River Valley Psychology, PLLC
Melanie Cooke, LCSW
3101 West 2nd Ct · Russellville, AR · 72801 P 479.567.5654 F 479.567.5661

Patient Information for Minor Child

Parent Information

Date: _____

Are you the custodial parent? Yes No If not, name of custodial parent: _____

Name: _____ Date of Birth: _____ SSN:_____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

OK to leave a message? _____ OK to leave a message? _____ OK to leave a message? _____

Address: _____ City/Zip: _____

Referred by: _____

Spouse's Name: _____

Marital Status of Parents: _____ Date divorced/separated, if applicable: _____ Are both parents living? Yes No

If no, date of death? _____ Which parent? _____

Please indicate any recent family stressors (financial, births, deaths, marital conflicts, etc.): _____

_____

_____

Patient Information

Name: _____ Date of Birth: _____

Address: _____ City/Zip: _____

Grade: _____ School: _____ Teacher: _____

Is your child currently under a doctor's care for any medical problems? Yes No

If yes, please describe: _____

Has your child had any previous psychological treatment or evaluation? Yes No

If yes, please describe: _____

What have you told/or plan to tell your child about coming to this office?

_____

What are his/her feelings about coming?

_____

Please list a few of your child's strengths/assets:

_____

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Patient Information

Please check any of the following concerns that apply to your child.

___ Sleep Problems

___ Guilt

___Energy Level

___Elation

___Memory

___Aggression

___Toileting concerns

___Irritability

___Poor judgement

___Loss of enjoyment of activities

___Compulsive behavior

___Alcohol/substance abuse

___Excessive shyness

___Racing heart/Difficulty breathing

___Eating Problems

___Fears of dying or going crazy

___Academic problems

___Poor social skills

___Sadness

___Hopelessness

___Self-injury

___Increased talking

___Defiance to authority

___Temper tantrums

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Patient Information

Last Name:_____ First Name: _____ MI: _____
Address:_____ City/State:_____ Zip: _____
Phone (C): _____ Phone (H): _____ SSN: _____
Can we leave a msg? ○ Yes ○ No Can we leave a msg? ○ Yes ○ No
Date of Birth:_____ Sex: ○ Female ○ Male ○ Other

Emergency Contact Information

Name:_____ Relationship:_____ Phone:_____

Primary Insurance Information

○ NO INSURANCE / PRIVATE PAY

Patient's relationship to Policy Holder: ○ Self ○ Spouse ○ Child ○ Step-Child ○ Other
Insurance Company:_____ Insurance Phone:_____
Policy Holder Name (First, Last, MI) :_____
Date of Birth:_____ Policy Holder Phone Number: _____
Policy Holder Address:_____ City/State:_____ Zip:_____
ID /Policy#:_____ Group #:_____
Employer:_____

Secondary Insurance Information (ALL insurances must be disclosed.)

○ NO SECONDARY INSURANCE

Patient's relationship to Policy Holder: ○ Self ○ Spouse ○ Child ○ Step-Child ○ Other
Insurance Company:_____ Insurance Phone:_____
Policy Holder Name (First, Last, MI): _____
Date of Birth:_____ Policy Holder Phone Number: _____
Policy Holder Address:_____ City/State:_____ Zip:_____
ID /Policy#:_____ Group #:_____
Employer:_____

Person Responsible for Payment

○ Patient ○ Parent ○ Other

Name:_____ Date of Birth:_____ Relationship:_____
Phone:_____ Address:_____ City/State/Zip:_____

Authorization for Insurance Payment

My signature below Indicates that I agree to authorize payment of insurance benefits to the service provider, authorize the release of any information necessary to process insurance claims, and accept payment responsibility of the portion of the bill which Insurance does not cover.

Patient / Custodial Parent / Guardian Signature: _____ Date: _____

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INFORMED CONSENT TO TREAT

I understand there are risks, varying lengths and methods of treatment, as well as possible consequences of the decided treatment.

1. I understand that this mental health provider does not provide emergency service and I will be informed of whom/where to call in an emergency or during the evening or weekend hours.
2. I understand that regular attendance will produce the maximum possible benefits but that I am free to discontinue treatment at any time in accordance with office policies.
3. I understand that I am financially responsible for any portion of the fees not covered or reimbursed by my health insurance.
4. I have been informed and understand the limits of confidentiality, that by law, the therapist must report to appropriate authorities any suspected child abuse or serious threat of harm to myself or another person.
5. I am not aware of any reason why I should not proceed with therapy/treatment and I agree to participate fully and voluntarily.
6. While I expect benefits from this treatment I fully understand and accept that because of factors beyond our control, such benefits and desired outcomes cannot be guaranteed.

