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Client Information

Primary Client Information:

Name: _____ Date of Birth: _____

Social Security Number: ____-____-_____ Marital Status: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Leave Message: (Y/N): _____

Cell Phone: _____ Leave Message: (Y/N): _____

Work Phone: _____ Leave Message: (Y/N): _____

Email Address: _____

Occupation: _____ Employer: _____

Partner/Spouse Information (If Applicable):

Partner/Spouse Name: _____

Cell Phone: _____ Leave Message: (Y/N): _____

Emergency Contact:

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Leave Message: (Y/N): _____

Relationship to Primary Client: _____

Referral:

How did you hear about Dayspring Behavioral Health?

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Responsible Party/Guardian (If the client is a minor):

Name: _____ Date of Birth: _____

Social Security Number: ____-____-_____ Relationship to Client: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Leave Message: (Y/N): _____

Insurance Information:

Insurance Company: _____

ID Number: _____ Group Number: _____

Plan Name: _____ Employer: _____

Address of Insurance: _____

Billing Information Guidelines:

- Payment for all service fees, as outlined in the *Informed Consent* document, are to be paid in full by the above-mentioned "Responsible Party" at the time of service
- A $50 fee will be charged for appointments that are cancelled less than 24 hours in advance and missed appointments will be charged up to the full fee
- DBH accepts cash, check, and most major credit & HSA cards

By Signing below, you indicate that you have read the "*Billing Information Guidelines*", and have been offered a copy of the agreement. The signature represents a binding agreement between Dayspring Behavioral Health and the Responsible Party.

_____ _____

Printed Name of Client Signature of Client

_____ _____

Printed Name Responsible Party/Guardian Signature Responsible Party/Guardian

Date: _____

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EVALUATION DISCLOSURE AND POLICY STATEMENT

Please read and sign!

These office policies are provided for your information. Please ask me if you have any questions.

General Standards: As a psychologist licensed by the state of Washington Board of Psychologist Examiners I subscribe to the APA Revised Ethical Principles. Although I am a Clinical Psychologist with the practice at *Dayspring Behavioral Health*, I am an independent practitioner and am solely responsible for the services I provide. I am not responsible or liable for the practices of any other practitioners in this office, nor are they responsible or liable for my practices.

Education and Training:

I have been involved in the evaluation and treatment of children and their families for over 11 years. Some of my experiences include:

- Founder/Director Dayspring Behavioral Health PLLC in 2012
- University of Washington Care Clinic Post Doctoral Internship Neurodevelopmental Disabilities 2011
- Center for Autism and Related Disorders Predoctoral Internship Evaluation and Treatment 2010
- Harborview Hospital Epilepsy Center Psychometrician
- Western Washington Medical Group Psychometrician
- Washington School of Professional Psychology Psy.D. Clinical Psychology 2012
- Pepperdine University MA Marriage and Family Therapy 2004

Confidentiality and Records:

This office is compliant with the privacy rules of the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Please see my separate "Notice of Privacy Practices" for detailed information regarding how I handle healthcare information collected about you in my practice. For clients under the age of 13 years of age who are not emancipated, the law may allow parents to examine their child's mental health records.

As you know, I share office space with a group of independent professionals. Although we share certain expenses and administrative functions, I am completely independent in providing you with clinical services and I alone am responsible for those services.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my client. The consultation is 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.

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 at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney. Please note that the confidentiality of email communication is not guaranteed to be secure. I will on occasion use

email (with your permission) to arrange for appointment scheduling or other communications, including delivery for final evaluations. If you do not wish for me to use email, please inform me directly and in writing.

Exceptions to Confidentiality:
There are some situations where I am permitted or legally required to disclose information without your consent or authorization:

- If a government agency is requesting the information for health oversight activities
- If you file a complaint or lawsuit against me, I am permitted to disclose information as relevant for my defense
- If you file a worker's compensation claim, and your psychotherapy or evaluation is relevant to the injury involved in your claim, if properly requested, I must provide a copy of your record to your employer and the Department of Labor and Industries
- If I have reasonable suspicion that a child has suffered abuse or neglect, the law requires that I file a report with the appropriate government agency
- If I have reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred, the law requires that I file a report with the appropriate government agency
- If I have reason to believe that you or someone else is in imminent danger, I may be required to take protective action, including notifying potential victims, contacting the police, seeking hospitalization for you, or contacting family members or others who can help provide for your protection
- I am required to report myself or another healthcare provider in the event of a final determination of unprofessional conduct, a determination of risk to patient safety due to a mental or physical condition, or if I have actual knowledge of unprofessional conduct. If you have any questions or concerns about this requirement, please talk with me about them.

