This document (referred to as “the Agreement”) contains important information about our professional services and business policies. It also contains summary information about the Health Insurances Portability and Accountability Act (HIPAA), which is a federal law that provides privacy protections and patient rights regarding the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and healthcare procedures. HIPAA requires that I provide you with a Notice of Privacy Practices (“the Notice”) for use and disclosure of PHI for treatment, payment and healthcare operations. The Notice, which is a part of this Agreement, explains HIPAA and its application to your PHI in greater detail. This is a legal document; please read it carefully before signing. If you have any questions about this document and/or would like a copy, please ask your provider or a staff member. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have already taken action in reliance on it; if there are obligations imposed on me by your health insurer to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

**West Virginia Patient Rights**

You are entitled by law to receive information about methods of assessment and treatment the nature of any clinical techniques used, the duration of planned care (if known), and about your doctor’s fee schedule. You may always seek a second opinion and may terminate any elective treatment with any practitioner at any time. Sexual intimacy is never appropriate in a relationship with any health care provider and should be reported to the provider’s respective licensing board. Your communications with our providers are confidential; although, you should be aware of the exceptions to this rule under certain circumstances (listed elsewhere in this document).

The practice of mental health services in West Virginia is regulated by the West Virginia Board of Examiners of Psychologists. Any questions, concerns, or complaints regarding the practice of mental health services may be directed to the Board by mail at P.O. Box 3955, Charleston, WV 25339-3955 or by phone at (304) 558-3040.

**The Nature of Psychological Consultations/Psychotherapy**

There may be both risks and benefits associated with psychotherapy. Psychotherapy may improve your ability to relate to others, provide a better understanding of yourself, assist in diagnosis and treating mental health issues and/or coping with medical issues, and help you cope with stressors in your life. Although psychotherapy can be beneficial, it may not be helpful for everyone. Notably, the process of therapy can be emotionally taxing and patients may experience uncomfortable feelings or unpleasant memories. For example, when engaging in psychotherapy, there is risk you will experience varying levels of sadness, guilt, anxiety, anger, frustration, loneliness, helplessness, or other distressing feelings. Further, patients may recall unpleasant memories. These feelings or memories may emerge during or after a therapy session and could bother you while engaging in other activities (e.g. work, school, etc.). Most of these risks are common and to be expected when people are making changes in their lives. While therapy has been proven to be effective for many patients, there is a risk that therapy may not work well for you.

**The Nature of Psychological/Neuropsychological Assessment**

There may also be both risks and benefits associated with psychological/neuropsychological assessment. The process may help you and your treatment team have a clearer understanding of the psychological, personality, and behavioral factors at work in your emotional, cognitive, and physical functioning at a given moment in time. Depending on the case, assessment may include an interview and various paper-and-pencil tests or computerized tests. The goals may include helping to better inform your care team when considering various surgical procedures, treatment plans/options, and/or psychotherapy or psychiatric treatment. Such evaluations typically take a number of hours and may be scheduled over more than one session or day. After your provider has had time to analyze the data, there will be a meeting to discuss the results, impressions, and recommendations for treatment and follow-up, as indicated. Your provider will also send a formal report to the physician or other health care provider who referred you for the evaluation. Psychological/neuropsychological assessment requires your cooperation and full effort to obtain accurate results. While the assessment process is designed to be helpful, it may also be emotionally challenging and may, at times, cause distress.
Confidentiality

Our providers maintain confidentiality in accordance with the ethical guidelines and legal requirements of their profession. Effective treatment sometimes requires that staff members share confidential information with other staff members within WVU Medicine. The most common cases, in which my confidentiality is not protected, include:

1. When doing so is necessary to protect patients or someone else from imminent physical and/or life-threatening harm.
2. When a patient is “gravely disabled,” meaning that he or she lacks the capacity or refuses to care for him/herself and such lack of self-care presents substantial threat to his/her well-being.
3. When the abuse, neglect, or exploitation of a child, elder adult, or dependent adult is suspected.
4. When a patient pursues ethical, civil, or criminal action against WVU Medicine or its staff.
5. When a patient is involved in a legal proceeding and there is a court order for the release of records or when a release is otherwise required by law.

