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 _____

CHILD BACKGROUND INFORMATION

NAME _____DOB_____AGE____GRADE____SSN_____
GENDER_____PRONOUNS: ☐ he/him/his ☐ she/her/hers ☐ they/them/theirs ☐ ze/hir/hirs
ADDRESS _____CITY_____ZIP_____
PHONE (H) _____ PARENTS WORK _____
REFERRED BY: _____
EMERGENCY CONTACT: _____PHONE_____RELATION_____
FAMILY PHYSICIAN: _____PHONE _____

PERSON FILLING OUT THIS FORM: (CIRCLE ONE)
MOTHER FATHER STEPMOTHER STEPFATHER GUARDIAN FOSTER PARENT

HOUSEHOLD INFORMATION *Who lives in the home?*

NAME	RELATIONSHIP	AGE	SEX	OCCUPATION/GRADE
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

DEVELOPMENTAL HISTORY:

Please check any which are problems in the home of the child:

____Frequent moves
____Parents divorce
____Parents remarriage
____Parents separated
____Family illness
____Personal illness
____Alcohol/Drugs
____Legal problems
____Parent conflict
____Parent job loss
____Financial stress
____Learning problems
____Death of family member
____Physical abuse/Neglect
____Sexual abuse
____Domestic violence
____Emotional problems
____Other

Please check what problems your child has experienced during their childhood:

____Premature birth
____Nervous
____Eating problems
____Learning difficulties
____Poor coordination
____Visual difficulties
____"Worry wart"
____ Overweight
____ Fighting
____Development delays
____Avoiding others
____Fidgety/restless
____Talking/refusing
____Speech problems
____Hearing/ear problems
____Fear leaving home
____ Leaving a loved one
____ Small for age
____Picked on
____Trouble with police
____Bedwetting
____Head injury
____Frequent tantrums
____Sleepwalking/Nightmares
____School behavior
____Behavioral problems
____Toilet training
____ Shy
____Repeated grade
____Engages in dangerous behavior
____Birth Defect
____Abuse/neglect
____Bad dreams
____School behavior
____Feeling rejected
____Strong willed
____Few friends/loner
____Ran away from home
____Did not like to be held as a baby

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

Father	____Good	____Fair	____Poor	____Problem for you	____N/A
Mother	____Good	____Fair	____Poor	____Problem for you	____N/A
Stepfather	____Good	____Fair	____Poor	____Problem for you	____N/A
Stepmother	____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
Friends	____Good	____Fair	____Poor	____Problem for you	____N/A
Teacher	____Good	____Fair	____Poor	____Problem for you	____N/A

EDUCATIONAL HISTORY

School _____ Location_____
Is your child in a special education class? yes ____ no ____ What kind _____
Does you child received special tutoring or therapy in school? yes ____ no ____

OCCUPATIONAL HISTORY

Is your child presently employed? ___ yes ___ no Type of work _____ How long? _____

PRIOR MENTAL HEALTH HISTORY

Has your child ever had prior mental health treatment? ____yes ____no (If no, skip)
When _____ Who_____
Was this person a: ____Psychiatrist ____Psychologist ____Clinical social worker ____Clinical Counselor
____Minister ____Other
Has your child ever been hospitalized for emotional problems? ____yes ____no (If no, skip)
When _____ Where_____

ALCOHOL/DRUG HISTORY

Does your child have a history of alcohol/drug abuse? ____yes ____no (If no, skip)
Has your child ever been hospitalized for drug/alcohol abuse? ____yes ____no
When _____ Where_____

MEDICAL HISTORY

Date of last physical exam _____ Family physician_____
Where located? _____
Are immunizations up to date? ____yes ____no

Does your child have any special problems with hearing, speech or vision? ____yes ____no
Please explain:

Is your child taking any medications? ____yes ____no
If yes, please list:

Describe any side effects of medication(s):

Please list any allergies, serious illnesses, injuries or surgeries?

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

____Alcoholism	_____	____Cancer	_____
____Allergies	_____	____Diabetes	_____
____ Obesity	_____	____Epilepsy	_____
____ Degenerative dis.	_____	____High blood press.	_____
____ Mental health probs.	_____	____Heart trouble	_____
____ Bi-Polar	_____	____Suicide	_____
____Schizophrenia	_____	____Other	_____
____ Developmental Disabilites	_____	____Depression	_____
		____Anxiety	_____
____Attention Deficit	_____		