Email Communication Agreement:
I understand that Dr. Amy Ford will use reasonable means to protect the security and confidentiality of email sent and received. However, these are known and unknown risks that may affect the privacy of personal healthcare information when using email to communicate. These risks include, but are not limited to:

- Email can be forwarded, printed, and stored in numerous paper and electronic forms and can be received by unintended recipients without my knowledge or agreement
- Email may be sent to the wrong address by any sender or receiver
- Email is easier to forge than handwritten or signed papers
- Copies of email may exist even after the sender or the receiver has deleted his or her copy
- Email service providers have a right to archive and inspect emails sent through their systems
- Email can be intercepted, altered, forwarded, or used without detection or authorization
- Email can spread computer viruses
- Email deliver is not guaranteed

By Signing below, you agree not to use email for emergencies or to send time sensitive information. It is also agreed that it is your responsibility to follow up with Dr. Amy Ford if you have not received a response to an email within a reasonable time period. By signing below, you give permission for Dr. Amy Ford to send email messages that include patient healthcare information and you acknowledge that you have read and understand the risks of

using email as stated above. If you wish to not use email or wish to stop using email as a means of communication, please request immediately in writing to Dr. Amy Ford.

Contacting Me/Emergencies:
You may have a confidential voicemail for me at my office at (425) 296-7697, 24 hours a day. My administrative staff checks the voicemail regularly and will make every effort to return your call within 24 hours (with the exception of weekends or holidays). If you are difficult to reach, please inform me of some times when you will be available.

If you cannot wait for me to return an urgent call, please call the Crisis Line at (206) 461-3222, go to the nearest emergency room, or dial 911. If I am gone for an extended period of time, I will arrange for a colleague to be available for urgent matters.

Billing and Payments:
You will be expected to pay for each session at the time of service, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. I currently am in-network with Premera Blue Cross, Lifewise, Regence, First Choice Health, and Aetna (subject to change, please verify with my office staff). In some cases there is specific testing that is considered "not medically necessary" by insurance companies and will not be covered by your plan policy.

It is very important that you contact your insurance company to determine if your policy covers either psychological or neuropsychological evaluations. In the event that the evaluation is conducted and is later found to be not covered, then the hourly rate ($190 per hour) will apply for all services rendered. Evaluations typically take 14-16 hours. All applicable copays will also be collected before each session. Payment schedules for other professional services will be agreed to when they are requested.

Professional Fees:
A complete neuropsychological or psychological evaluation is billed at $190 per hour, which includes all work performed in support of the evaluation, interview, consultation with other providers, review of pertinent documentation, 3-4 hour testing session, scoring/ interpretation of all tests, (1) 1 ½ hour feedback session, and completion of a written report. A complete neuropsychological evaluation typically takes about 14-18 hours to complete.

Education Consultation/Assessment: It should be noted that educational testing is typically not covered by insurance and will be billed separately (typically $400 to $600) and in addition to the fee for a complete neuropsychological or psychological evaluation.

Cognitive/Intellectual Assessment & Early Entrance to Kindergarten Screening: This is billed at $500, which includes the interview, review of pertinent documentation, administration of cognitive and intellectual testing, scoring, interpretation and completion of a written report.

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Appointments and Cancellations:
Your appointment time(s) is set-aside exclusively for you, and I cannot fill that time slot without sufficient notice. To cancel an appointment, please provide at least **48 hours notice**, or you will be billed at the hourly rate of $190 and hour for testing appointments or therapy sessions; the time that has been set aside for your child's session, unless we both agree that the appointment was unable to be kept due to circumstances beyond your control. If you will be arriving late to your appointment, please call my office as soon as possible so that I know you are coming and have not forgotten about the appointment. If you arrive late for an appointment, you will be billed for the full fee of your session. Please note that insurance companies will not provide reimbursement for late cancelled or missed appointments.

Other Professional Services:
Sometimes families seek services which are not covered by insurance, for example, attending school-based meetings or school observations. For these types of services I charge $190.00 an hour 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 attendance at meetings with other professionals you have authorized, program evaluations, and the time spent performing any other service you may request from me. If you request a classroom observation and/or home visit/evaluation the cost for drive time is equal to my hourly fee ($190).

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $500 per hour for preparation time, drive time, and attendance at any legal proceedings. A retainer of $3,000 is required prior to any participation in legal proceedings.

