the grievance as requested.

Patient Responsibilities

As a patient you are expected to:

- respect the dignity and rights of others, clients and staff alike, and to exercise care for the physical surroundings (agency property);
- comply with all reasonable requests for information in the intake/admissions process;
- participate fully in the formulation of your treatment plan and to carry out the agreement to the fullest extent of your ability;
- respect the confidentiality of others, especially in the family, group, and educational sessions;
- give written permission for the release of necessary information to other institutions or professionals in the treatment program; and
- contribute, according to the fee structure, to the cost of services.

Effective: 01/01/2016

Notice of Privacy Practices
for Kent Psychological Associates, LLC

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

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- Get an electronic or paper copy of your medical record
 - You can ask to see or get 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.
- Ask us to correct 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.
- 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.
- 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.
- Get a list of those with whom we’ve 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, and 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.
- Get 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.
- 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 make sure the person has this authority and can act for you before we take any action.
- 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
 - 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 by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

- In these cases, you have both the right and choice to tell us to:
 - Share information with your family, close friends, or others involved in your care
 - Share information in a disaster relief situation
 - Include 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.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- In the case of fundraising:
 - We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your 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.*

How else can we use or share your health information? 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.

- Help with public health and safety issues
 - We can share health information about you for certain situations 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 if state or federal laws require it, 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.
- Address workers' compensation, law enforcement, and other government requests
 - We can use or share health information 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 action.
 - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

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

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.

We must follow the duties and privacy practices described in this notice and give you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing. 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.

Changes to the Terms of this Notice

This Notice describes how Kent Psychological Associates, LLC may use and disclose your protected health information. The terms of this Notice of Privacy Practices are effective January 1, 2016. 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 web site.

If you have any questions about this Notice, please contact the following Privacy Officer:

- **Leslie McClure, Psy.D.**
190 Currie Hall Parkway, Suite A Kent, OH 44240
(330) 673-5812





Telehealth Contact Form

Prior to telehealth services being rendered, this form must be completed. A copy will be provided to the client/family, as well as placed into the patient's medical record. Provided information must be accurate, may be verified by the provider or another appointed designee through the organization, and will be utilized to ensure the safety of all parties. If the treating provider determines there is a justifiable reason to break confidentiality to ensure the safety of the patient or another person due to the client's behavior, the provider is authorized to do so. Conditions for breaking confidentiality may include, but are not limited to: if the client is determined to be an active harm to themselves or to another, if abuse is recognized, or for a medical or behavioral emergency. If confidentiality must be broken, the treating provider will make reasonable efforts to inform the client/parents prior to or following the disclosure, as allowed.

General Contact Information:

Client Name:

DOB:

Legal Guardian Name:

Relationship to Client:

Client Home Address

Street:

City:

Zipcode:

Best Phone Number to Reach You During your Telehealth Session:

Emergency Contact Information:

Best Alternative Contact Person 1:

Relationship to Client:

Best Phone Number to Reach:

Best Alternative Contact Person 2:

Relationship to Client:

Best Phone Number to Reach:

Nearest Medical Center Name:
Nearest Medical Center Address
Street:
City:
Zipcode:
Phone Number:

Nearest Police Department Name:
Nearest Police Department Address
Street:
City:
Zipcode:
Phone Number:

Emergency Plan:

•If there is no fear of harm to patient or another person, the client/family is asked to write down information to be discussed at the next session. Should more immediate responses be required, the patient/family may call or secure message the provider. Depending on the nature of the information, the provider may require either a brief phone meeting, or an additional session to manage situations.

•If there appears to be a possibility of harm to the patient or to another person, the client/family is to immediately go to the local medical center/emergency room listed on this form. They are asked to contact the provider after safety has been ensured. If the client/family is closer to another medical center than what is listed, they are to go to that location. Following stabilization and discharge, the client/family is to provide the provider with an indication of what led to the need for a hospital visit, details of the hospital stay (e.g., medications, diagnoses, treatment summary), and both emotional and behavioral status post-discharge.

•Note: At any time, the provider can decide that telehealth services are no longer appropriate and as such, may be terminated. If such an event occurs, the provider will provide alternative referral options should face-to-face treatment not be possible.

Client Printed Name:
Client/Legal Guardian Signature:
Date:



INFORMED CONSENT FOR TELEHEALTH SERVICES

- There are potential benefits and risks of telehealth (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telehealth services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the clinician will explain how to use it.
- You need to use a webcam or smartphone during the session.
- A phone call may be appropriate in the event that video-conferencing is not possible.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify your clinician in advance by phone or secure messaging.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the telehealth sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your clinician, I may determine that due to certain circumstances, telehealth is no longer appropriate and that we should resume our sessions in-person.

Patient Name:

Patient DOB:

Signature of Patient/Patient's Legal Representative:

Date:

CREDIT CARD AUTHORIZATION

I would like to keep a credit card number on file Yes No

If you do not wish to keep a credit card number on file, please sign the form at the bottom of this page to acknowledge your understanding of our payment policy, including patients with account balances greater than 30 days may be restricted from further visits.

CREDIT CARDHOLDER INFORMATION					
NAME ON CREDIT CARD					
TYPE OF CREDIT CARD	VISA	MC	AMEX	DISCOVER	OTHER
TYPE OF ACCOUNT	PERSONAL			BUSINESS	
COMPANY NAME					

ACCOUNT NUMBER					
EXPIRATION DATE					
BILLING ADDRESS					
CITY		STATE		ZIP CODE	
PHONE		EMAIL		FAX NUMBER	

AUTHORIZED USER OF CREDIT CARD	
NAME	
COMPANY	
PHONE NUMBER	
EMAIL ADDRESS	
IDENTIFICATION	
RELATION TO OWNER	
TYPE OF CHARGES	
AUTHORIZED AMOUNT	
DATES OF CHARGES	

AUTHORIZATION OF CARD USE
<p>I certify that I am the authorized holder and signer of the credit card reference above.</p> <p>I certify that all information above is complete and accurate.</p> <p>I hereby authorize collection of payment for all charges as indicated above. Charges may not exceed the amount listed above in the "AUTHORIZED AMOUNT" field. I understand this is only for up to this amount during the time period of "DATES OF CHARGES" referenced above. If additional charges are going to be authorized a new form will have to be completed.</p>

CARDHOLDER NAME			
SIGNATURE		DATE	





Please attach a picture of your **Photo ID/Drivers License** and **Insurance Card** below to complete your intake packet.

This is to confirm identity and insurance so that you can be seen by your clinician via telehealth.

Photo ID/ Drivers License

Insurance Card

Front of Card

Back of Card

Thank you for taking the time to complete your intake packet and entrusting us with your care.