This provider practices with an association of independently practicing professionals which share certain expenses and administrative functions under the name River Valley Psychology, PLLC. While they share office space, this provider is a completely independent professional rendering clinical services and is fully responsible for those services. Clinical records are separately maintained and other professionals cannot have access to them without your specific written permission.

If you have any questions regarding this policy, please discuss these with this provider as soon as possible. Your signature on our patient form indicates consent for psychological treatment and indicates that you have read the above statement and agree to the above terms. Your commitment to this process and your assistance in understanding these necessary policies are an important part of your care.

_____	_____	_____
Patient Name	Signature (Patient or Minor's Custodial Parent/Guardian)	Date

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Limits of Patient Confidentiality

Mental Health Providers have a legal obligation or duty to maintain the confidentiality of their communications with their patients. There are exceptions, however, to this right of confidentiality. These include the following:

- You are a danger to yourself or others.
- Child abuse is disclosed or suspected.
- Elder abuse is disclosed or suspected.
- You are the victim of a crime or suspected abuse.
- You file suit against your therapist for breach of duty or your therapist files suit against you.
- You have filed suit against anyone and have claimed mental/emotional damages as part of the suit.
- Your insurance company paying for services has the right to review all records.

If you have any questions about these limitations, please discuss them with your therapist.

I am consenting to receiving outpatient treatment and understand my legal right to confidence and the aforementioned exceptions.

_____	_____	_____
Patient Name	Signature (Patient or Minor's Custodial Parent/Guardian)	Date

Appointment Reminders

As a courtesy to our patients we offer appointment reminders before each scheduled appointment. Please mark below your preferred method to receive appointment reminders and the best phone number for these.

____ I would prefer appointment reminders by phone call
____ I would prefer appointment reminders by text
____ I prefer to not receive appointment reminders

Phone number appointment reminders should be sent to: _____

Please remember that appointment reminders are sent as a courtesy and cancellation fees will apply to any appointments not canceled 24 hours prior to the appointment per our office's Cancellation/No Show Policy, with the exception of mutually agreed upon emergencies whether or not a reminder is sent.

_____	_____	_____
Patient Name	Signature (Patient or Minor's Custodial Parent/Guardian)	Date

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Authorization to Contact

Patient Name: _____ Patient Date of Birth: _____

Acknowledgement of Receipt of Privacy Practices

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the notice may be changed at any time and that I may obtain a revised copy of the notice at the clinic location where I receive healthcare services.

Patient / Custodial Parent / Guardian Signature:_____ Date: _____

If you are not the patient fill out the following information:
Name:_____ Relationship to Patient: _____
Address:_____ City/State/Zip:_____
Phone: _____

Release of Information for Referring Provider

I authorize Melanie Cooke, LCSW to contact or confirm with, the referring provider, _____, an appointment made for follow-up, as well as general information pertaining to psychological and emotional function if indicated. I understand detailed clinical information will not be released without my written consent.

○ DECLINE ○ N/A

Patient / Custodial Parent / Guardian Signature:_____ Date: _____

Email Authorization

By providing my email address below, I hereby agree to allow Melanie Cooke, LCSW/River Valley Psychology, PLLC to contact me by email regarding myself or my child and understand information can only be shared within the rules of the organization's privacy practices.

Email Address:_____ @ _____ ○ DECLINE

Patient / Custodial Parent / Guardian Signature:_____ Date: _____

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Notice of Privacy Practices

River Valley Psychology, PLLC and its employees collect information through a variety of means and this notice describes how your medical information may be used and disclosed, as well as, how you can obtain access to this information.

HIPAA and Your Health Information: River Valley Psychology, PLLC is dedicated to protecting your medical information. Due to "HIPAA Privacy Rule," a federal regulation, we are required to provide you written notice of the privacy practices. Your Protected Health Information (PHI) is information that identifies you. It is information that relates to your past, present, and/or future health or condition, the provision of healthcare to you, or information related to payments for the healthcare. By law, our office/providers are required to maintain the privacy of your PHI and provide you notice of when, how, and why this information may be disclosed. We are also required by law to follow the privacy practices described in this notice as well as notify you following a breach of your unsecured PHI. Our office/providers reserve the right to make changes to the privacy practices and terms of this notice at any time. If any changes are made, these changes will apply to all PHI in our possession. If such changes are made, notices will be posted in the office and we will have revised notices available. We are happy to provide you with a copy of the revised notice upon your request.

