Dr. Kinsler & Associates, LLC

Help…when life hurts

PREMARITAL COUNSELING INTAKE

Bride's Name:_____ **WEDDING DATE**:_____

Age:_____ Birthdate:_____ Birthplace:_____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Highest level of education (grade/degree): _____

Occupation: _____ Employer: _____

Religion: _____

Are your biological parents still married? Yes _____ No _____

Groom's Name:_____

Age:_____ Birthdate:_____ Birthplace:_____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Highest level of education (grade/degree): _____

Occupation: _____ Employer: _____

Religion: _____

Are your biological parents still married? Yes _____ No _____

Whom may we thank for your referral: _____

Relationship status:
How long have you been together: _____
If engaged, how long have you been engaged?_____
How long have you known your fiancé? _____
How many times have either of you been engaged? _____
Have either of you ever been married before?_____

Children (if any):

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Business Address: 3262 Cove Bend Drive * Tampa, Florida 33613
Mailing Address: P.O. Box 272374 * Tampa, Florida 33688
Phone: (813) 443-5311 * Fax: (813) 443-5312
Website: www.kinslerpsychology.com

Briefly describe your relationship with your <u>father</u>:
Bride - _____

Groom - _____

Briefly describe your relationship with your <u>mother</u>:
Bride - _____

Groom - _____

MEDICAL HISTORY

Hospitalizations, serious illnesses and/or injuries (list date(s) and describe): _____

_____

_____

Current medications: _____

MENTAL HEALTH HISTORY

(Please identify whether bride or groom)

Previous counseling or psychiatric treatment: No ___ Yes ____ If yes, list date(s) and name of therapist/psychiatrist: _____

Psychiatric medication taken currently or in the past: No ___ Yes ___ If yes, date(s) and what kind: _____

History of suicidal thoughts or attempts: No ____ Yes ____ If yes, date(s) _____

History of physical or sexual abuse or assault: No ___ Yes ____ If yes, date(s) _____

History of incarceration: No ___ Yes ____ If yes, please explain _____

Have either of you ever received treatment for alcohol and/or drug use? No ___ Yes ____ If yes, specify dates and type of treatment: _____

If alcohol or drug use is current, list frequency per week: _____

GOALS

What do you hope to achieve or accomplish through premarital counseling?

_____

_____

Are there any concerns that you hope to resolve by the time you get married?

_____

_____

**********STOP. THIS WILL BE SIGNED FOLLOWING THE FIRST APPOINTMENT*********

CONSENT FOR TREATMENT

I voluntarily agree to, and give consent for premarital counseling services by Dr. Kinsler & Associates, LLC.

Bride: _____ Date: _____

Printed Name: _____

Groom: _____ Date: _____

Printed Name: _____

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Patient Payment Responsibility and Agreement

I have discussed responsibility of payment for treatment and I assume financial responsibility for myself and/or my family members. I agree to pay for premarital counseling sessions at a rate of $175.00 per session. A psychotherapy session is 55 - minutes in length. Extended 75 - minute sessions are conducted at a rate of $200 per extended session. I understand that payment is due at the time services are rendered unless special arrangements have been made. I accept responsibility for prompt payment for any treatment and services rendered to myself and/or my family.

Because my time has been reserved exclusively for me and/or my family members, I understand that I am required to provide at least 24 hours advance notice if unable to keep the scheduled appointment. In the event that I do not provide 24 hours advance notice, I am financially responsible for the reserved appointment and I will be charged a $35.00 fee per scheduled hour. Upon prior discussion and agreement, I understand that charges will be added to my account for other professional services rendered (e.g., preparation of letters/reports, review of medical records, court time, etc.).

A certificate of completion will be awarded upon completion of the 8-session program.

Insurance Claims

Please note that *premarital counseling* is not a covered insurance benefit and, therefore, claims are not submitted to your insurance company. However, Dr. Kinsler & Associates, LLC will gladly provide documentation for clients attempting to obtain insurance reimbursement.

I fully understand and agree to the above policies and conditions.

