CLINIC NOTES

Robert H. Kammen, Psy.D.
250 Pierce Street, Suite 214
Kingston, PA 18704 (570) 718-1760

Name____

ROBERT H. KAMMEN, PSY.D.
LICENSED PSYCHOLOGIST
250 Pierce Street, Suite 214
Kingston, PA 18704
Telephone (570) 718-1760 Fax (570) 718-1763

CONSENT TO OBTAIN/RELEASE INFORMATION

I,____ (*date of birth*)____________________, hereby authorize

_________________Robert H. Kammen, Psy.D., Licensed Psychologist_________________to Release to: ____ Obtain from: ____

(*name and address of person, organization or facility*) ____

____

information from records pertinent to my mental health/mental retardation and/or drug/alcohol treatment for treatment rendered from

______________________________ to ______________________________. The information which may be released is limited to:

____Treatment Summary ____Discharge Summary ____Teacher Reports ____Psychological Evaluation

____School transcript (information needed for progress) _____Other________________________________

____I give my consent for the above parties to engage in professional conversations regarding my case.

These records are required for the specific purpose of coordination of treatment.

I understand the nature of this authorization to release/obtain information. I understand that my authorization shall remain in effect for the length of my participation in therapy in the office of Dr. Robert Kammen. I understand that I may revoke this authorization (except to the extent action has already been taken in reliance thereon or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim) at any time by written, dated communication to Robert H. Kammen, Psy.D.

I have also been informed of my rights – subject to section 5100.31, .33, .34 of the Pennsylvania Mental Health Procedures Act - to inspect the information to be released. Furthermore, I consent to the disclosure of information, if any, relating to my drug and alcohol abuse or dependency provided that disclosure is limited, pursuant to Section 8(c) of the Pennsylvania Drug and Alcohol Abuse Control Act of 1972, Federal Code of Regulations (42 CFR Part), and the HIV Related Information Act 148.

I understand that my psychologist generally may not make psychological services conditioned upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

____ ____________________
(Signature of Client/Patient) (Date)

____ ____________________
(Signature of Parent or Guardian IF MINOR UNDER 14) (Date)

____ ____________________
(Signature of Staff member Obtaining Consent) (Date)

Robert H. Kammen, Psy.D.
250 Pierce Street, Suite 214
Kingston, PA 18704
Phone (570) 718-1760

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

NOTICE OF PSYCHOLOGISTS' POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

PATIENT FILE COPY

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE INFORMATION IN THE PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT AND AGREE TO ABIDE BY ITS TERMS DURING OUR PROFESSIONAL RELATIONSHIP AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE NOTICE OF PSYCHOLOGISTS' POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION FORM DESCRIBED ABOVE.

______________________________ ______________________________
Signature Date

Rev. 06/01/2007

Robert H. Kammen, Psy.D.
Licensed Psychologist
250 Pierce Street, Suite 214
Kingston, PA 18704
Telephone (570) 718-1760 Fax (570) 718-1763

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Welcome to my independent psychology practice. Although I share office functions with Linda S. Keck, M.A., psychologist, our clinical practices are independent and separate. This document (the Agreement) contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. This document also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use, it is very important that you read it carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 45-50-minute session (one appointment hour of 45-50 minutes duration) every other week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. As noted on the original "Welcome" page you received, a $50 charge will be levied for second last minute cancellations/first no notice missed sessions; $75 for the next late cancel/missed session; $100 for any future last minute cancellation or missed session. At least twenty-four hour notice is necessary to reschedule a patient on my waiting list.

PROFESSIONAL FEES

My hourly fee is **$160** for our initial meeting and **$120** for each individual session and **$140** for each couple/family session. In addition to biweekly appointments, I charge this amount **($160**) for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than **10** minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time at least two weeks in advance in the form of a legal retainer. Legal services may include preparation and transportation costs for court, even if I am called to testify by another party. Other legal related services may include telephone consultations with attorneys, report preparation and letter and report writing. Because of the difficulty of legal involvement, I charge **$200** per hour for preparation and attendance at any legal proceeding, as well any legal related services you may request of me.

CONTACTING ME

Due to my schedule, I am often not immediately available by telephone. While I am usually in my office between 9 AM and 5 PM, I probably will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by my secretary (between 9am and 2pm) and voice mail at other times. I will make every effort to return your call within 24 hours of when you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. In case of an emergency where moments count, please call Helpline (at 829-1341 or 1-800-432-8007) or call 911 or proceed to the nearest emergency room. If you need to reach me on an urgent/emergent basis, the secretary or my voice mail message has my pager number. Please leave a brief message describing the urgent problem with the secretary or in my voice mailbox and then page me. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician, your psychiatrist, Helpline or go to the nearest emergency room. If I will be unavailable for an extended time, my secretary or voice mail will provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations

that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.
- If a patient seriously threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning the professional services I provided to you, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If I am treating a patient who files a worker's compensation claim, I may, upon appropriate request, be required to provide otherwise confidential information to your employer.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reason to believe that a child who I am evaluating or treating is an abused child, the law requires that I file a report with the appropriate government agency, usually the Department of Public Welfare. Once such a report is filed, I may be required to provide additional information.
- If I have reason to believe that an elderly person or other adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), the law allows me to report this to appropriate authorities, usually the Department of Aging, in the case of an elderly person. Once such a report is filed, I may be required to provide additional information.