There are two primary situations in which part of your case may be discussed with another medical provider. First, when your provider is unavailable or away from the office for a few days, another psychologist may be available in times of emergencies. Therefore, he or she needs to know about you. Generally, this provider will only what he or she would need to know for an emergency. Of course, this provider is bound by the same laws and rules to protect your confidentiality. Second, your behavioral health notes are available to view to our medical team and other professionals within the WVU Medicine, University Healthcare Physicians, and Epic/Integrated Providers systems. This provides the opportunity for high-quality treatment and comprehensive care. These people are also required to keep patient information private. If you wish for something to not be in your behavioral health note, please let your provider know.

Minors and Parents

Patients under 14 years of age (who are not emancipated) and their parents/guardians should be aware that the law may allow parents/guardians to examine the child’s treatment records, unless the psychologist decides that such access is likely to injure the child. Because privacy in psychotherapy is often crucial to successful progress, it is sometimes a provider’s policy to request an agreement from parents that they consent to let their child have his/her own confidentiality, because this is best for treatment progress. Of course, the parents would be notified immediately in the case of any danger presented to the child or others.

Emergency

If you are experiencing a psychological emergency and is life threatening, call 911 or go to the emergency room.

Agreement

I certify that I have read, understand, and agree to abide by the information outlines above regarding my utilization of WVU MEDICINE Behavioral Medicine and Psychiatry services and about my patient rights. I acknowledge that I have received and reviewed the HIPAA agreement. I have had the opportunity to discuss any questions regarding the above information and have had my questions, if any, completely answered. I hereby give my consent to authorize WVU MEDICINE Behavioral Medicine and Psychiatry to evaluate, treat, and/or refer me to others, as needed. I agree to act according to the points covered in the agreement. I, the patient (or his or her parent or guardian), understand I have the right not to sign this form and can withdraw consent at any time. I understand I can choose to discuss my concerns with you, the provider, before I start (or the patient starts) treatment. I hereby agree to enter into treatment with this provider (or to have the patient enter treatment), and to cooperate fully and to the best of my ability, as shown by my signature here.

Signature of Patient (14 and older) Printed Name of Patient Date

Signature of Parent/Guardian Relationship to Patient: □ Self □ Custodial Parent □ Guardian

□ Other person authorized to act on behalf of the patient: ____________________________________________

Signature of Provider Date

□ Copy requested by patient □ Copy kept by office

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1. **Required for All Appointments** - At each visit you must bring your current insurance card, photo identification, and a method of payment. We accept cash, check, credit/debit cards. Failure to provide your insurance card with co-pay or payment in full (if no insurance) may result in your appointment being rescheduled. Additionally, please notify our staff of any address or insurance changes before your appointment.

2. **Payment for Services** - Payment for services rendered is required at the time of the visit.

3. **Insurance** - We have made prior arrangements with many insurers and health plans. We will bill those plans with which we have an agreement and will collect any required co-payment at the time of service. **In the event your health plan determines a service to be “NOT COVERED,” you will be responsible for the complete charge.** In that event, we will bill you and payment is due upon receipt of that statement.
   a. **Medicare** - We will bill Medicare for you. We do accept Medicare assignment; however, the patient is responsible for the yearly DEDUCTIBLE plus the 20% Medicare doesn’t pay if you do not have a secondary insurance.

4. **Emergencies** - **Our office does not provide “emergency services.”** If the patient during the course of his/her treatment has an urgent concern, an appointment will be scheduled as soon as possible. If the patient has a critical emergency, we recommend that patients present to their nearest emergency department or call 911.
   a. **After Hour Calls** - The office has an answering service that you may leave a message with after office hours. They will page the provider, if indicated. The provider will then provide recommendations through the answering service.

5. **Cancellation Policy** - Please notify our office **24 hours in advance** if an appointment will be missed to avoid being charged for the time that was reserved for you. **Failure to show up for two appointments without notification or repeated late cancellations are grounds for termination of services and referral.**

6. **Prescription refill** - Please contact your pharmacist to request maintenance medication refills. If you do not have additional refills authorized, the pharmacy will need to fax a refill request to our office for approval. **Call your pharmacist at least five (5) business days ahead** of the need for a refill. Before we approve a refill request we will need to look at your chart, verify the proper dosage, check for the appropriate response to the drug, and see if any lab test is needed prior to filling your medication. If you have a prescription that has to be hand written, please call the office and make the request. There will be no refills approved on weekends or holidays.
   a. **Controlled medications** - Physicians will not re-write any controlled medications before it is time for them to be filled again. It is your responsibility to maintain safeguard of your prescriptions once you leave the office. We will not make any exceptions.

