Tyler Psychological Services

CLIENT INFORMATION

Basic Information

Client's name: _____

Parent or Guardian (if applicable): _____

Client's date of birth: _____ Age: _____

Home Address: _____ Apt/Unit # _____

City _____ State _____ Zip Code _____

Contact Information

Cell: _____ OK to leave a message? ____Yes ____No

Home: _____ OK to leave a message? ____Yes ____No

Work: _____ OK to leave a message? ____Yes ____No

Email: _____ OK to email? ____Yes ____No

Referral Information

How were you referred to this practice? _____Psychology Today ____ Google Search ___ Friend or Family

_____ Another provider ____ Google Ad ____ Other

Emergency Contact

Name: _____ Phone Number: _____

Relationship to Client: _____ Email: _____

Payment Information

What is your payment method? ___ Self-Pay ___ Insurance (Please complete Release to Bill Insurance form)

Signature

By signing below, I acknowledge the above information is accurate and Tyler Psychological Services, L.L.C. can contact my emergency contact if there is an emergency.

_____ _____ _____ _____

Client Signature **Date** **Witness Signature** **Date**

CLIENT AGREEMENT & INFORMED CONSENT

This document contains important information about Tyler Psychological Services, LLC's policies, as well as brief information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections. It is very important that you read this document carefully. The contents of this document can be discussed during the first intake session if there are any questions or concerns.

After reviewing it, please sign this form, as it will constitute an agreement between you and your therapist at Tyler Psychological Services, L.L.C. You may revoke this agreement in writing at any time; however, please note that we cannot continue treatment after revocation of this form.

Psychological Serves
Psychotherapy is a mutually agreed upon professional relationship between the psychotherapist and the client(s) that seeks to improve the mental health functioning of the client(s). The exact process will vary depending on the particular problems you are experiencing and the type of treatment that is indicated. It is important to note that the duration, intensity and goals of treatment differ significantly from one client to another.

Psychotherapy can have both benefits and risks. On the one hand, it often involves discussing unpleasant aspects of your life. You may experience uncomfortable feelings as you address the issues that initially brought you to therapy. On the other hand, it has also been shown to have many benefits, such as better relationships, solutions to specific problems, and significant reductions in feelings of distress. Change will sometimes be easy and swift. However, more often the changes you are hoping to see happen gradually over time. While there is no guarantee that psychotherapy will produce positive results or help you make lasting changes, it is often reported that psychotherapy helps to improve overall functioning.

Client Rights and Responsibilities
You become a client of Tyler Psychological Services, LLC, when you attend the intake evaluation and when you sign this paperwork. As a client, you have rights and responsibilities. You have the right to information regarding your therapist's qualifications, including but not limited to education, training and licensure status. You also have the right to inquire about the procedures, approaches or skills being used at any time throughout the therapy. In addition, you have the right to stop therapy at any time without any financial consequences. Lastly, you have the right to have your Protected Health Information (PHI) kept confidential unless there is a life threatening emergency that requires disclosure of this information for safety purposes. Scheduled sessions will last between 40-60 minutes depending on the needs of the client. The frequency, duration, and specific scheduling needs will be discussed in the intake.

Not surprisingly, psychotherapy requires active participation on the part of the client. You will be expected to work on the things discussed in the therapy session in the interim of your next scheduled appointment. You are encouraged to discuss both the positive and difficult aspects of therapy, and re-address goals as needed. You are also responsible for arriving to your appointments on time and informing your clinician if you will be late for any reason. As a note, if you are late, your session will still end at the regularly scheduled ending time. You are responsible for keeping up to date on your payments for services and canceling any appointments within 24 hours. Payments can be made either with credit card or check. **If you miss a scheduled session, or cancel a session within 24 hours, you will be responsible for a $100 late fee. Insurance companies do not pay for missed sessions; therefore, the above fee will be the sole responsibility of the client.** Also, please note that consistent attendance in therapy is necessary to see measurable growth and change. To meet your needs and to ensure the highest level of care, it is strongly recommended that you do not miss too many sessions throughout our work together. If the first intake session is missed, the clinician reserves the right to offer this time slot to another client. If there are three consecutive cancellations, your therapist will reach out to discuss your interest in services and may not be able to hold the time slot for you.