- If I believe that one of my patients presents a specific and immediate threat of serious bodily injury regarding a specifically identified or a reasonably identifiable victim and he/she is likely to carry out the threat or intent, I may be required to take protective actions such as warning the potential victim, contacting the police, or initiating proceedings for hospitalization

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I may keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others or where information has been supplied to me by others confidentially, or the record makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge a copying fee per page (and charge for certain other expenses, as well) according to the guidelines in PA Act 26. If I refuse your request for access to your records, you have a right of review (except for information supplied to me confidentially by others) which I will discuss with you upon request.

In addition, I may also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed Authorization or a court order. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is often my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. I can also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. Time payment arrangements can be made in advance under certain circumstances. An interest charge of 1.5% monthly (18% APR) will be added to any balance which is over 30 days past due as well as a $5.00 billing service fee. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim. You will be charged a minimum of $25 for any returned checks given in payment.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health

services. If you have questions about the coverage, call your plan administrator. Of course, I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. “Managed Health Care” plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person’s usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above unless prohibited by contract.

YOUR SIGNATURE ON THE ATTACHED SIGNATURE PAGE 7 INDICATES THAT YOU HAVE READ THE INFORMATION IN THIS DOCUMENT AND AGREE TO ABIDE BY ITS TERMS DURING OUR PROFESSIONAL RELATIONSHIP AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

(Rev 09/08)

PENNSYLVANIA NOTICE FORM

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  – *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reasonable cause, on the basis of my professional judgment, to suspect abuse of children with whom I come into contact in my professional capacity, I am required by law to report this to the Pennsylvania Department of Public Welfare.

- **Adult and Domestic Abuse:** If I have reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), I may report such to the local agency which provides protective services.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services I provided you or the records thereof, such information is privileged under state law, and I will not release the information without your written consent, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** If you express a serious threat, or intent to kill or seriously injure an identified or readily identifiable person or group of people, and I determine that you are likely to carry out the threat, I must take reasonable measures to prevent harm. Reasonable measures may include directly advising the potential victim of the threat or intent.

- **Worker's Compensation:** If you file a worker's compensation claim, I will be required to file periodic reports with your employer, which shall include, where pertinent, history, diagnosis, treatment, and prognosis.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, I will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you in writing at our next scheduled session

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact Robert H. Kammen, Psy.D at 570-718-1760.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 10, 2003.

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice in writing at your next scheduled visit.

PLEASE READ THE FOLLOWING

1) "NOTICE OF PSYCHOLOGISTS' POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION" FORM

AND THE

2) " PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT"

THEN SIGN THE DETACHED PAGE 7 INDICATING YOU HAVE READ BOTH DOCUMENTS.

PLEASE RETURN ONLY THE *DETACHED* SIGNED PAGE 7 SIGNATURE PAGE TO THE OFFICE AND TAKE BOTH THE "PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT" AND THE "PRIVACY OF HEALTH INFORMATION" HOME WITH YOU FOR YOUR INFORMATION.

(Please note: You do not have to take the "Privacy of Health Information" document home if you have already received a copy from another provider - in this case, just return it to the office with the signed page 7 signature page.)

THANK YOU

MEDICATIONS

CLIENT NAME______________________________________ DATE _________________

****

1) Are you, or have you ever been, allergic to any medication? ___Yes ___No If Yes, please list:

____

____

2) Have you ever had an adverse reaction to any medication? ___Yes ___No If Yes, please explain:

____

____

3) Please list below any current medications you are taking:

PHYSICIAN	DATE	PRESCRIPTION	DOSAGE	PURPOSE

(9-23-05)

INTAKE FORM – ADULT

PATIENT'S NAME_______________________________________ BIRTHDATE_________________________

ADDRESS____ TELEPHONE_________________________

____ DATE______________________________

****

MARITAL STATUS (*Circle One*) Single Married Separated Divorced Widowed Cohabiting

Spouse/Significant Other's full name:____

Who lives with you? (Name, Age, Relationship)

_____________________ _____ __________ ______________________ _____ __________

_____________________ _____ __________ ______________________ _____ __________

_____________________ _____ __________ ______________________ _____ __________

Are there any other family members not in the home? Please list them.

____

List your parents' ages and health, or when and of what they died.

Mother:______________________________ Father:________________________________

Were you raised by your parents or others? Please explain:_____________________

____

MEDICAL HISTORY:

Do you have any major health problems (i.e., heart disease, diabetes, cancer)?

____

What medications do you currently take? (*Please complete separate "Medications" sheet – see next page.*)

Have you sustained any major illnesses/injuries or undergone any major surgery or hospitalizations? Please explain.