MEDICAL CONDITIONS AND SYMPTOMS

Past/Now	Past/Now	Past/Now
___ ___ Academic underachievement	___ ___ Anxiety	___ ___ Anger Outbursts
___ ___ Argumentative	___ ___ Asthma	___ ___ Baby Talk
___ ___ Bedwetting	___ ___ Body aches	___ ___ Broken bones
___ ___ Broken sleep	___ ___ Constipation	___ ___ Convulsions
___ ___ Cries easily	___ ___ Demands for attention	___ ___ Depression
___ ___ Difficulty going/staying asleep	___ ___ Difficulty concentrating	___ ___ Dieting
___ ___ Dizziness	___ ___ Eats non-edibles	___ ___ Emotional upsets
___ ___ Easily distracted	___ ___Encopresis (soiling clothes)	___ ___ Encephalitis
___ ___ Excessive sexual interest	___ ___ Fainting spells	___ ___ Fatigue
___ ___ Food craving for sweets	___ ___ Frequent sex play w/ other children	
___ ___ Headaches	___ ___ Hears voices	___ ___ High fever
___ ___ Hospitalization(s)	___ ___ Immature for age	___ ___ Injuries to head
___ ___ Itchy skin	___ ___ Leg cramps	___ ___ Loose bowel/gas often
___ ___ Loses temper easily	___ ___ Loss of consciousness	___ ___ Lying
___ ___ Masturbation	___ ___ Memory problems	___ ___ Mental condition
___ ___ Moody often	___ ___ Much sweating	___ ___ Muscle twitching
___ ___ Nervousness	___ ___ Nightmares	___ ___ Operation(s)
___ ___ Over dependent	___ ___ Overeating	___ ___ Perfectionistic
___ ___ Poor appetite	___ ___ Poor nutrition	___ ___ Rebellious
___ ___ Sleepwalking	___ ___ Stealing	___ ___ Stomach upsets
___ ___ Suicide attempt	___ ___ Temper tantrum	___ ___ Thumb sucking
___ ___ Vomiting	___ ___ Worries, insecurity	

CURRENT SOURCES OF STRESS

Briefly describe your child's current difficulties:

How long has this problem been a concern to you?

Describe any unusual fears, habits, or behaviors.

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

ADDITIONAL INFORMATION

Please add any special information you feel might be helpful in assisting in your child's treatment.

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

_____ _____

Signature of parent or guardian Date

Dear Client: Please list all of your medications below or provide the office with a copy of your current medication list. Many medications have side effects. It is important for your clinician to be aware of all of your medications (prescription, over-the-counter, and supplements) in order to determine if your medications may be contributing to any of the symptoms you are experiencing.

Medication List

Client name: _____ DOB: _____

Medication	**Dosage**	**Frequency**	**Prescribed by**	Date Added/Discontinued
				This column office use only.

KENT PSYCHOLOGICAL ASSOCIATES

Revised Children's Anxiety and Depression Scale

The two forms below are for you and your child to fill out, and both are very helpful to their clinician in determining the course of treatment.

The first form, RCADS-P-25, is for the parent(s) to fill out. If both parents participate in filling out this form, please determine the best answer together, as only one RCADS-P-25 will need completed for scoring purposes.

If your child is in the 3rd grade or older, they will need to fill out the second form, RCADS-25. Encourage them to do the best they can, as this again will be useful to their clinician in further assessing your child.

Date: _____ **Name/ID:** _____

RCADS-P-25 **Relationship to Child:** _____

Please put a circle around the word that shows how often each of these things happens for your child.

1. My child feels sad or empty	Never	Sometimes	Often	Always
2. My child worries when he/she thinks he/she has done poorly at something	Never	Sometimes	Often	Always
3. My child feels afraid of being alone at home	Never	Sometimes	Often	Always
4. Nothing is much fun for my child anymore	Never	Sometimes	Often	Always
5. My child worries that something awful will happen to someone in the family	Never	Sometimes	Often	Always
6. My child is afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
7. My child worries what other people think of him/her	Never	Sometimes	Often	Always
8. My child has trouble sleeping	Never	Sometimes	Often	Always
9. My child feels scared to sleep on his/her own	Never	Sometimes	Often	Always
10. My child has problems with his/her appetite	Never	Sometimes	Often	Always
11. My child suddenly becomes dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
12. My child has to do some things over and over again (like washing hands, cleaning, or putting things in a certain order)	Never	Sometimes	Often	Always
13. My child has no energy for things	Never	Sometimes	Often	Always
14. My child suddenly starts to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
15. My child cannot think clearly	Never	Sometimes	Often	Always
16. My child feels worthless	Never	Sometimes	Often	Always
17. My child has to think of special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
18. My child thinks about death	Never	Sometimes	Often	Always
19. My child feels like he/she doesn't want to move	Never	Sometimes	Often	Always
20. My child worries that he/she will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
21. My child is tired a lot	Never	Sometimes	Often	Always
22. My child feels afraid that he/she will make a fool of him/herself in front of people	Never	Sometimes	Often	Always
23. My child has to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
24. My child feels restless	Never	Sometimes	Often	Always
25. My child worries that something bad will happen to him/her	Never	Sometimes	Often	Always

Date: _____ **Name/ID: _____**

RCADS-25

Please put a circle around the word that shows how often each of these things happens to you. There are no right or wrong answers.