7. **Documents/Forms to be filled out** - Please allow at least **ten (10) days** for any documents/forms, etc. to be completed by the provider. If an address or fax number is provided to us as to where it needs sent, we will mail or fax the forms for you. Otherwise, we will call you when they are finished and ready to be picked up.

**Patient Agreement**
I have read the office policies and agree to abide by them. I, the undersigned, hereby authorize examination and any other medical services deemed necessary by the healthcare providers of WVU Medicine: University Healthcare Physicians Department of Behavioral Medicine and Psychiatry. I authorize my healthcare providers to release to my insurance company information concerning healthcare, advice, treatment, or supplies provided to me. I, the undersigned, authorize payment of medical benefits for services rendered to me. I understand that I am financially responsible for any amount not covered by my insurance contract. I authorize release of information acquired in the course of my examination and treatment to any other healthcare provider(s) involved in my care.

**Medicare Authorization**
I, the undersigned, authorize the healthcare provider to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed to determine benefits payable for related services. I authorize the same information to be sent to my secondary insurance carrier. I authorize the payment of Medicare benefits to WVU MEDICINE Behavioral Medicine and Psychiatry for any services furnished to me.

Signature of patient or legal guardian: __________________________________ Date: ______________________
PATIENT INFORMATION

Patient Name: ________________________________  ______________________________
Last                  First                  Middle

Prior Last Names: __________________________________________________________

Social Security Number: ______ - ______ - ______   Date of Birth: ______/______/______

Sex: □ M  □ F  □ T  Marital Status: □ Single  □ Married  □ Divorced  □ Widow/er  □ Separated  □ Other: __________

Sexual Orientation: □ Heterosexual  □ Homosexual  □ Bisexual  □ Asexual  □ Questioning  □ Other: __________

Race: □ African American  □ Asian  □ Caucasian  □ Hispanic  □ Native American  □ Other: __________

Mailing Address: ______________________________________________________________

City: ___________________________   State: ______________   Zip: __________

Email Address: ____________________________  (Permission to Leave Message: □ Yes □ No)

Phone:  Home: ____________________________  (Permission to Leave Message: □ Yes □ No)

Cell: ____________________________________________  (Permission to Leave Message: □ Yes □ No)

Other: ____________________________________________  (Permission to Leave Message: □ Yes □ No)

Preferred Method of Contact/Number: ____________________________  (Permission to Leave Message: □ Yes □ No)

Guarantor Information:  (Person responsible for the payment. Parent / Guardian if under age 18)

Guarantor Name: ______________________________________________________________
Last                  First                  Middle

Guarantor relationship to patient: ________________________________________________

Social Security Number: ______ - ______ - ______   Date of Birth: ______/______/______

Mailing Address: ______________________________________________________________

City: ___________________________   State: ______________   Zip: __________

Phone: ____________________________   Cell / Other: __________________________

Insurance Information:

Name of Primary Insurance: ____________________________________________ Policy ID Number: __________________

Subscriber Name: ____________________________________________ Subscriber Social Security # ______ - ______

Subscriber relationship to patient: ____________________________________________ Subscriber Date of Birth: ______/______/______

Insurance Address: __________________________________________________________

Group Number: ____________________________ Subscriber Employer / Group Name: ____________________________

Insurance Effective Date: ______/______/______   Subscriber work status: □ Full Time  □ Part Time  □ Retired
**Secondary Insurance Information:** (Please fill out secondary insurance if applicable)

Name of Secondary Insurance: ___________________________________ Policy ID Number: ________________________

Subscriber Name: __________________________ Subscriber Social Security # ______-____-____

Subscriber relationship to patient: __________________________ Subscriber Date of Birth: ______/____/_______

Insurance Address: ________________________________________________________________

