Welcome Letter

Dear New Patient,

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

Before we schedule your initial appointment:

- Click on the link in your email from MyIO to sign up for the Patient Portal.
- **Once in the MyIO Patient Portal, click on "Fill Required Forms" in the top-right to find your initial paperwork. Your initial appointment can not be scheduled until all your forms are completed.**
- **Please upload a photo of your Insurance Card and Photo ID to the Patient Portal, or email the photos to info@kentpsychological.com**
- If you have difficulty with the forms, contact our office for assistance.
- You can access the Crisis Resource List, Notice of Patient Rights and Responsibilities, Notice of Privacy Policies, and the Doxy links for telehealth sessions in the Resources tab of your Patient Portal or directly on our website at www.kentpsychological.com

Day of your appointment:

- Arrive 15 minutes early for your in-office appointment.
- Log-on 15 minutes early for your telehealth appointment to ensure all technology is working properly.
- Your credit card on file will be charged for co-pays and high deductibles at the time of service.

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

- We are committed to providing care to as many patients as possible. When a patient cancels without sufficient notice, this prevents another patient from being seen.
- **You will be charged a $75 fee for No-Show appointments and a $60 fee for Late Cancel appointments.**
- We do waive fees for cases of sudden-onset contagious/impairing illnesses or true emergencies. Please speak with our Office Manager or your clinician in these circumstances.

If you have concerns or questions, you can reach our business office Monday through Friday between the hours of 8:00 a.m. and 4:00 p.m.

We look forward to meeting you.

Please sign below indicating your have read the cancellation policy.

Signature: * ×

Date:

Adult Background Info

Name: *

Date of Birth: *

Gender and Pronouns: *

Race/Ethnicity/Culture: *

Emergency contact (name, relationship, phone number): *

What are your main reasons for seeking mental health treatment/evaluation at this time? *

HOUSEHOLD INFORMATION

Who lives with you? Check all that apply. Then, please provide their names, ages, genders, and relationships to you below. *

- [ ] My partner/significant other/spouse
- [ ] My child(ren)
- [ ] Other relative(s)
- [ ] Other roommate(s)
- [ ] No other humans (We love pets, but we do not need their info.)

Name, age, gender, relationship:

Name, age, gender, relationship:

Name, age, gender, relationship:

Name, age, gender, relationship:

Please list any other members of your household along with their names, ages, genders, and relationships to you:

Do you have any children who do not live with you? (If yes, please list their names, ages, and genders.) *

DEVELOPMENTAL HISTORY

Who was your primary caregiver/guardian as a child? *

How many siblings do you have? *

EDUCATIONAL HISTORY

What is your highest level of education? *

Have you had any academic, behavioral, or social problems in school? (If yes, please describe.) *

OCCUPATIONAL HISTORY

Occupation: *

Are you a military veteran? *

Do you have any concerns regarding work? (If yes, please describe.) *

RELATIONSHIP HISTORY

Sexual orientation: *

Current relationship status: *

MENTAL HEALTH HISTORY

What mental health symptoms are you currently experiencing? *

Do you have any history of mental health treatment, such as counseling, hospitalization, or medication? (If yes, please describe.) *

Do you have any history of self-harm, such as suicide attempts, cutting, or other purposeful self-injury? (If yes, please describe.) *

Does anyone close to you have a history of self-harm or suicide? (If yes, please describe.) *

ALCOHOL/DRUG USE HISTORY

Do you currently drink alcohol or use any other substances? (If yes, please describe.) *

Do you have any concerns about your current pattern of substance use? (If yes, please describe.) *

Do you have any history of substance use problems? (If yes, please describe.) *

Do you have any history of substance use treatment? (If yes, please describe.) *

LEGAL HISTORY

Do you have any history of charges, arrests, convictions, or incarcerations? (If yes, please describe.) *

MEDICAL HISTORY

Do you currently have a primary care provider or general practitioner? (If yes, please provide their name.) *

When was the last time you met with your medical provider? *

Do you have any current medical concerns, such as chronic medical issues or new physical health symptoms? (If yes, please describe.) *

Please list all current medications with their dosages or bring/upload your medication list.

Please list any allergies (medications, food, environmental). *

PAST SIGNIFICANT STRESSORS OR TRAUMAS

Please describe any history of significant stressors or traumas: *

CURRENT SOURCES OF STRESS

Please list your most significant sources of stress currently: *

EXPECTATIONS FOR TREATMENT/EVALUATION

How would your life be different if you could better manage some of these problems and stressors? *

What are the main goals you would like to attain by participating in mental health treatment/evaluation at this time? *

Any other information you would like us to know before we meet:

Signature: * ×

"No Secrets" Policy

This written policy is intended to inform you, the participants in therapy, that when I agree to treat a couple or a family, I consider that couple or family (the treatment unit) to be the patient. For instance, if there is a request for the treatment records of the couple or the family, I will seek authorization of all members of the treatment unit before I release confidential information to third parties. If only one person authorizes release of records, I will release a partially redacted record with only the information disclosed by that particular person.

