C. Duarte & Associates

The Meadows Professional Office Park
1130 Ten Rod Road, Building E, Suite 101, North Kingstown, RI 02852
Phone: 401-921-5400
Web: cduarteandassociates.com

INTAKE FORM

Clinician's Name _____ Date _____

PERSONAL INFORMATION:

Patient Name _____ Date of Birth _____
Address _____
City/State/Zip _____
Phone Home (_____) _____ Cell (____) _____ Office (_____) _____

Who referred you to our office? _____

RESPONSIBLE PARTY: (fill in if under 18 or if someone other than patient is responsible for payment)

Name _____
Address _____

City/State/Zip _____
Home Phone (_____) _____ Business Phone (_____) _____

INSURANCE INFORMATION:

Primary Insurance Company _____
Provider Phone (located on back of card) (_____) _____
Subscriber Name (if other than patient) _____

Insurance ID# _____

FINANCIAL POLICY

Appointments cancelled with less than 24 hour notice will be charged to me at the full fee per hour.
I am responsible for the entire balance of services performed regardless of whether there is insurance coverage.
Secondary insurance will be billed as a courtesy.
I understand and agree to the above stated financial policy.

Signed _____ Date _____

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS FOR INSURANCE

I authorize the use or disclosure of my individually identifiable health insurance information necessary to process insurance claims. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations.

Signed _____ Date _____

I authorize payment of medical benefits to my provider for services performed.

Signed _____ Date _____

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HIPAA Privacy Notice

Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information

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

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *Protected Health Information* (*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 healthcare. 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, and 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, and 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, and the 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:** If I have reasonable cause to know or suspect that any child has been abused or neglected, as defined below, or is a victim of sexual abuse by another child, I must, within 24 hours, transfer that information to the Rhode Island Department of Child, Youth and Families, or its agent.

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Child abuse and/or neglect is defined as a child whose physical or mental health or welfare is harmed, or threatened with harm when his or her parent or other person responsible for his or her welfare:

- Inflicts, or allows to be inflicted physical or mental injury;
- Creates or allows to be created a substantial risk of physical or mental injury;
- Commits or allows to be committed an act of sexual abuse, sexual assault against, or exploitation of the child;
- Fails to supply the child with adequate food, clothing, shelter, or medical care;
- Fails to provide the child with a minimum degree of care or proper supervision or guardianship because of his/her unwillingness or inability to do so; and abandons or deserts the child.

- **Health Oversight:** If a complaint is filed against me with the Rhode Island Board of Psychology, the Administrator of Professional Regulation (of the Division of Health) has the authority to subpoena confidential mental health information from me relevant to that complaint.

- **Judicial or administrative proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that I provided to you and the records thereof, such information is privileged under state law, and I will not release this information without: 1) written authorization by you or your legal representative; or 2) a subpoena of which you have received official notification and you have failed to inform me that you are opposing the subpoena; or 3) 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:** I may release your confidential health care information to appropriate law enforcement personnel, or to a person, if I believe that person or their family to be in danger from you.

- **Workers' Compensation**: If you file a worker's compensation claim, I must release your relevant mental health care information for the proceedings.

There may be additional disclosures of PHI that I am required or permitted by law to make without your consent or authorization; however, the disclosures listed above are the most common.

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 about you. 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. Upon 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. On your request, I will discuss with you the details of the request 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 regarding you. 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:

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- 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 either in person or by mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, believe that your privacy rights have been violated and wish to file a complaint, or have other concerns about your privacy rights, you may discuss these with me at 931 Jefferson Blvd., Suite 2009, Warwick, RI 02886, (401) 921-5400.

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.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on September 5, 2006.

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. At such time I will notify you of this change either in person or by mail. The current version of this document will always be available to you at my office.

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Acknowledgment of Required Intake Forms

I acknowledge that I have been given copies of:

- the *Psychotherapist-Patient Services Agreement* and
- the *HIPAA Privacy Notice*

to review and discuss with my therapist.

Please review and sign the *Psychotherapist-Patient Services Agreement*.

Please also review the *HIPAA Privacy Notice*. The *HIPAA Privacy Notice* does not require your signature.

Please let me know as soon as possible if you have any questions or concerns about doing this.

_____ _____
Signature of Patient (or Parent/ Legal Guardian) Date

_____
Relationship to Patient