Group Number: __________________________ Subscriber Employer / Group Name: ______________________

Insurance Effective Date: ______/____/_______ Subscriber work status: □ Full Time □ Part Time □ Retired

**Emergency Contact Information:**

Person to notify / Next of kin: ______________________________________________________

Last    First    Middle

Mailing Address: _________________________________________________________________

City: __________________________ State: _______________ Zip: _______________________

Phone: __________________________ Cell / Other: _________________________________

Relationship to Patient: _________________________________________________________

**Protected Health Information Permission:** (Optional)

I, ____________________________, give WVU Medicine: University Healthcare Physicians: Behavioral Medicine and Psychiatry permission to disclose future appointments and protected health information with the person(s) listed below:

Name: __________________________ Phone Number: __________________________

Name: __________________________ Phone Number: __________________________

Name: __________________________ Phone Number: __________________________

Patient Signature: __________________________ Date: _______________________

**Patient Employer Information:**

Work Status: □ Full Time □ Part Time □ Unemployed □ Full Time Student □ Part Time Student

Employer/School Name: __________________________________________________________

Mailing Address: _________________________________________________________________

City: __________________________ State: _______________ Zip: _______________________

Phone: __________________________ Department: _________________________________
Child and Adolescent for Psychological or Psychiatric Services

Please fill out the following completely and to the best of your ability. If you have copies of previous evaluations or school records (e.g., IEP, 504-Plan, etc) please feel free to bring them.

CONFIDENTIAL

Patient’s Name: ___________________________ Date of Birth: ___________________________ Age: ________

Sex: ________ Preferred pronouns: ________ Race: ___________________________ Ethnicity: □ Hispanic  □ Non-Hispanic

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS INFORMATION. THIS WILL HELP US MATCH YOUR CHILD WITH THE APPROPRIATE PROVIDER TO MEET HIS/ HER/ THEIR NEEDS.

Please give a brief summary of what you need to be seen for:

__________________________________________________________________________________________________________________________________________

Current Symptoms Checklist: ( ) Socially withdrawn  ( ) Repetitive behaviors  ( ) Delayed development

( ) Sleep pattern disturbance  ( ) Racing thoughts  ( ) Excessive worry  ( ) Anxiety Attacks

( ) Unable to enjoy activities  ( ) Impulsivity  ( ) Depressed Mood  ( ) Avoidance

( ) Increase in risky behavior  ( ) Hallucinations  ( ) Loss of Interest  ( ) Suspiciousness

( ) Concentration/forgetfulness  ( ) Excessive guilt  ( ) Change in appetite  ( ) Crying spells

( ) Decreased need for sleep  ( ) Excessive Energy  ( ) Fatigue  ( ) Increased irritability

( ) Defiance  ( ) Aggression  ( ) Outbursts/ Tantrums  ( ) Running away

I would like for my child to receive the following (circle all that apply):

CLEAR DIAGNOSIS  TESTING  THERAPY  MEDICATION EVALUATION

I DON’T KNOW  OTHER (Please specify):

Primary Caregiver’s Name: ___________________________ Age: __________

Relationship to Child: ____________________________________________________________________

Occupation: __________________________________________ Length of Employment: __________

Second Primary Caregiver’s Name: ___________________________ Age: __________

Relationship to Child: ____________________________________________________________________

Occupation: ___________________________ Length of Employment: __________

Current Status of Caregivers:

□ Separated (Date of Separation ________________)  □ Divorce (Date of Divorce ________________)

□ Married (Date of Marriage ________________)  □ Never Married (Legal Custodian: ________________)

Check if child is in foster care: ( ) Yes  ( ) No

Legal custody of children*: ___________________________ Physical custody of children: ___________________________

*If there is a custody agreement, please attach documentation verifying legal custody.
Medical History
Hand Preference: □ Left □ Right □ Ambidextrous
Please check all that apply to your child:
□ Corrective lenses (e.g., glasses or contacts) □ Hearing aid or any hearing impairment
□ Seizures or epilepsy □ Traumatic brain injury
□ Cancer □ Congenital heart defects
□ Neonatal Abstinence Syndrome □ Prenatal exposure to substances
□ Other neurological condition (e.g., Spina Bifida) □ Other chronic medical condition
□ Other chronic medical condition
If yes, please list: ____________________________________________
If yes, please list: ____________________________________________