____

____

SOCIAL HISTORY:

What is the highest grade you have completed?___________________________________

Have you had any special vocational training?___________________________________

- Please continue on next page -

SOCIAL HISTORY(CONT'D):

Have you served in the military?____

What is your present job? Describe your satisfaction with it.

____

____

Please list some of your social interests, activities, and/or hobbies:

____

____

PSYCHOLOGICAL/PSYCHIATRIC HISTORY:

Have you received counseling or therapy before? Please explain.

____

____

Do any members of your family have a history of psychological, behavioral, or psychiatric problems or treatment? Please explain briefly.

____

____

What are your reasons for seeking psychological services at this time?

____

____

____

When did these problems begin?____

Are there any other things that you think we should know about as we begin to evaluate your need for psychological treatment?

____

____

____

(Thank you for taking the time before your appointment to complete this form in a thoughtful manner. We have found that it is helpful to us and to our clients.)

Robert H. Kammen, Psy.D.
Licensed Psychologist
PATIENT INFORMATION, INSURANCE & AUTHORIZATION FOR RELEASE
(Please print clearly)

Patient's Name____ Birth Date:________________ Sex: __M __F

Address___________________________________ City___________________ State_________ Zip__________

Home Phone______________________ Cell Phone_____________________ Work Phone__________________

Social Security Number__________________________ Marital Status: Single Married Divorced Widowed

Emergency Contact Name & Phone____

Referred by:______________________ Primary Care Physician & Phone:______________________________

Primary Health Insurance Copay: $	**Secondary Health Insurance Copay: $**
Insurance Company Name:	Insurance Company Name:
Address & Phone No.:	Address & Phone No.:
Behavioral Health Phone No.:	Behavioral Health Phone No.:
I.D. Number (Card):	I. D. Number (Card):
Group Number: Behavioral Health Authorization No. (if required):	Group Number: Behavioral Health Authorization No. (if required):
Subscriber's Name (Primary Insured):	Subscriber's Name (Primary Insured):
Subscriber's Birth Date & Relationship to Patient:	Subscriber's Birth Date & Relationship to Patient:

ACCIDENT? WORK AUTO SCHOOL (Please circle one) OR OTHER:______________________________

Accident happened where:________________________________ Time & Date:___________________________

Claim Number:_________________________________ Policy Number:_________________________________

Send Bills to:____

____

(Continued on next page)

PATIENT INFORMATION, INSURANCE, AND AUTHORIZATION FOR RELEASE (CONT'D):

I hereby assign all mental/behavioral health benefits to which I am entitled to Robert H. Kammen, Psy.D. for services rendered. This assignment shall remain in effect until revoked by me in writing. I authorize assignee to release all information necessary to secure payment of said benefits. A copy of this authorization may be used in place of the original. **Medicare Patients:** "I request that payment of authorized Medicare benefits be made either to me or on my behalf to Robert H. Kammen, Psy.D. for any services furnished to me by Robert H. Kammen, Psy.D. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service." I acknowledge that I am aware of and in agreement with the Privacy Policy of this practice.

I understand that I am financially responsible for all charges not covered by my health plan(s). Should this account go to collections for non-payment, I agree to pay any/all collection costs to secure payment of this account, including but not limited to interest charges and attorney fees.

Patient's or Guarantor's Signature:_____________________________ Date:_______________

Robert H. Kammen, Psy.D.
Licensed Psychologist
250 Pierce Street, Suite 214
Kingston, PA 18704
(570) 718-1760

WELCOME

I would like to take this opportunity to welcome you to my office. I look forward to a productive working relationship and sincerely hope that you will feel comfortable in working together with me and benefit from therapy. To that end, please read the important information in this packet.

I realize that everyone has a busy schedule and it is sometimes necessary to cancel an appointment. Unpredictable emergencies are understandable. When an appointment is made the time is reserved just for you and cannot be used by others who may need that time. I therefore ask that you respectfully give 24 HOURS ADVANCE NOTICE to reschedule if you are unable to keep an appointment so that I may have the time to arrange for someone else on our waiting list to benefit from therapy. IF YOU NEGLECT TO CANCEL WITHIN SUFFICIENT TIME, YOU WILL BE CHARGED A GRADUATED FEE FOR LAST MINUTE CANCELLATIONS OR MISSED SESSIONS: $50 – second last minute cancellation or 1st missed session; $75 for next late cancel/ missed session; $100 for any future last minute cancellation or missed session.

You are ultimately responsible for your account and for understanding your mental health insurance coverage. Even if you have insurance coverage, you may choose to pay out of pocket. If you do not present your insurance card for us to copy during the first visit, we will consider your account to be self-pay. In addition, if you choose to use your insurance, it is up to you to pay the co-payment amount or agreed upon fee AT THE TIME OF EACH VISIT. You may wish to make special arrangements; this must be done in advance.

I HAVE READ AND FULLY UNDERSTAND THE TERMS AND CONDITIONS OF CANCELING APPOINTMENTS AND MAKING PAYMENTS AT EACH SESSION.

SIGNATURE:____

DATE:____

(TO BE PLACED IN CLIENT'S FILE)

(Revised 7-29-05)