Bride Signature _____

Groom Signature _____

Dr. Kinsler & Associates, LLC

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HIPPA Notice of Privacy Practices for Protected Health Information (PHI)

This notice describes how information about you may be used and disclosed and how you can have access to this information.

Introduction:
At Dr. Kinsler & Associates, LLC, we are committed to treating and using your PHI responsibly. This HIPPA Notice describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they related to your PHI. This HIPPA Notice applies to all PHI as defined by federal regulations.

Understanding Your Health Record/Information:
Each time you visit Dr. Kinsler & Associates, LLC, a record of your visit is made. Typically, this record contains your symptoms, diagnoses, treatment, and a plan for future care or treatment. This is referred to as your health or medical record and serves as a:

- Basis for planning your care and treatment,
- Means of communicating among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer (i.e., insurance company) can verify that services billed were actually provided,
- Source of information for public health officials charged with improving the health of the State and the nation, as required by law (i.e., reporting child/elder abuse and neglect or domestic violence),
- Basis for disclosing health information to a law enforcement official, for purposes such as identifying or locating an individual, in complying with a court order or subpoena, and other law enforcement purposes,
- Source for public safety. We may disclose health information to appropriate persons in order to prevent or lessen a serious threat to health or safety of a particular person, or the general public, and
- Tool in educating health professionals, source of data for medical research, and tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your PHI is used helps you to ensure its accuracy, better understand the reasons that others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Dr. Kinsler & Associates, LLC, the information belongs to you. As provided for in federal regulations, you have the right to:

- Obtain a paper copy of this Notice of Health Information Practices upon request,
- Inspect and copy your health record,
- Obtain an accounting of disclosures of your health information
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information, and
- Revoke your authorization to use or disclose health information, except to the extent that action has already been taken.

Our Responsibilities

Dr. Kinsler & Associates, LLC is requited to:

- Maintain the privacy of your health information,
- Provide you with a copy of this Notice as to your legal duties and privacy practices with respect to information that is collected and maintained about you,
- Abide by the terms of this Notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this Notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization, according to the procedures included in the Authorization.

For More Information or to Report a Problem

If your have any questions or would like additional information, you may contact Dr. Kinsler & Associates, LLC at (813) 443-5311. You believe your privacy rights have been violated, complaints should also be directed to Dr. Kinsler & Associates, LLC.

Acknowledgement of Receipt of HIPPA Privacy Notice and New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, (print name of adult patient, parent or guardian of minor), understand that as a part of my or my family's health care, Dr. Kinsler & Associates, LLC originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and treatment information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals.

I have been presented with a copy of Dr. Kinsler & Associates, LLC's Notice of Privacy Policies detailing how my information may be used and disclosed under Federal and State law. I understand the contents of the Notice. Further, I permit a copy of this Acknowledgement to be used in place of the original and, if applicable, request payment of medical insurance benefits either to myself or to the party who accepts assignments. Regulations pertaining to medical assignment of benefits apply. I understand and have been provided with a Notice of Health Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the Notice prior to signing this Consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that I may revoke this Consent in writing, except to the extent that the organization has already taken action in reliance thereon. I understand that by refusing to sign the Consent or revoking this Consent, Dr. Kinsler & Associates, LLC may refuse to treat me, as permitted by Federal regulations. I further understand that Dr. Kinsler & Associates, LLC reserves the right to change its notice and practices prior to implementation, in accord with Federal regulations. Should Dr. Kinsler & Associates, LLC change its practices, it will send a copy of any revised notice to the address I have provided by U.S. mail, or email, if I agree.

I understand that as a part of Dr. Kinsler & Associates, LLC's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity (i.e., insurance, emergency, etc.), and I consent to such disclosure for these permitted uses, including disclosures via fax and email only to appropriate parties.

I fully understand and accept the terms of this Consent and acknowledge the receipt of the Privacy Notice.

Name of Patients (printed) _____ Date_____

Patients signature_____

If refused, reason for refusal_____

Restrictions noted_____