1. I feel sad or empty	Never	Sometimes	Often	Always
2. I worry when I think I have done poorly at something	Never	Sometimes	Often	Always
3. I would feel afraid of being on my own at home	Never	Sometimes	Often	Always
4. Nothing is much fun anymore	Never	Sometimes	Often	Always
5. I worry that something awful will happen to someone in my family	Never	Sometimes	Often	Always
6. I am afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
7. I worry what other people think of me	Never	Sometimes	Often	Always
8. I have trouble sleeping	Never	Sometimes	Often	Always
9. I feel scared if I have to sleep on my own	Never	Sometimes	Often	Always
10. I have problems with my appetite	Never	Sometimes	Often	Always
11. I suddenly become dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
12. I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)	Never	Sometimes	Often	Always
13. I have no energy for things	Never	Sometimes	Often	Always
14. I suddenly start to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
15. I cannot think clearly	Never	Sometimes	Often	Always
16. I feel worthless	Never	Sometimes	Often	Always
17. I have to think of special thoughts (like numbers or words) to stop bad things from happening	Never	Sometimes	Often	Always
18. I think about death	Never	Sometimes	Often	Always
19. I feel like I don't want to move	Never	Sometimes	Often	Always
20. I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
21. I am tired a lot	Never	Sometimes	Often	Always
22. I feel afraid that I will make a fool of myself in front of people	Never	Sometimes	Often	Always
23. I have to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
24. I feel restless	Never	Sometimes	Often	Always
25. I worry that something bad will happen to me	Never	Sometimes	Often	Always

KENT PSYCHOLOGICAL ASSOCIATES

Treatment of Minor Children

The initial appointment will be for the parental/legal guardian and the child. The parent/legal guardian will need to provide a photo ID at time of service to verify identity. If you are divorced parents, we ask that you provide us with your court paperwork that indicates the custodianship agreement. If you are not the parent and are the legal guardian, please provide your court approved guardianship papers. If this documentation is not provided by the first appointment, or if someone other than the parent or legal guardian joins the child to the first appointment, the appointment will be rescheduled.

Per our ethics boards, it is best practice to inform both parents when a minor is in treatment. We ask that the parent who is consenting to treatment provide the other parent's information. The clinician seeing your child will attempt to reach out to inform them that their child is in treatment and to gather any further necessary information for the assessment and treatment of your child. Input from both parents is preferable as it increases the likelihood that both parents will view the therapist as a neutral party, and it helps to create a safe, balanced treatment environment for the child. Parents often have very divergent views about their child's problems and about what is in their child's best interests. It is ideal for both parents to meet with the therapist together to discuss their concerns about the child, so that both participate in formulating the child's treatment plan and goals.

*See ORC 4757-02 B(1-5) and 5122.04 A,B for Ohio laws regarding treatment of minors

Divorced or Separated Parents

It is not ethical for a treating mental health professional to offer an expert opinion regarding custody and visitation issues in court. Your child's therapist is a treating professional who is an expert on your child's mental health diagnosis and treatment. Any expert opinion regarding custody and visitation matters is properly performed by a court-appointed examining professional, who conducts a balanced child and parent evaluation separate from the child's treatment needs. In addition, a therapist's involvement in parental disputes creates potentially serious role conflicts that negatively impact a child's treatment.

Regarding Fees

With respect to payment for psychological services rendered to a child with divorced or separated parents, we have no standing in court actions which allocate financial responsibility for the child's health needs, and we are not in a position to enforce existing court orders. We prefer, when possible, that both parents attend the first session with the child to sign required financial agreement forms. If the parents do not initially appear together and concur on an arrangement for sharing these expenses, our policy is that the parent who brings the child to session will pay any applicable copay.

Parent Signature _____ Date _____

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

⇦ AND ⇨

My Primary Care Provider:
Name: _____
Street: _____
City:_____State: Zip:_____
Phone:_____Fax:_____

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

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

REQUESTED INFORMATION FROM PRIMARY CARE PROVIDER INCLUDES THE FOLLOWING:

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

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

REVOCATION 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.

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.

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)

KENT PSYCHOLOGICAL ASSOCIATES

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 insurances 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**

Revised 04/17/2018

KENT PSYCHOLOGICAL ASSOCIATES

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.

<u>Patient Responsibilities</u>

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.

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

KENT PSYCHOLOGICAL ASSOCIATES

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:

KENT PSYCHOLOGICAL ASSOCIATES

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

I certify that I am the authorized holder and signer of the credit card reference above.

I certify that all information above is complete and accurate.

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.

CARDHOLDER NAME			
SIGNATURE		DATE	

KENT PSYCHOLOGICAL ASSOCIATES

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 your child can be seen by their 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.