Psychotherapist Responsibilities
Your therapist is responsible for providing the highest quality psychotherapy services to each client. It is also the responsibility of that therapist to adhere to the Health Information Portability and Accountability Act (HIPAA) and the rules and ethical principles of the professional governing bodies in their field (APA, ACA, etc). The therapist with whom you work is responsible for creating a safe, respectful environment that is free from discrimination based on race, ethnicity, color, gender, sexual orientation, age, religion, national origin, source of payment or socioeconomic

status. The therapist is also obligated to disclose to you your diagnosis, treatment progress and treatment options to the insurance company, if requested. If after a thorough evaluation of your presenting difficulties it is determined that you would benefit from a provider with more specialized training, we will provide referrals and support to transition the care. Lastly, consultation is advised and highly encouraged in this field. As such, the therapist may consult with other professionals about how to provide the best care for you as the client. The information disclosed will be de-identified and vague so as to maintain your privacy, and will be discussed with you prior to the consultation.

Fees

Your therapist will discuss the fee schedule, sliding scale options, and copays during the intake session. Payment is due at the time of service and it is advised that the client understand his or her insurance benefits prior to attending therapy. If you are having trouble paying for services, please discuss this with your therapist in advance. Payment plans can be implemented, though please note that if no payments are made within 30 days of service, a $30 late fee per month will be added to your account. Tyler Psychological Services, L.L.C. also reserves the right to submit information to a collection agency after 90 days of non-payment.

Credit cards and checks are accepted. Fees will be processed at the start of each therapy session so as to not interfere with the therapeutic process. Fees for phone consultations, reports and summaries released to individuals named by the client, consultation with other professionals, release of information, reading extensive records, and other types of services will be discussed if/when these situations arise.

Confidentiality

Tyler Psychological Services, L.L.C. is committed to maintaining your confidentiality and not disclosing Protected Health Information (PHI). In most cases, your therapist can only release information about your treatment to others if you sign a written authorization form. However, there are some situations in which the therapist with whom you work will be legally obligated to disclose information without your expressed consent. Below are the situations in which information can be disclosed even if an authorization form is not signed:

- A child under 18 is being abused or neglected. The information will be reported to the appropriate state agencies.
- An individual with a disability is being abused or neglected. The information will be reported to the appropriate state agencies.
- You, the client, poses a clear, imminent risk of serious physical harm to yourself or another person. Your therapist has a duty to keep both you and others safe. All attempts to help you maintain safety without disclosure will be explored. However, if deemed necessary, your therapist will disclose information to keep you and others safe from harm.

Tyler Psychological Services, L.L.C. is also obligated to disclose information if: compelled by a court order signed by a judge that legally mandates release of information contained in your medical records; compelled by in the event of death; or if otherwise specifically required by the law. If such a situation arises, your therapist and the company will make every effort to fully discuss the matter with you before taking any action, and will limit their disclosure to only the information necessary.

Your therapist will attempt to return all emails and calls within 48 hours. However, if you are experiencing a medical or psychiatric emergency, please call 911 or go to your nearest emergency room.

Your signature below indicates that you have read the information in this document, agree to abide by its terms during this professional relationship, and consent to treatment at Tyler Psychological Services, L.L.C.

_____	_____	_____	_____
Client Signature	Date	Witness Signature	Date

NOTICE OF PRIVACY PRACTICE

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

CLIENT 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.

