Registration form

Pharmacy name/number:	**PCP:**

Patient information

Last name: **First:** **Middle:**			☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ☐ Yes ☐ No	**If not, what is your legal name?**	**(Former name):**	**Birth date:** / /	**Age:**	**Sex:** ☐ M ☐ F
Street address:		**Apt. #:**	**Social Security #:**		
P.O. box:	**City:**		**State:**	**ZIP code:**	
Home phone #: ( ) -	**Work phone #:** ( ) -	**Cell phone #:** ( ) -	**Email address:**		
Occupation:	**Employer:**		**Employer phone #:** ( ) -		
Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Other	Languages spoken:				
Chose clinic because/referred to clinic by (please check one box): ☐ Family ☐ Friend ☐ Dr. ☐ Close to home/work ☐ Insurance plan ☐ Yellow pages ☐ Hospital ☐ Other					
Other family members seen here:					

Insurance information (Please give your insurance card to the receptionist.)

Person responsible for bill:	**Birth date:** / /	**Address (if different):**	**Home phone #:** ( ) -
Is this person a patient here? ☐ Yes ☐ No			
Employer:	**Employer address:**		**Employer phone #:** ( ) -
Is this patient covered by insurance? ☐ Yes ☐ No			
Please indicate primary insurance: ☐ Medicare ☐ BCBS ☐ Aetna ☐ UHC ☐ Cigna ☐ Lifewise ☐ HealthNet ☐ Arizona Foundation ☐ Great West ☐ Pacificare PPO ☐ Secure Horizons ☐ Other			

Subscriber's name:	**Subscriber's S.S. #:**	**Birth date:** / /	**Group #:**	**Policy #:**	**Copayment:** $
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other					
Name of secondary insurance (if applicable):		**Subscriber's name:**		**Group #:**	**Policy #:**
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other					

In case of emergency

Name of local friend or relative (not living at same address):	**Relationship to patient:**	**Home phone #:** ( ) -	**Work phone #:** ( ) -

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Optum or insurance company to release any information required to process my claims.

Signature: **Date:**

Optum

Financial policy

Thank you for choosing Optum as your health care provider. We are committed to providing quality medical care. In an effort to avoid confusion and misunderstanding, we have adopted the following financial policy and require you to read and sign it prior to the commencement of any treatment.

Insurance — all patients
Your insurance policy is a contract between you and your insurance plan. We cannot bill your insurance company unless you give us current and valid insurance information. As a courtesy to you, we will file claims for those plans with which we have an agreement. Please be advised that you are ultimately financially responsible for payment of medical services rendered by this clinic. All health plans are not the same, and they do not always cover the same services. In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge. Optum does not bill any third-party insurers. If you received services that are payable by a third-party insurer, you will be charged the appropriate amount from our standard fee schedule, and are responsible for payment at the time of service.

Non-insured patients
If you have insurance coverage with a plan with which we do not participate or you have no health insurance plan, our charges for your care and treatment are due at the time of service. We will, as a convenience to you, provide a prepared claim form to allow the patient to submit for reimbursement if desired. We offer a competitive cash fee schedule for our patients with no insurance.

Deductibles/copays
Our insurance contracts require us to collect deductibles and copays at the time of service.

Appointments
We strive to provide the best possible service and availability to all of our patients. Our policy is to charge for missed appointments unless canceled at least 24 hours in advance. Our no-show/late cancellation charge is $25. Please help us serve you better by keeping your scheduled appointments or by calling as early as possible to cancel.

Paperwork services
Any paperwork filled out by our providers such as short-term disability, or FMLA are subject to a $25 charge.

Medical record copies
Copies of medical records for personal use or for parties other than your insurance company or other physicians involved with your care are subject to a $25 charge.

Returned checks
All checks returned from the bank for non-payment are subject to a $25 charge.

Collection agency
Any account turned over to a collection agency is subject to a fee amounting to 30% of the total amount turned over.

This financial policy supersedes all prior written financial policies, contracts, or verbal agreements.