Who Will Follow This Notice

This notice describes our office's practices regarding the use of your medical information and that of:

- Any healthcare professional authorized to enter information into your medical chart or medical record, including without limitation, mental health providers, technicians, and psychologists.
- All employees, staff and other personnel who may need access to your information.

How Your PHI May Be Used and Disclosed

Treatment, Healthcare Operations and Payment: As described below, our office will use or disclose your PHI for treatment, payment, or healthcare operations. The examples below do not list every possible use or disclosure in a category.

Treatment: Your PHI may be used and disclosed to other healthcare providers in order to provide, coordinate, and manage your healthcare and related services. Our providers may consult with other healthcare providers regarding your treatment, or send a letter or report to other healthcare providers to coordinate care as needed.

Healthcare Operations: Your PHI may be used in performing certain business activities which are called healthcare operations. Some examples of these operations include our business, accounting, and managements activities. These healthcare operations also may include quality assurance, utilization review, and internal auditing, such as auditing and reviewing and evaluating the skills, qualifications, and performance of healthcare providers taking care of you and other patients and providing training programs to help students develop or improve their skills. If another healthcare provider, company, or health plan that is required to comply with the HIPAA Privacy Rule has or once had a relationship with you, we may disclose PHI about you for certain healthcare operations of that healthcare provider or company.

Payment/Insurance: Your PHI may be used and disclosed in order to bill and collect payment for the services you receive. Specifically, we may release specific medical information to your health insurance company in order to determine whether treatment is covered under your policy or to send your insurance company a bill for services you have received. When necessary, your PHI may also be used for billing, claims management, and collection activities. Your PHI may also be released to a company or health plan required to comply with HIPAA Privacy Rule for the payment activities of that company or health plan. For instance, one may allow a health insurance company to review PHI relating to their enrollees to determine the insurance benefits to be paid for their enrollee's care.

Communications with Our Office: Our office may use or disclose your medical information in order to remind you of your appointment or inform you about health related benefits or services that may be of interest to you.

Communication with Friends or Family Within Your Consent or Do Not Object: Your PHI may be disclosed to relatives, close friends, or others you identify if the PHI is directly related to that person's involvement in your care or payment for your care. With the exception of emergencies, our providers will notify you of the intention to release information and provide you an opportunity, at that time, to object. However, if you are not present or are unable to agree or object to the disclosure, clinical judgment will be used to determine if the disclosure is in your best interest. In the case of a disaster or emergency situation, our office/providers may also use and disclose your health information for the purpose of locating and informing organizations involved, your relatives or close personal friends of your location, general condition, or death.

Other Uses Authorized by HIPAA Privacy Rule

When disclosures comply with our providers ethical requirements and professional confidentiality requirements, our office/providers may use and disclose PHI about you in the following circumstances, provided that we comply with certain legal conditions set forth in the HIPAA Privacy Rule:

Required by Law: PHI may be used and disclosed as required by federal state, or local law if the disclosure complies with the law and is limited to the requirements of the law.

Public Health Activities: Under specific circumstances, your PHI may be used and disclosed to public health authorities or authorized persons to carry out certain activities related to public health.

Abuse, Neglect, or Domestic Violence: Our providers may disclose PHI to proper government authorities if they reasonably believe that a patient has been a victim of domestic violence, abuse, or neglect.

Health Oversight: PHI may be disclosed to a health oversight agency for; audits, investigations, inspections, licensure and disciplinary activities, and other activities to monitor the healthcare system, government healthcare programs, and compliance with certain laws.

Legal Proceedings: As required by a court or administrative tribunal order or in compliance with state law, our office/providers may also disclose PHI. Your medical information may also be released in response to subpoenas, discovery requests or other legal process after receiving satisfactory assurance that efforts have been made to advise you of the request or to obtain an order protecting the information requested.

Law Enforcement: If authorized by law, your PHI may be used or disclosed under specific conditions to law enforcement.

Threat to Health or Safety: In specific and limited situations, your PHI may be disclosed if the disclosure is believed to be necessary in preventing a serious and imminent threat to the health or safety of an individual or to the public.

Compliance Review: If requested to review our office's compliance with HIPAA Privacy Rule, we are required to release PHI to the Secretary of the United States Department of Health and Human Services.

Worker's Compensation: When requested, your PHI may be released in order to comply with laws relating to workers' compensation or other similar programs.

Emergencies: Your PHI may be used or disclosed in an emergency treatment situation in compliance with applicable laws and regulations.

Written Consent: All other uses and disclosures of your PHI will be made only with your written authorization. You may revoke your authorization at any time to the extent we have taken action based on the authorization.