1. **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 me how to do this. I will provide a copy or a summary of your health information, usually within 30 days of your request. I may charge a reasonable, cost-based fee.
2. **Ask me to correct your medical record**
   You can ask me to correct health information about you that you think is incorrect or incomplete. Ask me how to do this. I may say "no" to your request, but I will tell you why in writing within 60 days.
3. **Request confidential communications**
   You can ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address. I will say "yes" to all reasonable requests.
4. **Ask me to limit what I use or share**
   You can ask me not to use or share certain health information for treatment, payment, or our operations. I am not required to agree to your request, and I 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 me not to share that information for the purpose of payment or our operations with your health insurer. I will say "yes" unless a law requires me to share that information.
5. **Get a list of those with whom I've shared information**
   You can ask for a list (accounting) of the times I've shared your health information for six years prior to the date you ask, who I shared it with, and why. I 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). I'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
6. **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. I will provide you with a paper copy promptly.
7. **Chose 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. I will make sure the person has this authority and can act for you before I take any action.
8. **File a complaint if you feel your rights are violated**
   You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/

CLIENT CHOICES

For certain health information, you can tell me your choices about what I share. If you have a clear preference for how I share your information in the situations described below, please talk to me. Tell me what you want me to do, and I will make every attempt to follow your instructions. You have both the right and choice to tell me:

- 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
- Contact you for fundraising efforts

If you are not able to tell me your preference, for example if you are unconscious, I may go ahead and share your information if we believe it is in your best interest. **I may also share your information when needed to lessen a serious and imminent threat to health or safety.**
In these cases I never share your information unless you give me written permission:

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

OTHER USES AND DISCLOSURES
I use or share your health information in the following ways:

- **Treat you:** I can use your health information and share it with other professionals who are treating you.
- **Run my organization:** I can use and share your health information to run my practice, improve your care, and contact you when necessary.
- **Bill for your services:** I can use and share your health information to bill and get payment from health plans or other entities.

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

- **Help with public health and safety issues**: I can share health information about you for certain situations, such as:
    - Reporting suspected abuse, neglect, or domestic violence of a child, elderly person or disability individual.
    - Preventing or reducing a serious threat to anyone's health or safety. This includes risk of serious and imminent harm to yourself or to someone else.
- **Do research**: I can use or share your information for health research.
- **Comply with the law:** I 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 I am complying with federal laws.
- **Address workers' compensation, law enforcement and other government requests:** I 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 actions:** I can share health information about you in response to a court or administrative order, or in response to a subpoena.

MY RESPONSIBILITIES
I am required by law to maintain the privacy and security of your protected health information.

- I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- I must follow the duties and privacy practices described in this notice and give you a copy of it.
- I will not use or share your information other than as described here unless you tell me I can in writing. If you tell me I can, you may change your mind at any time. Let me 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
I can change the terms of this notice, and the changes will apply to all information I have about you. The new notice will be available upon request, in my office, and on my web site.

By signing below, you agree to the above privacy practices and acknowledge that you have read them carefully.

_____	_____	_____	_____
Client Signature	Date	Witness Signature	Date

RELEASE TO BILL INSURANCE

Tyler Psychological Services, L.L.C. is an in-network provider for Blue Cross Blue Shield PPO and Blue Cross Blue Shield Blue Choice. The practice is considered out-of-network for all other insurance plans/providers. By signing this release, you acknowledge the following:

- I understand that my therapist at Tyler Psychological Services, L.L.C. is required to submit a diagnosis to my insurance provider so that my provider may determine if my treatment expenses will be covered.
- I understand this diagnosis may become part of my permanent insurance record.
- I understand that my insurance provider may have limitations on the type and amount of services authorized.
- I understand that my insurance provider may ask for additional information from Tyler Psychological Services, L.L.C. and that my therapist may need to release this information in order for my psychotherapy services to be covered.

Your therapist will make efforts to minimize the amount of information released to your insurance provider. As an alternative, you may elect to self-pay for psychotherapy services. In this case, any psychotherapy services you receive are kept private from your insurance provider records. As such, no diagnosis will be released. However, you understand that you are financially responsible for full-fee psychotherapy services at the time that you are seen.