Patient name _____ **Date** _____

Assignment of benefits:

I request that payment of authorized insurance or medicare benefits be made to Optum for any services furnished me by the physician. I authorize any holder of medical information about me to release to the insurance company or to CMS (Centers for Medicare and Medicaid Services, formerly know as HCFA) and its agents any information needed to determine these benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges, whether or not paid by said insurance.**

Patient name **Date**

Acknowledgment of privacy practices and permission to leave messages

Patient name: _____ **Date of birth:** ___/___/_____

I acknowledge that I have received and/or reviewed a copy of Optum notice of privacy practices.

I give permission to communicate messages in the following manner:
☐ You may leave a message on my answering machine located at this number: (____) ____-_____
☐ You may leave a message on my cell phone: (____) ____-_____
☐ You may leave a message with my spouse, _____, at this number: (____) ____-_____
☐ You may leave a message with another person, _____, at this number: (____) ____-_____

I give permission to communicate messages about the following:
☐ Labs, X-rays and other test results
☐ Prescriptions
☐ Billing or insurance matters

_____ _____

Patient name **Date**

Authorization for the release of patient information

Provider or facility records are being requested from:

Provider/facility: _____

Address: _____

City, state, ZIP code: _____

Phone #: (____) ____-_____ **Fax #:** (____) ____-_____

RE: Patient name: _____ **DOB:** ___/___/_____

I authorize and request the disclosure of all protected information for the purpose of review and evaluation. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

- ☐ Complete medical record, meaning every page in my record
- ☐ Office notes, consult notes, operative reports and hospital records
- ☐ Labs including, but not limited to, blood chemistry, pathology and histology
- ☐ X-rays and other imaging reports
- ☐ Pharmacy and prescription records
- ☐ Billing records

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the purpose of: _____

You are authorized to release the above records to:

Name: _____

Address: _____

City, state, ZIP code: _____

Phone #: (____) ____-_____ **Fax #:** (____) ____-_____

I understand the following:

That I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization; that the information released in response to this authorization may be re-disclosed to other parties; and that my treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy, or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____ _____

Patient signature or legal representative **Date**

Optum behavioral health intake form – biographical information

Please fill out this biographical background form as completely as possible. It will help me in our work together. Information is confidential as outlined in the office policy form and the Health Insurance Portability and Accountability Act (HIPAA) notice of privacy practices. If you do not desire to answer any question, merely write, "Do not care to answer." Please print or write clearly and bring it with you to the first session.

Name: _____ **Gender:** _____ **Date:** ___/___/_____

Date of birth: ___/___/_____ **Place of birth:** _____ **Age:** _____

Address: _____

Home #: (____) ____-_____ **Cell #:** (____) ____-_____ **Work/office #:** (____) ____-_____ **Fax #:** (____) ____-_____

For routine messages, phone #: (____) ____-_____ **Email:** _____

For confidential/private messages, phone #: (____) ____-_____ **Email:** _____

Highest grade: _____ **Highest degree:** _____ **Type of degree:** _____

Person to call in emergency: _____ **Phone #:** (____) ____-_____

Referral source: _____

Occupation (former, if retired): _____

Presenting problem (be as specific as you can: When did it start? How does it affect you?):

_____

_____

_____

_____

_____

Estimate the severity of above problem: ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

Current marital status: _____ **Living with someone:** _____

Name: _____ **Years:** _____

Past and present marriage(s): **Name:** **Years together:**

_____

_____

_____

_____

_____

Present spouse/partner education: _____ **Occupation:** _____

Children/stepchildren/grandchildren (ages and brief statement on your relationship with the person)

_____

_____

_____

_____

_____

Siblings (name/age; if deceased, age and cause of death, and brief statement about the relationship):

Past/present drug/alcohol use/abuse (AA, NA, treatments):

Suicide attempt(s) or violent behavior (ages, reasons, circumstances, how, etc.):

Past/present psychotherapy:

If parents divorced, your age at the time: _____

Estimate how many hours per day you spend online (Facebook, YouTube, internet gaming, texting, browsing, etc.):

Facebook: ___ YouTube: ___ Gaming: ___ Texting: ___ Browsing: ___ Work/school: ___ Other: ___

Do you feel your technology use is balanced and healthy or could it use improvement? Please explain:

Family history of alcoholism, mental illness, or violence (including suicide, depression, hospitalizations in mental institutions, abuse, etc.):

Are you involved in any current or pending civil or criminal litigation(s), lawsuit(s) or divorce or custody dispute(s)?