Psychotherapy Notes: A separate and specific authorization is required before we release your Psychotherapy Notes. Psychotherapy Notes are notes kept regarding specific conversations or impressions during a private, group, joint or family counseling session, which are kept separate from the rest of your medical record. These notes are given a greater degree of protections than PHI. In some cases, it is not appropriate for Psychotherapy Notes to be disclosed to anyone and in such a case we may decline to disclose them.

Alcohol and drug abuse prevention, treatment and referral notes: We will not share any substance abuse treatment records without your written permission.

Your Individual Rights Regarding Your PHI

Rights to Request Restrictions: You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or healthcare operations, or that we disclose to those who may be involved in your care or payment for your care. While your requests will be carefully considered, we are not required to agree to it. If we agree to your request, we will comply with your request except as required by law or for emergency treatment. To request restrictions, you must make your request in writing and submit to our Office Manager.

Right to Receive Confidential Communications: You have the right to request that you receive communications regarding your PHI in a certain manner and/or location. For instance, you may request we contact you at home, rather than at work. This request may be completed on the initial paperwork, or may be revised with written request.

Right to Inspect and Copy: You have the right to inspect and receive a copy of your PHI contained in records our office/providers maintain that may be used to make decisions about your care. These records usually include your medical and billing records but do not include psychotherapy notes; information gathered or prepared for a civil, criminal or administrative proceeding; or PHI that is subject to law that prohibits access. To inspect and copy your PHI, please contact our Office Manager at the address at the top of the first page of this Notice or at 479-567-5654. If you request a copy of the PHI about you, our office may charge you a reasonable fee for the copying, postage, labor, and supplies used in meeting your request. We may deny your request to inspect and copy PHI only under limited circumstances, and in some cases, a denial of access may be reviewable.

Right to Amend: If you feel that medical information our office/providers have about you is incorrect or incomplete, you may ask me to amend the information for as long as such information is kept by or for our office/providers. You must submit your request to amend in writing to the Office Manager and give a reason for your request. Our providers may deny your request in certain cases. If your request is denied, you may submit a written statement disagreeing with the denial, which we will keep on file and distributed with all future disclosure of the information to which it relates.

Right to Receive an Accounting of Disclosures: You have the right to request a list of certain disclosures of PHI made by our office/providers during a specified period of time. If you wish to make such a request, please contact our Office Manager. The first accounting that you request in a 12-month period will be free, but our office may charge you for reasonable costs for providing additional lists in the same 12-month period. Our office will tell you about these costs, and you may choose to cancel your request at any time before costs are incurred.

Right to a Paper Copy of this Notice: You have a right to receive a paper copy of this notice at any time. To obtain a paper copy of this notice, please contact our Office Manager at 479-567-5654 or at the address listed at the top of the first page of this notice.

Right to Choose someone to act for you: You may name another individual to act as your personal representative. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action

Actions You May Take Regarding Your PHI

Complaints: If you believe your privacy rights have been violated, you may file a complaint with this office, or with the Secretary of the United States Department of Health and Human Services. To file a complaint with this office, please contact the Office Manager at 479-567-5654 or at the address listed at the top of the first page of this notice. You can also file a complaint with the U.S. Department of Health and Human Services office for Civil Rights by sending a letter to 200 Independence Avenue, S.W. Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not take action against you or retaliate against you in any way for filing a complaint.

Contact Us: If you have any questions or need additional information about this notice or your PHI please contact our Office Manager at 479-567-5654 or at the address listed at the top of the first page of this notice.

Effective Date: These privacy practices were last updated May 25th, 2017 and will remain in effect until we revise them as permitted or required by law.

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Release to Discuss Financial Information

We cannot share information about your financial account with anyone unless we have your written consent. Exceptions to this are biological parents of a minor child, legal guardians of adults, or anyone listed below.

I hereby authorize the provider and/or staff to disclose financial information with the following person(s):

○ DECLINE

Name:_____ Relationship to Patient: _____
Address:_____ City/State/Zip:_____
Phone: _____

Name:_____ Relationship to Patient: _____
Address:_____ City/State/Zip:_____
Phone: _____

Patient / Custodial Parent / Guardian Signature:_____ Date: _____

Patient Responsibility for Litigation

I understand that I have contracted for psychiatric services with Melanie Cooke, LCSW. and that I alone am responsible for paying the amount that is billed for services. In particular,