If you would like Tyler Psychological Services, L.L.C. to bill your insurance provider for psychotherapy services, you are required to pay the deductible (if any), and co-pay/co-insurance in full at the time services are rendered.

If you would like to use an insurance provider for which our practice is not in- network, you agree to pay your full-fee at the time services are rendered. We will provide you with paperwork at the end of each calendar month for you to submit to your insurance provider. It is then the determination of your insurance provider if they will cover the services and the amount they will reimburse.

Please complete the insurance form on the following page

Client Information

Name of Client: _____

Is the client the primary policy holder (insured)?_____Yes____No

Insured Information

Name of Insured (policy holder):_____

Relationship to client: ___ parent ___ spouse ___life partner ___ other:_____

Home address of Insured: _____
Street Apt/Unit #

_____
City State Zip Code

Insured's date of birth: _____

Phone number of insured: Home_____ Cell_____

Insurance Information

Insurance Provider: _____

Policy ID #: _____ Group #: _____ Customer

Service # (on back of Insurance Card): _____

I give permission to Tyler Psychological Services, LLC, to release information deemed necessary by my insurance provider in order to receive payment for services. I also authorize my insurance carrier to directly pay my provider for services. My signature below indicates my understanding that this is not a guarantee of coverage or payment by my insurance provider and if at any time my insurance provider does not reimburse the contracted amount I am responsible for paying the full-fee for service(s). My payment portion is due at the time of service unless other arrangements have been made.

_____ _____
Client Signature Date

_____ _____
Witness Signature Date

Tyler Psychological Services

CREDIT CARD AUTHORIZATION FORM

Prior to receiving services, our office requests that you provide a credit card to have on file. This information will be used to reserve appointments and ensure payment in the event reimbursement is not made by an insurance company or otherwise. Please fill out the information below.

Credit Card Information

Credit Card Type: ____Visa ____ MasterCard ____ Discover ____ AmEx

Name as it appears on card: _____

Billing address:

_____

Street Apt/Unit #

_____

City State Zip

Credit Card Number: _____

Expiration Date: _____ CCV: _____

I hereby authorize Tyler Psychological Services, LLC to charge my credit card account for fees related to rendered services. These fees include, but are not limited to: copays/co-insurances, deductibles, services not covered by my insurance, and/or self-pay fees**. I understand that I will be able to provide payment through the method of my choice on current balances**; however, outstanding balances that are past due 30 days will be charged to the credit card on file, unless other arrangements have been made, and are subject to a $30 late fee.

This authorization is valid until I provide Tyler Psychological Services, LLC with a written notice of cancellation.

_____ _____

Client Signature Date

_____

Client Print Name

_____ _____

Witness Date

Tyler Psychological Services

Consent and Authorization to Use and Disclose Information

I, _____ (client's name), born on _____ (DOB), hereby authorize Tyler Psychological Services, L.L.C. to exchange information and records obtained in the course of my counseling with:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

Including the following information:

_____ Dates of Treatment _____ Treatment Recommendations _____Diagnosis/Assessment

_____ Treatment Plan _____ Progress Report/Client Status _____ Other: _____

For the Purpose of:

_____ Continuity/Coordination of Mental Health Treatment

_____ Case Management including reimbursement determinations and processing of benefit claims.

_____ Other (specify) _____

I understand that I may revoke this consent at any time by giving written notice to Tyler Psychological Services, L.L.C. I understand that my records and any information about me are protected under the Illinois Confidentiality Act (740 ILCS 110/1 et seq.) and cannot be disclosed without my written consent unless otherwise provided in the regulations. However, revocation will not be effective to the extent that action has been taken to reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer maintains a legal right to consent a claim. I understand that I have the right to inspect the disclosed mental health information at any time.

The consequences, if any, of not signing this release are: Information will not be exchanged.

This consent is valid until: _____.

Client's Name: _____

Client's Signature: _____ Date _____

Witness Name: _____

Witness's Signature: _____ Date _____