Optum behavioral health

Informed consent for services and Health Insurance Portability and Accountability Act (HIPAA) privacy notice

Informed consent for services and HIPAA privacy notice

Welcome to Optum behavioral health. As an independent contractor for Optum behavioral health, my goal is to provide quality psychological services in a friendly, relaxed, personalized environment. We strive to help you accomplish your specific goals that will lead to improved quality of life and more fulfilling relationships. This agreement contains information about my services, business policies, and HIPAA. HIPAA is, a federal law that provides privacy protections and 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 and disclosure of PHI for treatment, payment and health care operations. The notice, which was given with this agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. When you sign this document, it will represent an agreement between us about our work together and that you have received HIPAA information. 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

Psychological services received from me can vary depending on the particular symptoms or concerns you may be experiencing. Services could include testing, assessment, evaluation or talking about and actively changing behaviors, thoughts or emotions. During our first couple of meetings, we will gather information and determine your specific needs. We will determine goals and a plan of action to accomplish the needed change. Periodically, we will discuss how things are progressing and if we need to re-adjust our plan of action. There will be times that you will be asked to read something or do certain activities between our meetings together. Psychotherapy can have benefits and risks. It can include discussing unpleasant aspects of your life and you may experience unpleasant feelings. If you are working on improving a relationship, it is possible that new insights may lead to dissolution of the relationship. However, if you come for couples counseling with the goal of improving the relationship, I will make every effort to support and further that process. Psychotherapy has also been shown to have benefits such as better relationships, solutions to specific problems, and a significant reduction in feelings of distress. But there is no guarantee of what you will experience. If you have any concerns about our work together, we should discuss them whenever they arise. If you would like a second opinion, I would be happy to help facilitate this process. In order to provide the best possible service to you, I may sometimes participate in consultation with other professionals about complex clinical issues. If clinical issues related to your case are discussed, any identifying information is omitted in order to protect your privacy.

Confidentiality

At Optum behavioral health, I am committed to protecting your privacy. I understand that therapy is most effective in a place that the client feels safe and secure in the knowledge that the thoughts and feelings they share will be respected and held in the utmost confidence. In general, the privacy of all communications between a client and psychologist are protected by law and can only be released to others with your permission. This confidentiality is only limited if you express an intent to hurt yourself or others, or a report of child or elder abuse. In these instances I am obligated legally and ethically to report these circumstances to appropriate individuals, authorities, and agencies.

Meetings
The frequency of our meetings could be twice a week, once a week, every two weeks, or once a month, depending on your specific treatment goals. After assessment, we will discuss and determine the frequency and length of our meetings. We require a 24-hour notice for cancellations so that we can re-schedule that time. Please see cancellation policy below.

Billing, payment, and insurance
Optum processes and administers all billing, payments and insurances for behavioral health services we provide. Please direct any questions in these regards to Optum.

Contacting Optum behavioral health
For specific clinical questions you may leave a message at Optum behavioral health. You may leave messages after hours. However, the phone and email address are not emergency lines of communication. If you are experiencing a life-threatening emergency or if you are unable to wait until I return your call, please call 911, go to the nearest hospital emergency room and/or contact your psychiatrist or family physician.

Professional records
Pursuant to HIPAA, I reserve the right to keep PHI in two sets of professional records. One set constitutes your clinical record. It may include 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 (if you have requested anything to be sent to your insurance). Except in unusual circumstances that involve danger to yourself and others or where information has been supplied to us by others confidentially, 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. For this reason, we recommend that you initially review them with your treatment provider, or have them forwarded to another mental health professional so you can discuss the contents. The exceptions to this policy are contained in the notice of privacy policy section. If I refuse your request for access to your records, you have a right of review, which will be discussed with you upon request. In addition, I may keep a set of psychotherapy notes. These notes are for our personal use and are designed to assist 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, our analysis of those conversations, and how they impact on your therapy. These psychotherapy notes are kept separate from your clinical record and are granted special protection under HIPAA. Insurance companies cannot require your authorization for release of psychotherapy notes as a condition of coverage nor penalize you in any way for your refusal.