During the course of my work with a couple or a family, I may see a smaller part of the treatment unit (e.g., an individual or two siblings) for one or more sessions. These sessions should be seen by you as a part of the work that I am doing with the family or the couple unless otherwise indicated. If you are involved in one or more of such sessions with me, please understand that generally these sessions are confidential is the sense that I will not release any confidential information to a third party unless I am required to by law to do so or unless I have your written authorization. In fact, since those sessions can and should be considered a part of the treatment of the couple or family, I would seek authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However, I may need to share information learned in an individual session (or a session with only a portion of the treatment unit being present) with the entire treatment unit-that is, the family or the couple, if I am to effectively serve the unit being treated. I will use my best judgement as to whether, when, and to what extent I will make disclosures to the treatment unit, and will also, if appropriate, first give the individual or the smaller part of the treatment unit being seen the opportunity to make the disclosure. Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually.

This "no secrets" policy is intended to allow me to continue to treat the couple or family by preventing, to the extent possible, a conflict of interest to arise where an individuals interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or the family. If I am not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during their therapy, I might be placed in a situation where I will have to terminate treatment of the couple or the family. This policy is intended to prevent the need for such a termination.

Signature: * ×

Couples Therapy Contract

1. The counseling being provided is couples counseling. The "patient" in this counseling is the relationship, the couple, not either person individually.
2. The patient in this counseling is the relationship, the couple, not either person individually.
3. In couples counseling, each participant has all of the rights and privilege's afforded to people involved in individual psychological psychotherapy, as defined by law and ethics and stated in the written information provided to each person prior to the initial counseling appointment.
4. The specifics of what is said and discussed in counseling sessions is confidential and privileged information and cannot be shared or discussed with anyone without the express, written consent of the individuals involved.
5. Since the success of couples counseling cannot be predicted or assured, it is possible that one or both of you may decide during the course of counseling that the best answer to your relationship issues and concerns is separation, dissolution, or divorce. If either party or parties attorney requests information, the above described procedures on release of records will apply.
6. You should be aware that once we begin couples counseling, that it is unethical for me to give any opinion about custody or visitation arrangements, even if I am compelled to be a witness in any legal proceedings, actions, or venues.
7. Should one and/ or both of you decide to move to dissolution of the marriage or divorce, and a custody evaluation is orders by the court, I want your permission to provide information to anyone appointed by the court to perform a custody evaluation or to represent the legal interests of your children. I would not in such case make any recommendation about the final decision but will provide a copy of the records through the process described above.
8. Typically we do not see couples individually other than within the assessment process. From time to time, it may be necessary or advisable to have one or more individual counseling sessions with one or both of the couples counseling participants and this is up to the clinician discretion of your clinician. Any and all such individual sessions should be understood to be part of the couples counseling process and in service to the couples counseling and, not an action that establishes an individual counseling relationship between the treating couples therapist and either of the participants involved in couples counseling.
9. During the course of the couples counseling, the treating counselor may identify individual and/or personal issues the one and/or both of the participants may have that require individual counseling. If such situation arises, the treating therapist reserves the right to recommend and/or strongly advise individual counseling with a mental health therapist to one or both of the couples counseling participants.
10. Should one of the participants of the coupes counseling process decided to discontinue participation in the previously agreed upon couples counseling, each and/or either of the

couples counseling participants, should he/she desire continued counseling, will be referred to another therapist for individual counseling.

While I have taken training in the Gottman Method Couples therapy, I want you to know that I and my agency are completely independent in providing you with clinical services and that I alone am fully responsible for those services. The Gottman Institute or its agents have no responsibility for the services you receive.

Signature: * ×

Credit Card on File Policy

Thank you for choosing Kent Psychological Associates. We are committed to providing exceptional mental health care as well as providing access to care by remaining in-network with the majority of insurance companies in NE Ohio. To maintain this commitment, our insurance billing must be as simple and efficient as possible. Therefore, it has become necessary for our practice to have a guaranteed form of payment on file in our office.

Effective February 12, 2024, Kent Psychological Associates requires all non-Medicaid patients to keep an active credit card on file with us. Circumstances when your credit card would be charged include:

· Co-pays, co-insurance, and deductibles

· Any non-covered services and/or denial of services that your insurance company lists as "patient responsibility" on the Explanation of Benefits

· Missed or cancelled appointments without sufficient notice as detailed in our office policy

How my credit card information will be collected:

You have three options for providing your credit card information. With all options, the information will be immediately encrypted in the payment processing system and not stored in our office.

· Provide information over the telephone when you schedule your intake appointment.

· Provide your credit card information in-person at your first appointment in our office.

· Log-in to our Patient Portal and enter your credit card information yourself in the Card Manager. This can be completed while filling out the initial forms.

FAQ's about our new Credit Card on File Policy:

Why the change? The financial burden for the cost of healthcare has shifted more towards the patient in the form of higher deductibles and co-pays. We collect more money directly from patients, instead of insurance companies, than ever before. While many of our patients are very good at paying for their services in a timely manner, this is not always the case. We understand that your life is busy and complicated. Our goal is to make the collection of fees streamlined and simple for patients and our office.

