Heather Smith, Ph.D., LLC
757-502-8992

PATIENT REGISTRATION

NAME _____ DOB _____

ADDRESS _____

TOWN _____ STATE _____ ZIP _____

HOME NUMBER _____ CELL _____
Is it ok to text to the cell number? _____

If patient is a Minor: PARENT/GUARDIAN _____
ADDRESS (if different from patient)
_____

Parent cell number: _____
Is it ok to text to the cell number: _____

EMERGENCY CONTACT _____

RELATIONSHIP _____ PHONE NUMBER _____

INSURANCE CARRIER: _____ Policy #_____

Group # _____ Member ID:_____

Subscriber's Name _____ Subscriber's DOB _____

Subscriber's social security number _____ Relationship to patient _____

Deductible _____ Copay _____

Secondary Insurance _____ Policy # _____

Group # _____ Member ID:_____

Subscriber's Name _____ Subscriber's DOB _____

Subscriber's social security number _____ Relationship to patient _____

Deductible _____ Copay _____

I understand that my sessions are confidential. However, legal and ethical guidelines mandate that if I express an intention to harm myself, harm another, or commit a crime, such information will be conveyed to the appropriate person.

I understand that I am responsible for canceling my scheduled appointment at least 24 hours prior to my appointment, else I will be charged for the session.

I understand that I am responsible for payment at each session. I am also responsible for all billing fees (including interest, collection costs, and attorney fees) if I do not pay my expenses at the time of the session.

I authorize the release of medial information necessary to process a claim I file.

I agree to pay for additional services I may request (telephone consultation, letters, attendance at meetings, etc.) at the regular hourly rate.

I have read/ received a copy of Heather Smith, Ph.D., LLC Notice of Privacy Practices. The above information is true to the best of my knowledge.

_____ _____

Patient Date

_____ _____

Parent/ Guardian Date

Current medications

MEDICATION	REASON TAKEN	AMOUNT

Previous medications

Health problems

_____

Family history of mental illness (ie, depression, anxiety, alcoholism, etc)

FAMILY MEMBER	ILLNESS

HISTORY OF ABUSE: sexual physical emotional substances

PREVIOUS THERAPY (include date, reason, and provider)

_____

REASON FOR TODAY'S VISIT

_____
_____
_____

PAYMENT CONSENT

I agree to pay for sessions/ services from Heather Smith, Ph.D., LLC using one of the following options:
Please i**nitial** your choice

_____ I agree to pay for each session/ service at the beginning of the appointment using cash or credit card

_____ I will be using my insurance to pay for sessions and understand that I am responsible for the copay, as well as my deductible, if applicable. I understand that should my insurance coverage terminate during therapy, I am responsible for notifying Dr. Smith. I am also responsible for full payment should I not have or if I chose not to use my insurance coverage.

In order to minimize time during your session spent on payment, you may put a credit card on file. This card will be utilized for your copays, non-covered sessions, missed appointments, or sessions held prior to your deductible being met. A $5.00 billing fee applies to each charge.

You may pay with an alternative card, payment service, or cash at any session.

Please complete the following information to authorize Dr. Smith, Ph.D., LLC to charge the credit card on file.

_____ _____
Name as it appears on the card Type of card

_____ _____/_____
Card number Expiration

_____ _____
Security code Billing zip code

_____ _____
Patient / Parent or Guardian Signature Date

Financial Policy ~ Heather Smith, Ph.D., LLC

APPOINTMENT POLICY: **MISSED or CANCELED** appointments will be charged at the full fee unless 24 business hours notice is given. Insurance carriers do not cover missed or canceled appointments.

Insurance Benefits: Every effort will be made to work with you and your insurance company(ies), but remember your insurance policy is a contract between you and your insurance carrier, and not between your insurance company and Dr. Smith. If for any reason your insurance policy does not pay, or IF YOU FAIL TO ADVISE US OF ANY CHANGES IN YOUR INSURANCE COVERAGE, you are responsible for the remaining balance.

Please initial one option:

_____ I do not have or have chosen not to use insurance coverage. I will pay the day of my appointment for the service in full.

_____ Heather Smith, Ph.D., LLC will submit claims to my insurance carrier, and I authorize the insurance payments to be made directly to Dr. Smith. I will pay my deductible and/ or copay at the time of the appointment. It is my responsibility to negotiate with my insurance carrier if incorrect payment is made and the balance in question is my responsibility.

_____ I will submit my own insurance claims and have the insurance payment paid directly to me. I will pay in full at the time of my appointment for services.

FEES FOR PROFESSIONAL SERVICES:

Individual, marital, family sessions	45-50 min	$205.00
Psychological Testing (including administering tests, analysis, report writing, data collection, collateral information)		$250.00/ hr
Letters, phone calls, collaboration		$175.00/ hr
Court appearance (including travel time to and from court, time spent at court, testimony, depositions, time spent in negotiations)		$370.00/ hr

Balances not paid in full within 30 days are subject to a 1.5% fee, as well as a $5.00 rebilling fee. If the bill is not paid, collection expenses, court costs, and attorney fees will be your responsibility and added to your bill. The parent who brings a child is responsible for the payment. We do not bill other parties.

I have read and understand this service and financial policy statement. I agree to the terms stated.

I personally guarantee payment of this account:

PRINT NAME _____

SIGNATURE _____ DATE _____

RELATIONSHIP TO PATIENT _____

HIPAA NOTICE OF PRACTICES
Heather Smith, Ph.D., LLC

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

Heather Smith, Ph.D. has been, and always will be, totally committed to maintaining patients' confidentiality. I will only release healthcare information about you in accordance with federal and state laws and ethics of the psychiatric profession. This notice describes my policies related to the use and disclosure of your healthcare information.

Uses and disclosures of your health information for the purpose of providing services
Providing treatment services, collecting payment, and conducting operations are necessary activities for quality care. State and federal laws allow me to use and disclose your healthcare information for these purposes, even without your specific authorization.

Treatment: I may need to disclose health information about you to provide, manage, or coordinate your care with other healthcare professionals involved in your care.

Payment: Information needed to verify insurance coverage and/ or benefits with your insurance carrier, to process your claims, as well as information needed for billing and collection purposes.

Healthcare operations: I may need to use information about you to review treatment procedures and business activity.

Other uses or disclosures of your information which do not require your consent:
There are some instances where I may be required to use and disclose information without your consent. For example, but not limited to: 1) information about physical or sexual abuse of a minor or elderly: 2) if you provide information that you are in imminent or credible danger of harming yourself or another; 3) information to remind you of/ or to reschedule appointments; 4) information shared with law enforcement if a crime is committed on our premises or against staff or as required by law, such as subpoena or court order; and 5) information about treatments of a minor if requested by a non-custodial parent.

Please initial one _____ I decline a copy of the HIPAA policy
_____ I request a copy of the HIPAA policy

PRINT Patient's Legal Name _____

Signature of patient _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION
Heather Smith, Ph.D., LLC

I understand that my records are protected under the applicable state law governing healthcare information that relates to mental health services and under the federal regulation governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CRF pt.2) and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke my consent at any time, except to the extent that action has already been taken. This release will automatically expire in 12 months from the date signed.

I, _____, hereby authorize Heather Smith, Ph.D., LLC

Please initial one _____ Please **do** exchange information with my PCP (primary care physician)

_____ Please **do not** exchange information with my PCP (primary care physician)

PRINT Patient's legal name _____

Signature of patient _____

Patient's DOB _____ Date _____

<u>Only complete if you are requesting Dr. Smith contact your PCP</u>

Primary Care Physician Name _____

Address _____

Phone Number _____ Fax number _____