Minors and parents
Clients under 18 years of age who are not emancipated need their parent's permission for psychological services. The law may allow parents to examine their child's treatment records. However, because privacy in psychotherapy is often crucial to successful progress, particularly with adolescents, it is sometimes our 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, 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. It is therapeutically beneficial for me to discuss with your child first any information given to the parents. I understand that as a parent, you are concerned and may want to know about the content of your child's discussions. It is our experience that a child will progress better in treatment if they know their parent will not know the specific content of the therapeutic discussions. Many times, this is not due to the child wanting to "keep secrets" from the parents, but due to the child being embarrassed, guilty, or otherwise lacking the communication skills. It is often beneficial to have parents or siblings join in on some therapy sessions. We expect parents to be open to this kind of participation if it is indicated for successful treatment.

Records and termination of practice

In the event of my voluntarily terminating the practice, current clients (seen within the past 2 months) will be notified. Optum behavioral health will maintain a professional telephone number for contacting me for a period of 3 to 6 months. I will post two notices in the newspaper (two weeks apart) regarding the closing of my practice and information on obtaining medical records. I will maintain the records in a secure location in the event of an untimely closing of practice due to death, disability, or disappearance. In one of these instances, you may contact a professional executor that will have been assigned for these purposes. If for some reason, you are unable to reach the professional executor, you may contact the Arizona Psychological Association or the Board of Psychologist Examiners who will instruct you on how to obtain your records.

Privacy policy to protect your health information

I. Uses and disclosures for treatment, payment, and health care operations

I may use or disclose your 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 health care. 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 such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

"Disclosure" applies to activities outside of my office 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, or 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 or 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, 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 —** I am required to report PHI to the appropriate authorities when I have reasonable grounds to believe that a minor is or has been the victim of neglect or physical and/or sexual abuse.
- **Adult and domestic abuse —** If I have the responsibility for the care of an incapacitated or vulnerable adult, I am required to disclose PHI when I have a reasonable basis to believe that abuse or neglect of the adult has occurred or that exploitation of the adult's property has occurred.
- **Health oversight activities —** If the Arizona Board of Psychological Examiners is conducting an investigation, then I am required to disclose PHI upon receipt of a subpoena from the Board.
- **Judicial and administrative proceedings —** If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legally appointed representative 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 communicate to me an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) and I believe you have the intent and ability to carry out such a threat, I have a duty to take reasonable precautions to prevent the harm from occurring, including disclosing information to the potential victim and the police and in order to initiate hospitalization procedures. If I believe there is an imminent risk that you will inflict serious harm on yourself, I may disclose information in order to protect you.
- **Workers' compensation —** I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

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. 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. On 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. 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 inform you and provide you with written documentation during our session at that time.

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 me to discuss your concerns. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I can provide you with the appropriate address upon request.

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VI. Cancellation policy

Dr. Stockman's Psychological and Behavioral Health Services are an important and integrated part of Optum. Because of the increased demand for his services, a waiting list has been established. As a courtesy to those waiting for appointments a cancellation policy is necessary. Dr. Stockman understands you may have to miss/cancel an appointment for whatever reason; so all you need to do is simply give the office a call to cancel and reschedule. A 24-hour notice for cancellation is required for a scheduled therapy session. This is to allow the time to offer the appointment to another patient who may be on a cancellation list waiting for an appointment. A $50 fee will be charged for non-attendance or less than 24 hours notice of cancellation. As a reminder most insurance companies will not pay for missed or canceled appointments. Please understand that Dr. Stockman holds your scheduled appointment time specifically for you and you alone. He is able to see a limited number of patients so that he can give you the focus and attention you deserve. In the case of emergencies and other exceptional circumstances that prevent you from calling 24 hours in advance, please discuss with Dr. Stockman.

Signing below indicates you understand and agree to the terms of this policy.

VII. Effective date, restrictions, and changes to privacy policy

This notice is effective immediately.

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 written notice during our session.

Patient acknowledgment

I or we (both names if a couple), _____, have read this **informed consent agreement** and **policy to protect the privacy of my health information** and **cancellation policy** and have received a copy. I agree to abide by the agreement for services.

Signature of patient or legal guardian	**Date**
Signature of patient or legal guardian	**Date**

Optum