What are my options for the card on file?

· Credit card (Visa, Mastercard, American Express or Discover)

· Debit card

· HSA card

· FSA card

· HRA card

*Please note that we do not except Care Credit

How will I know how much you are going to charge me?

We verify insurance coverage and benefits when a patient initiates services with us. Please check with your insurance company or ask us about your benefits if you have questions about your specific coverage. We will be able to give you an estimate of your per visit cost based on information provided by your insurance company. Insurance companies provide us with copay, co-insurance, and deductible amounts.

How do I know my credit card information is safe in your office?

We do not store your full credit card information in our office or in our computer system. Once our administrative staff enters your credit card information, it is “tokenized” and meets Payment Card Industry (PCI) Security Standards. Our staff no longer have access to anything other than the last 4 digits of your credit card.

What if I need to dispute my bill?

We will always work with you and your insurance company to determine if there has been a billing error. If a billing error is identified, refunds will be issued back to the credit card in a timely manner. You can contact our office and ask to speak with the office manager if you have any questions about your account.

Our staff is happy to speak with you about your account at any time. Please contact our office during business hours with any additional questions.

Thank you!

Signature: * ×

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. Credit Card on File. All non-Medicaid clients must keep an active credit card on file. Credit cards will be charged for co-pays, co-insurance, deductibles, non-covered services, denied services, missed appointments, or appointments cancelled without sufficient 24 hour notice. Ask for a copy of our full Credit Card on File Policy if you have any questions.

I understand that my payment information will be maintained in a secure encrypted format for future use by the practice. **I authorize the collection of payment for all charges listed above.** I understand that I will not be provided with advance notice of authorized transactions up to the amount of $300. Transaction receipts will be sent through the Patient Portal, with an alert to the email address I provided. Authorization will remain in effect until I provide written notice of cancellation to the practice.

2. Missed appointments. There is a $75 fee for missed appointments and a $60 fee for appointments cancelled without sufficient prior notice of 24 hours. 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.

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

4. 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.

5. Co-payments. All co-payments will be charged to the credit card on file at the time of service. Unpaid co-pays, due to declined or expired credit cards, must be paid in full prior to your next appointment or your appointment may be rescheduled.

6. Co-Insurance. Your co-insurance balance will be charged to your credit card on file once we receive the explanation of benefits (EOB) from your insurance company. We are able to assist you with an estimate of the per visit co-insurance cost if needed.

7. 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. **Your credit card on file will be charged for the full estimated out-of-pocket cost at each visit. Any remaining balance will be charged once we receive the EOB from your insurance company.** 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.

8. 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.

·A full schedule of fees is available upon request or in the Patient Portal

9. 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.

10. 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.

11. 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.

12. 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.

13. Financial Hardship: If you experience temporary financial difficulties that affect timely payment of your account, please discuss this issue with our billing staff at your earliest possible convenience, before any misunderstandings can develop.

14. 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 a reduced fee, a prompt pay discount is available.

15. 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: * ×

Date:

Release of Information

Kent Psychological Associates

190 Currie Hall Prkwy

Kent, Ohio 44240

Ph: 330-673-5812 Fax: 330-673-7162

Preferences for coordination of care between Kent Psychological Associates (KPA) and my Primary Care Provider (PCP): *

Name and address of PCP: *

I UNDERSTAND:

1. This authorization will expire 1 year from the date of signing.

2. I may revoke this authorization at any time by providing any 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.

5. 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 designated above, which may include treatment for mental illness (ORC 5122.31), alcohol/drug abuse (42 CRF Part 2), and/or Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) test results or diagnoses (ORC 3701.24.3).

Signature: * ×

Permission to Treat and Acknowledgement of Policies

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: The Notice can be viewed or downloaded in the Patient Portal under Resources or on our website. A paper copy can be obtained from the front desk. I have received a 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: The Notice can be viewed or downloaded in the Patient Portal under Resources or on our website. A paper copy can be obtained from the front desk. 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, and reporting of specific threats to harm another or oneself. A licensed therapist must also obey a court order to produce or discuss records.

Case Consultation: 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 care with be taken to disclose the minimum necessary information to ensure good clinical decision making.

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.

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

Guarantee of Account: I understand that 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.

Telehealth Services: I understand that telehealth services may, at times, be part of my treatment. I understand that there are benefits and risks associated with telehealth services, including but not limited to, disruption of sessions by technology failures, interruption and/or breech of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies. Additionally, at any time, my provider can decide that telehealth services are no longer clinically appropriate and recommend alternative options for face-to-face services.

My clinician needs to know my location in case of an emergency. I agree to inform my clinician of my location at the beginning of each telehealth session.

If we encounter technical difficulties resulting in session disruption and are unable to reconnect, my clinician may call me at the following number: *

Emergency Contact: I understand that I must provide an emergency contact person who my provider may contact on my behalf in a life-threatening emergency. (Please list name, phone, and address.) *

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: * ×

Date:

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	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
D	D	D	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*____=_____ + ____ + ____)