

STEVEN KATKIN AND ASSOCIATES, INC

All Matter Discussed Is Confidential Except As Required By Law, As In Cases Of Child Abuse Or In Cases Of Declared Intention Of Harm To Others Or Self.

Patient Information:

Patient Legal Name: \_\_\_\_\_  
Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
Employer: \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
relationship \_\_\_\_\_

Circle one: (Marital Status): Single Divorced Married Widowed  
Sex: male female

If Child, lives with: Mother Father Both Parents  
Other \_\_\_\_\_

Custodial Parent/Guardian

If you are not the custodial parent we will require "Permission to Treat" form to be completed by the custodial parent

Insurance Carrier's Information:

Relationship, is this the patient's (circle one): self parent Step-parent spouse  
Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address: city/st/zip \_\_\_\_\_  
Employer \_\_\_\_\_ Phone \_\_\_\_\_  
Social Security # \_\_\_\_\_ Date birth \_\_\_\_\_  
Insurance Co. \_\_\_\_\_ Have you called for authorization: YES or  
NO Authorization # \_\_\_\_\_  
Who referred you? \_\_\_\_\_

If you are using an Employee Assistance Program (EAP), please indicate who referred you?  
\_\_\_\_\_ and their phone # \_\_\_\_\_

WE REQUIRE A COPY OF YOUR INSURANCE CARD TO BILL SERVICES

*Insurance billing is provided as a courtesy, however, you are responsible for all charges from the date the service is rendered.*

*All copay's and deductibles are to be paid at the time of the service unless prior arrangements have been made*

*Appointments cancelled without 24 hours notice: the client will be charged the full fee*

*I have read the above information*

*I understand that regardless of my insurance status,*

*I am ultimately responsible for the balance of my account*

Signature \_\_\_\_\_ Date \_\_\_\_\_

Release of Information

Past Therapist: \_\_\_\_\_ Phone \_\_\_\_\_

Can we contact this physician for any records, testing, information that may assist in our treatment for you? \_\_\_\_\_

Please sign \_\_\_\_\_ date \_\_\_\_\_

Any release of information can be withdrawn at any time except to the extent that action has been taken in reliance thereon. Consent expires 60 days from the last date of treatment.

***Statement of Members' Rights:***

- Members have the right to be treated with dignity and respect.
- Members have the right to fair treatment. This is regardless of their race, religion, gender, ethnicity, age disability, or source of payment.
- Members have the right to have their treatment and other member information kept private.
- Only in an emergency, or if required by law, can records be released without member permission.
- Members have the right to information from staff/providers in a language they can understand.
- Members have the right to have an easy to understand explanation of their condition and treatment.
- Members have the right to know all about their treatment choices. This would mean no matter of cost or if they are covered or not.
- Members have the right to get information about services and role in the treatment process.
- Members have the right to information about providers.
- Members have the right to know the clinical guidelines used in providing and /or managing their care.
- Members have the right to provide input on policies and services.
- Members have the right to know about the complaint, grievance, and appeal process.
- Members have the right to know about State and Federal laws that relate to their rights and responsibilities.
- Members have the right to know of their rights and responsibilities in the treatment process.

- Members have the right to share in the formation of their plan

***Statement of Members' Responsibilities***

- Members have the responsibility to give providers information they need. This is so they can deliver the best possible care.
- Members have the responsibility to let their provider know when the treatment plan no longer works for them.
- Members have the responsibility to follow their medication plan. They must tell their provider about medication changes, including medications given to them by other providers.
- Members have the responsibility to treat those giving them care with dignity and respect.
- Members should not take actions that could harm the lives of other employees, providers, or other members.
- Members have the responsibility to keep their appointments. Members should call their providers as soon as possible if they need to cancel visits.
- Members have the responsibility to ask their providers' question about their care. This is so they can understand their care and their role in that care.
- Members have the responsibility to let their provider know about problems with paying fees.
- Members have the responsibility to follow the plans and instructions for their care. The care is to be agreed upon by the member and provider.

I have read and understand my Member Rights and Responsibilities

Member Name \_\_\_\_\_ Date \_\_\_\_\_

Provider Name KATKIN & ASSOCIATES Date \_\_\_\_\_

Patient Name \_\_\_\_\_ SS# \_\_\_\_\_

### **Informed Consent for Treatment**

I \_\_\_\_\_ OR (parent or guardian) agree and consent to participate in mental health services offered and provided at/by \_\_\_\_\_ (name of provider), a mental health provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certification and training; or (2) the scope of license, certification and training of these mental health providers directly supervising the services received by the patient. If the patient is under the age of eighteen, I attest that I have legal custody of this child and am therefore allowed to initiate and consent for treatment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient \_\_\_\_\_

**Patient Care communication Form  
(Required if using insurance)**

Primary Care Physician name \_\_\_\_\_ phone # \_\_\_\_\_

Address \_\_\_\_\_

Dear Dr. \_\_\_\_\_

Your patient, \_\_\_\_\_, was recently referred by \_\_\_\_\_  
We hope that the following information will be helpful in coordination this patient's care.

**THIS SECTION IS TO BE FILLED OUT BY KATKIN & ASSOCIATES STAFF**

Date of Initial Consultation \_\_\_\_\_ Date of Next Appointment \_\_\_\_\_

Diagnoses and /or presenting problems \_\_\_\_\_

Treatment Recommendations \_\_\_\_\_

Medications: \_\_\_\_\_

Please call if further information would be helpful.