Does your child have any allergies? ( ) Yes ( ) No
If yes, please describe: ____________________________________________

Developmental History
Please check all that apply to your child:
□ Met all developmental milestones on time □ Premature birth
□ Speech delay □ Motor delay
□ Other developmental delays
If yes, please list: ____________________________________________

Did your child receive services through Birth-to-Three? ( ) Yes ( ) No

Psychiatric History (Please give dates of treatment, if possible)
Inpatient ______________________________________________________
_______________________________________________________________
Outpatient/ Counseling or Therapy _______________________________________
_______________________________________________________________

Past psychiatric medications (Please list dosage and frequency, if possible)
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________

Suicide Risk
Has your child ever had feelings or thoughts that he or she did not want to live? ( ) Yes ( ) No
Has your child ever harmed himself/ herself? ( ) Yes ( ) No
Has your child ever tried to kill himself/ herself in the past? ( ) Yes ( ) No
If YES to any questions above, please describe:
_____________________________________________________________
_____________________________________________________________

* If your child is in a crisis (suicidal) please take him/her to the Emergency Department at the nearest hospital or dial 9-1-1
School
Current School: __________________________________________ Grade: ______________

Please check all that apply to your child.

□ Special education services/ Individualized Education Plan  □ 504 Plan
□ Evaluation for learning problems in past  □ Failed a class
□ Repeated a grade  □ Skipped a grade
□ Speech and Language Therapy in school  □ Occupational Therapy in school
□ Physical Therapy in school  □ Other services: ______________________________

Substance Use
Has your child ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, please describe: __________________________________________________________

Has your child used alcohol, drugs, tobacco, or abused prescription medications in the past 3 months? ( ) Yes ( ) No
If yes, please describe: __________________________________________________________

Legal History
My child is experiencing legal difficulties: ( ) Yes ( ) No
If yes, please describe: __________________________________________________________

Family Health History
Please check if any family members have been diagnosed with the following:

□ Learning Disability- Relation(s): ________________________________
□ ADD/ADHD - Relation(s): ________________________________
□ Intellectual Disability - Relation(s): ________________________________
□ Depression - Relation(s): ________________________________
□ Anxiety - Relation(s): ________________________________
□ Psychiatric Illness - Relation(s): ________________________________
□ Problems with alcohol or substance abuse- Relation(s): ________________________________

Are there any medical conditions that run in your family? ( ) Yes ( ) No
If yes, please explain: __________________________________________________________

Has someone in your family experience intimate partner violence/ domestic violence, sexual abuse, physical abuse, neglect, or victimization by violence? ( ) Yes ( ) No
If yes, please explain: __________________________________________________________
**Leisure & Social History**

Please list everyone who lives with your child:

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Are there firearms within the home? □ No □ Yes

If yes, how are they stored? _____________________________________________________

Is your child involved in any extracurricular and/or community activities? □ No □ Yes

If yes, please describe: _________________________________________________________________

Does your child have any hobbies or special interests? □ No □ Yes

If yes, please describe: _____________________________________________________________

How does your child spend free time, relax, and/or have fun? __________________________

What is your child good at? _______________________________________________________

---

**For Therapy Patients Only:**

There may be times when we have a waitlist for therapy services. For therapy, most people come every week or every other week. As they make progress, they may not come as often.

Our office hours are Monday to Friday 8:30 AM to 5:00 PM. The last appointment is usually at 4:00 PM. After school is our most popular time. There is much more availability in the morning and early afternoon.

To help us match you with a provider who is able to meet your availability, please specify any days and times when you could commit to coming to therapy appointments. Please consider school schedules, work schedules, and extracurricular activities for family members who would attend and provide transportation to appointments.

Do you know of times when you and your child would be able to commit to coming to therapy on a regular basis?

□ No □ Yes

If YES, in the space provided please list the times when you and your child are available to attend appointments on a regular basis:

- Mondays: __________________________
- Tuesdays: _________________________
- Wednesdays: _______________________
- Thursdays: _________________________
- Fridays: ___________________________