Kinsler Psychology

Help… when life hurts

ADULT INTAKE HISTORY

Patient Name _____Date _____

Age _____ Birthdate _____ Birthplace _____ Gender Male/Female

Address _____

City _____ State _____ Zip _____ Social Security# _____

Home Phone _____ Cell Phone _____ Work Phone _____

Occupation: _____ Employer: _____

Name and number of emergency contact _____

Briefly state why you are seeking treatment at this time

_____

_____

Whom may we thank for your referral: _____

MEDICAL HISTORY

Primary care physician: _____ Phone #: _____

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

_____

Current medications:

_____

_____

MARITAL HISTORY

Marital Status: Married ____ Single ____Divorced ____ Widowed _____

Name of spouse/significant other: _____ Age: _____

Is this your first marriage: Yes ____ No ____ N/A ____Years married/years living together ____

Briefly describe your relationship with your spouse/significant other:

_____

Children (if any):

Name: _____ Age: _____

Name: _____ Age: _____

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Name: _____ Age: _____

Your father's name: _____ Age: _____ Living: _____ Deceased: _____

Your mother's name: _____ Age: _____ Living: _____ Deceased: _____

If a parent(s) is/are deceased, how old were you when this occurred: _____

Number of years parents are/were married: _____

If divorced, how old were you when parents divorced: _____

Siblings (brothers/sisters):

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

DEVELOPMENTAL HISTORY

Birth order: _____ Childhood health: _____ Good _____ Fair _____ Poor _____

If poor, explain: _____

If you were born in another country, how old were you when you moved to the U.S.? _____

Academic history: Excellent _____ Average _____ Poor _____

If poor, explain: _____

Highest level of education (grade/degree): _____

Religion: _____

MENTAL HEALTH HISTORY

Previous psychotherapy/counseling: No _____ Yes _____ If yes, list date(s) and name of therapist/agency: _____

Previous psychiatric treatment: No _____ Yes _____ If yes, list date(s): _____

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

Have you ever been hospitalized for mental health reasons? No _____ Yes _____ If yes, list date(s) and place: _____

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

Suicidal gestures and/or attempts: No _____ Yes _____ If yes, list dates and explain how:

_____

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

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

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

Have 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: _____

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

CONSENT FOR TREATMENT

I voluntarily agree to, and give consent for treatment by Dr. Kinsler & Associates, LLC for myself and/or my family members.

Signature: _____ Date: _____

Printed Name: _____

Patient Payment Responsibility and Agreement

Payment is due at the time services are rendered unless special arrangements have been made. *For psychotherapy, financial hardships will be considered on an individual basis*. We accept cash, checks and credit cards. As a courtesy, we will estimate your insurance portion and process your claims for you. You will be required to pay your estimated patient portion on the day services are started. Not all services are a covered benefit in all contracts. Authorizations are based on medical necessity and are not a guarantee of payment by your insurance company. Insurance companies determine "medical necessity" for services provided at the time the claim is received and reviewed by them. You are responsible for any balance remaining after insurance pays their portion or denies payment for any reason.

For psychological evaluations, until payment is received in full by either yourself or your insurance carrier, no further services will be rendered beyond the initial testing. This means that the tests used as part of the evaluation **WILL NOT BE SCORED OR INTERPRETED and NO REPORT WILL BE GENERATED and NO FEEDBACK WILL BE PROVIDED**. Denial of payment by either your insurance carrier and/or yourself will delay these services indefinitely. If your insurance carrier delays and/or denies payment for any reason and you wish to receive these services; you may pay the estimated portion due by your insurance carrier. Once your insurance carrier pays you will be reimbursed by check from Dr. Kinsler & Associates, LLC for any over payments.

Because my time has been reserved exclusively for me and/or my family members, 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 scheduled appointment and I will be charged a $150.00 fee for a no-show or late cancellation with the provider in our office.** 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.).

Insurance Claims

Direct insurance assignment is currently accepted from several major insurance companies. For clients with other insurance, Dr. Kinsler & Associates, LLC will gladly provide documentation of treatment for clients seeking insurance reimbursement for out-of-network benefits.
I fully understand and agree to the above policies and conditions.

Patient/Parent/Guardian Signature _____

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 required 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 you have any questions or would like additional information, you may contact Dr. Kinsler & Associates, LLC at (813) 443-4311. 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 Patient (printed) _____ Date_____
Patient, parent or guardian signature_____
If refused, reason for refusal_____
Restrictions noted_____