Delinquent Accounts:
If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, I retain the option of using legal means to secure the payment. This may involve hiring a collections agency or going through a small claims court. If such legal action is necessary, its costs will be included on the claim. In most collection situations, the only information I release regarding a client's treatment is his/her name, the nature of services provided, general contact information, and the amount due. These situations have rarely occurred within my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

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Credit Card on File Policy

Dayspring Behavioral Health is committed making our billing process as simple and easy as possible. We require that you provide a credit card on file with our office.

Credit Cards on file will be used to pay account balances after insurance adjudication.

- Once your insurance has processed your claims, they will send an Explanation of Benefits (EOB) to both you and our office showing what your total patient responsibility is. *You typically receive the EOB before we do, so if you disagree with the patient responsibility owed, it is your responsibility to contact your insurance carrier immediately.*
- When we receive the EOB, we will enter this information in our system. **If your total amount owed is $30 or less, we will process the payment on your card that day. If it is over $30, we will send you a statement at the end of the month showing your total responsibility (unless balances over $30 have been approved).** If you wish to give a different method of payment (cash or check), please call our office at (425) 295-7697 to make arrangements. You can also email our office manager Kelsey at kelsey@dayspringbh.com.
- **If we do not receive a payment for accounts over $30 two weeks after the statement date we will run the statement amount on the card on file (unless you have made other arrangements with our office).**
- If your payment is declined, we will call you to let you know on that next Monday.
- If we receive no response by Friday, a $35 declined payment will be applied to your account.

Notes:

- During the time you leave a card on file, if it expires or otherwise becomes uncollectable, we will expect you to promptly provide a new means of payment.
- Credits on your account after your insurance claims has been adjusted will be returned to the card on file or mailed as a reimbursement check.
- Should your credit card be mistakenly run, we will immediately issue a refund to your card.
- Ultimately, you are responsible for knowing what services are covered, how often, and how much of the cost is your responsibility. You will be responsible for any portion of services that your insurance does not cover.

Credit Card on File Authorization

I agree to place my credit card on file to be run by Dayspring Behavioral Health. I authorize their staff to run my credit card for the purposes stated above.

Name of guarantor as it appears on the card (print please): _____

Signature: _____ Date: _____

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Credit Card on File Policy

Dayspring Behavioral Health is committed to reducing waste and inefficiency through making our billing process as simple and easy as possible. We require that you provide a credit card on file with our office.

CARD HOLDER NAME: _____
(EXACTLY AS IT APPEARS ON CREDIT CARD)

CARD NUMBER: _____
EXPIRATION DATE: _____ **CV Code:** _____ **Billing Zip Code:** _____

I authorize **Dayspring Behavioral Health** to keep my signature on file and to charge my credit card for the patient responsibility.

CARD HOLDER SIGNATURE: _____DATE: _____

Credit Cards on file will be used to pay account balances:

- Credit cards will be charged at the time of service for your patient responsibility unless an alternate form of payment has been provided (cash or check).
- Out-of-network insurances will be charged the full rate at time of service. Your account will be credited and adjusted if insurance reimburses our office.
- We have a 3% convenience fee for debit/credit/HSA/FSA cards.
- If your card expires or otherwise becomes uncollectible, we will expect you to promptly provide a new means of payment.
- Ultimately, you are responsible for knowing what services are covered by your insurance company, how often, and how much of the cost is your responsibility. You will be responsible for any portion of services that your insurance does not cover.

Credit Card on File Authorization

I agree to place my credit card on file to be run by Dayspring Behavioral Health. I authorize their staff to run my credit card for the purposes stated above.

Name of guarantor as it appears on the card: _____
Signature: _____ Date: _____

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Informed Consent:

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

I have read the above and have had the opportunity to ask questions. I give permission for evaluation and treatment for myself (13 years or older).

Signature: _____ Date: _____

Name (Printed): _____

I have read the above and have had the opportunity to ask questions. I give permission for evaluation and treatment for my minor child (12 years of age or younger) and state that I am the parent or legal guardian for the child.