1. Due to complexity and difficulty of legal involvement, Melanie Cooke, LCSW. charges $300.00 per hour for preparation and attendance at any legal proceedings.
2. Court appearances are charged in 4-hour increments (e.g., 8:00 am to 12:00 pm or 1:00 pm to 5:00 pm. at $1,200 per half day). These charges apply regardless of whether testimony is given.
3. Payment will be required in full by 5:00 pm 3 business days prior to the scheduled court proceedings. In the event that the case is settled or less time is required, the excess amount paid will be promptly refunded.
4. We cannot bill your insurance company for any charges related to litigation.
5. By signing below, I acknowledge that the provider is not obligated to provide expert witness testimony or opinion in any court proceeding and shall only serve as a fact witness.
6. If a third party such as your attorney, is responsible for the fees incurred it is your responsibility to ensure payment. If the third party, even if contractually obligated to pay does not pay the patient or designated person responsible for payment will be responsible for the full balance plus any additional fees incurred if the account is turned over to collections for payment.

    a. If a third party is responsible for payment the obligations must be in writing, signed and preserved.
    b. Payment will be required in full by 5:00 pm 3 business days prior to the scheduled court proceedings.

Patient/Custodial Parent/Guardian Signature: _____ Date: _____

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Patient Responsibility

I understand that I have contracted services with Melanie Cooke, LCSW and that I alone am responsible for paying the amount that is billed for services. In particular,

1. I understand that River Valley Psychology, PLLC provides insurance filing as a courtesy and convenience to me and/or will seek authorizations from my health care provider; however, these activities do not guarantee that my insurer will pay. I understand that at any time I am free to file my own insurance, in which case full payment of fees will be required at the time of service.

2. I understands that the business office will attempt to help me understand my insurance or managed care benefits and procedures, but that denial of benefits by my insurer means that I am fully responsible for the contracted amount.

3. I understand that I am responsible for meeting the requirements of my health insurer or managed care provider. In particular, I am responsible for:

    - Obtaining the initial referral to the provider, if needed.
    - Ensuring I have pre-certification of visits, if needed.
    - Knowing limits regarding my deductible.
    - Keeping track of benefit limits. Keeping track of my benefits entails knowing any limits on my policy and ensuring that I do not exceed those limits (e.g., some insurers set a maximum of 20 mental health sessions per year). If I exceed my limits and my insurer refuses to pay, I will be responsible for the amount refused. Also, I understand that if I am seeing another social worker, psychologist, or psychiatrist, those sessions may count against my mental health benefits. I also realize that while my managed care provider may authorize visits as appropriate for me, that does not mean that they will necessarily pay for those visits (e.g., some insurers will authorize 35 visits, but they will only pay for 30 visits.)

4. I understand that if my policy changes or if I switch insurance companies, I should inform the office immediately. If the office does not have proper information and cannot collect payment from the insurer, I am responsible for the amount the insurance company will not pay.

5. I also understand that in the instance of my account getting turned over to collections, I am responsible for the entire bill *plus* 100% of the collection fees.

6. I understand that insurance cannot be billed to pay for missed appointments or for time I am not in attendance at my appointment, and I am responsible for any and all fees accrued as outlined in the Cancellation / No Show / Late Fee Agreement.

Patient Name	Signature (Patient or Minor's Custodial Parent/Guardian)	Date

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Cancellation / No Show / Late Fee Agreement

I understand that I have contracted services with Melanie Cooke, LCSW and that I alone am responsible for paying the amount that is billed for services. In particular,

1. I understand that a **Cancellation Fee of $80.00** will be charged per scheduled hour if I do not show or call to cancel an appointment at least 1 Business Day in advance *(Monday - Thursday, 8:00 am to 5:00 pm), **with the exception of mutually agreed upon emergencies.***

**For a 4-hour testing appointment this fee would be applied per hour as $80 per hour x 4 hours= $320.00*

2. I understand that a **Late Fee** will be charged if I arrive late to an appointment or if I am late to pick up my dependent after their appointment, ***with the exception of mutually agreed upon emergencies***. In particular, I understand fees will be charged as follows:

   - If I arrive late to an appointment, *a Late Fee of **$25.00*** will be charged for every 15 minutes I am late to the appointment.

   - If my tardiness exceeds 20 minutes, I will be required to reschedule my appointment. I also understand that tardiness exceeding 20 minutes is considered an untimely cancellation and *will **be processed using the Cancellation Fee guidelines with the exception of mutually agreed upon emergencies.***

   - If I am late to pick up my dependent, *a Late Fee of **$25.00** will be charged per 15 minutes.*

3. I understand that I am responsible for payment of my cancellation and late fees, as my insurance cannot be billed to pay for fees associated with time I am not in attendance at my appointment.

_____	_____	_____
Patient Name	Signature (Patient or Minor's Custodial Parent/Guardian)	Date