Clinician's Printed Name \_\_\_\_\_

Address 5720-A Signal Hill Ct

Address Milford, OH 45150

Telephone Number (513) 831-9408

Sincerely,

\_\_\_\_\_  
Clinician Signature

**NOTICE TO RECIPIENT OF INFORMATION**

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42CFR Part 2. A general information to criminally investigate or prosecute any alcohol or drug abuse patient.

**AUTHORIZATION**

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_  
PRINT PATIENT'S NAME PRINT TREATING CLINICIAN'S NAME

Please Check One: \_\_\_\_\_ To release any applicable mental health information to my primary care physician (PCP) named above.

\_\_\_\_\_ To release any applicable substance abuse information to my PCP named above.

\_\_\_\_\_ To release only medical information to my PCP named above.

\_\_\_\_\_ Not to release any information to my PCP named above.

I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. If I do not revoke this authorization, it will expire one (1) year after I have terminated treatment.

\_\_\_\_\_  
SIGNATURE OF PATIENT OR GUARDIAN ID # DATE OF BIRTH

Name: \_\_\_\_\_

HEALTH QUESTIONNAIRE

PLEASE LIST ANY ALLERGIES:

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MEDICATIONS YOU ARE PRESENTLY TAKING:

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MEDICAL DISORDERS:

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**Request for other ways of communicating with me**

I do not need to provide any reason and simply request the following alternatives to or limitations on communication with me by you or this practice:

1. Please telephone me ONLY at this number(s): \_\_\_\_\_

When you call please follow these directions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please do NOT telephone me at this number(s): \_\_\_\_\_

\_\_\_\_\_

2. Please direct all postal mail to this address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please do NOT send postal mail to this address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Signature of client or his or her personal representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of client or personal representative

\_\_\_\_\_  
Relationship to the client

\_\_\_\_\_  
Description of personal representative's authority

**Do not write Below this line**

Accepted

Refused

Reason (s): \_\_\_\_\_

\_\_\_\_\_  
Printed name of Privacy Officer

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**Notice of Privacy Practices – Brief Version**

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

**Our commitment to you privacy**

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We also are required by law to keep your information private. These laws are complicated, but we must give you this important information. This pamphlet is a shorter version of the full, legally required NPP which you received along with this so refer to it for more information. However, we can't cover all possible situations so please talk to our Privacy Officer (see the end of this pamphlet) about any questions or problems.

We will use the information about your health which we get from you or from others mainly to provide you with **treatment**, to arrange **payment** for our services, and for some other business activities which are called, in the law, health care **operations**. After you have read this NPP we will ask you to sign a **Consent Form** to let us use and share you information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an Authorization form to allow this.

Of course we will keep your health information private but there are some times when the laws require us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization which is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires to do so.
4. For Workers Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP.

## Notices, Consents, and Authorizations

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### Your rights regarding your health information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place, which is more private for you. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.
2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.
3. You have the right to look at the health information we have about you such as your medical and billing records. \* You can even get a copy of these records but we may charge you. Contact our Privacy Office to arrange how to see your records. See below.
4. If you believe the information in your records is incorrect or missing important information, you can ask us to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to our Privacy Officer. You must tell us the reasons you want to make the changes.
5. You have the right to a copy of this notice. If we change this NPP we will post the new version in our waiting area and you can always get a copy of the NPP from the Privacy Officer.
6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer who is Sue Hoehn and can be reached by phone at (513) 831-9408 or by e-mail at N/A.

The effective date of this notice is April 14, 2003

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Signature

**FINANCIAL AGREEMENT/CONTRACT**  
**between you and your therapist at Steven Katkin and Associates Inc.**

Each appointment is reserved for you and/or your family. If you do not show up for this appointment or cancel within a 24 hour time period, this appointment time often cannot be filled. Therefore, you will be responsible for payment of the full rate of \$125/session for cancellations within 24 hours or not showing up for an appointment. Appointment times are scheduled at 45 minute intervals unless otherwise specified by your therapist.

If you are using insurance, you will be responsible for any deductibles, co-payments or amounts not covered by your insurance. Many insurance plans require an "authorization" be in place prior to your first session. If this authorization is not in place or the insurance company refuses payment for any reason, you will be fully responsible for payment. **We provide insurance billing as a courtesy, but the overall bill remains your responsibility thus we strongly urge you to contact your insurance company prior to your first session or shortly after to understand your financial responsibilities.**

If you are using insurance, and your insurance requires a co-payment, the co-payment will be due at the time of your appointment. **If you do not pay your co-payment at the time of the appointment you will be charged an additional \$10 billing fee.**

We will only bill secondary insurance plans if the copy of the secondary insurance is presented at the time of the visit. If it is not, presented, you will be responsible for the amount your secondary insurance is/was to cover.

All unpaid balances are due in full within 30 days. Balances past 90 days will be turned over to a third party collections agency. A collections fee of \$50 will be added to the total bill.

Additional fees will be added for services rendered outside of the scheduled appointment. This could include (but are not limited to) phone contacts with the patient or collateral source exceeding 10 minutes and any additional paperwork such as work forms. Appearances for court or court-related activities are billed at \$100 per hour and this will include travel time to and from court. Any documentation written for court outside of a scheduled session will cost \$75 per page.

The parent who brings a child client to his/her session is responsible for the co-payment.

**I understand and agree with each of the above statements and stipulations.**

\_\_\_\_\_  
Adult Patient, Guardian or Legal Representative

\_\_\_\_\_  
Date