Signature: _____ Date: _____
Name (Printed): _____
Relationship to the client: _____

Signature: _____ Date: _____
Name (Printed): _____
Relationship to the client: _____

By signing below, I am giving consent for communication via (Circle all that apply):

Email Cell Phone Home Phone

Signature: _____ Date: _____

Name (Printed): _____

NOTICE OF PRIVACY PRACTICES

1700 NW Gilman Blvd, Suite 200, Issaquah WA 98027
www.dayspringbehavioralhealth.com
O: (425) 295-7697 | F: (818) 279-2296

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

Your health record contains personal information about you and your health. This information which may identify you and relates to your past, present, or future physical or mental health or condition and related healthcare services, is referred to as Protected Health Information (PHI). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this notice of Privacy Practices. I reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the reviewed Notice of Privacy Practices by sending out a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

For Treatment: Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your healthcare treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

I may leave a message for you regarding your appointment. I often leave messages on home answering machines or cell phone voicemails; if this creates a problem, please let me know. Privacy cannot be guaranteed with these devices.

For Payment: I may use or disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose a minimum amount of PHI necessary for purposes of collection.

For Health Care Operations: I may use or disclose, as needed, your PHI in order to support our business activities, including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business activities (e.g. billing or typing services) provided that I have a

written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes your PHI will be disclosed only with your authorization.

Required by Law: Under the law, I must make disclosures of your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Following is a list of categories of uses and disclosures permitted by HIPAA without an authorization.

- Abuse and Neglect
- Emergencies
- National Security
- Judicial and Administrative Proceedings
- Law Enforcement
- Public Safety (Duty to Warn)

Without authorization: Applicable law and ethical standards permits us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen the threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat

Verbal Permission: I may use or disclose your information to family members that are directly involved in your treatment with verbal permission.

With Authorization: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

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YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to Dr. Amy Ford, PsyD, at 1375 NW Mall Street, Suite 8, Issaquah WA 98027:

- **Right of Access to Inspect and Copy:** You have the right, which may be restricted to exceptional circumstances, to inspect and copy PHI that may be used to make decision about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that that access would cause serious harm to you. I may charge a reasonable, cost-based fee for copies.
- **Right to Amend:** If you feel that the PHI I have about you is incorrect or incomplete, you may ask us to amend the information, although I am not required to agree to the amendment.
- **Right to an Accounting Disclosure:** You have the right to request an accounting of certain copies of disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions:** You have the right to request a restriction or limitation on the use of disclosure of your PHI for treatment, payment, or healthcare operations. I am not required to agree to your request.
- **Right to Request Confidential Information:** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.
- **Right to Copy of this Notice:** You have the right to copy this notice.
- **Electronic Transactions Standards**

COMPLAINTS

If you believe that I have violated your privacy rights or your disagree with a decision that I make regarding access to your PHI or Progress Notes, you may contact the Examining Board of Psychology at (360) 236-4910 or by writing to them at P.O. Box 47869, Olympia WA 98504-7869. You may also send a written complaint to the Secretary of U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. **I will not in any way limit your care or take any actions against you if you file a complaint.**

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Receipt and Acknowledgement of Notice

Client Name: _____ Date of Birth: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Dr. Amy Ford's Privacy Practices. I understand that if I have any questions regarding the Notice of my privacy rights, I can contact Dr. Amy Ford at 1375 NW Mall Street, Suite 8, Issaquah WA 98027.

_____ Date: _____
Signature of Client

_____ Date: _____
Signature of Parent, Guardian, or Personal Representative*

_____
*If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____ Date: _____
Signature of Staff Member

NON-COVERED SERVICE WAIVER FORM

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There are items and services for which your health plan will not pay. Your health plan does not pay for all of your health care costs and only pays for covered benefits. When you or your dependent child receives a service that is not a covered benefit under your health plan (i.e. education or academic testing), you will be responsible for payment, personally or through any other insurance that you may have that covers the services rendered.

The purpose of this waiver is to help you make an informed choice about whether or not you want to receive these services, knowing that you will have to pay for them yourself. The fact that your health plan does not pay or provide coverage for a certain service does not mean that you should not receive it. There may be a good reason that your provider has recommended it.

Before you make a decision, you may want to contact your health plan to determine whether the recommended service is a covered benefit.

The anticipated cost of academic or educational testing is approximately $400.00 to $600.00 and is due at time of service, unless other arrangements are discussed and agreed upon.

By signing this waiver, I acknowledge that if the above referenced service (academic or educational testing) is deemed “Non-Covered” by my health plan, which includes determining that the service is “Not Medically Necessary”, I agree to be financially responsible for the full amount.

I have read the above and have had the opportunity to ask questions. I give permission and consent for additional academic or educational testing.

Signature: _____ Date: _____

Name (Printed): _____

Relationship to Client: _____