Dr. Kinsler & Associates, LLC

Help…when life hurts

CHILD INTAKE/HISTORY

Child's Name ____Date ______/______/_______
Age________ Birth date ______/______/_______ Birthplace____
Grade ______________ School _____________________________________ School Contact__________________
Home Street Address ____
City ______________________________________ State __________________ Zip Code ___________________

FAMILY INFORMATION

Mother's name ____________________________________ Age ___________ Birth date ______/______/_______
Occupation ____________________________________ Education ____________________________________
SSN #___________________Work Phone _______________________ Cell Phone_______________________
Email Address:____
Street Address____
City ______________________________________ State __________________ Zip Code ___________________
Age at time of marriage ______ Age at time of divorce (if applicable)______Type of Custody(if

applicable)_______________

Father's name ______________________________________ Age _________ Birth date______/______/_______
Occupation ____________________________________ Education ____________________________________
SSN #___________________Work Phone _______________________ Cell Phone_______________________
Email Address:____
Street Address____
City ______________________________________ State __________________ Zip Code ___________________
Age at time of marriage ______ Age at time of divorce (if applicable)______Type of Custody(if

applicable)_______________

Other Guardians ☐Step Mother ☐Step Father ☐Social Worker ☐Other__________________
Name ______________________________________ Age _________ Birth date______/______/_______
Occupation _____________________________________ Education ___________________________________
Work Phone ________________________________ Cell Phone _____________________________________
Email Address:____
Name ______________________________________ Age _________ Birth date ______/______/_______
Occupation _____________________________________ Education ___________________________________
Work Phone ________________________________ Cell Phone _____________________________________
Email Address:____

Sibling's Name	Gender	Age	School / Occupation

Other persons in the home

Name __________________________________ Age ___________ Relation _______________________________
Name __________________________________ Age ___________ Relation _______________________________
How does your child get along with:
Mother? _______________________________________ Father? ____________________________________
Sister(s)? ____________________________________ Brother(s)? _________________________________

Is the child living with both biological parents? ☐Yes ☐No *If not, please explain*_____________________________
Who usually disciplines your child, for what reason and
how?____

Locations: 3262 Cove Bend Dr., Tampa, FL 33613 * 17734 Hunting Bow Cir. Suite 101 Lutz, FL 33558
Mailing Address: P.O. Box 272374 * Tampa, FL 33688
Phone: (813) 443-5311 * Fax: (813) 443-5312 * Website: www.kinslerpsychology.com

Do parents differ on discipline? ☐No ☐Yes *If yes, please explain* ____

Has there ever been a protective service case open related to your child or family?☐No ☐Yes *If yes, please explain*____

DEVELOPMENTAL/MEDICAL INFORMATION

Pediatrician's name_____________________________________ Telephone number___________________________

Height____ Weight____ Current medications _______________________ Drug Allergies_________________________

What is your child's current health? ☐Excellent ☐Good ☐Fair *If fair, please explain* ___________________________

____

Birth weight__________ Months carried___________ Type of delivery____

Mother's age at delivery______________ Health during pregnancy____

Describe any complications during pregnancy or birth____

____

Describe Maternal Postpartum Depression (if applicable)____

____

Describe your child's health during and after delivery____

____

Describe any challenges faced during Infancy-Adolescence (i.e illness, divorce or trauma)________________________

____

*Please give **approximate ages** for the following (if applicable):*

Sat up________ Crawled________ Stood Unassisted________ Walked________Stopped bottle/breast feeding________

Fed Self________ Toilet trained________ Stopped pacifier________ First word________ Talked in sentences________

Dressed Self_______ Tied Shoes________ Menstruation_______ Voice Changes (Boys)________ Drivers License________

*Please **mark any areas**, which constitute a problem for your child:*

☐Eating ☐Sleeping ☐Nightmares ☐Thumb sucking ☐Nail biting ☐Bedwetting ☐Wetting clothing ☐Soiling clothing ☐Soiling in bed ☐Getting along with friends ☐Self-help skills(dressing, bathing, etc.) ☐Gender/ Sexuality Concerns ☐Unusual fears *If Checked, please describe* ______________________________

What is your child's Race/Ethnicity?_____________________ Is there another language spoken at home? ☐No ☐Yes *If yes, what language?*_________________ Are there any Cultural accommodations we should be aware of?☐No ☐Yes *if yes, please describe*____

____

SCHOOL AND EDUCATIONAL INFORMATION

By whom was your child cared for during the daytime as an infant?____

Age began daycare or preschool________________________ Age started kindergarten____________________________

List schools your child has attended (include daycare if applicable):

School	City	Grade	Reason for leaving

Is your child in special classes? ☐No ☐Yes *If yes, what kind?*____

Has your child ever repeated a grade? ☐No ☐Yes *If yes, which grade?*____________________________________

Does your child receive tutoring services outside of school? ☐No ☐Yes *If yes, which subjects?*___________________

Has any family member ever had learning difficulties or attended special classes? ☐No ☐Yes *If yes, what kind?*____

Child's feelings about school____

Your feelings about your child's school program ____

\

SOCIAL AND EMOTIONAL INFORMATION

List your child's major interests and hobbies____

Extracurricular activities? ☐No ☐Yes *If yes, what kind?*____

Does your child have a Job? ☐No ☐Yes *If yes, how many hours do they work?*_________________________________

Friends (how many): Male_____________ Age range_____________ Female_________ Age range_________________

Do you feel your child is having difficulties in school? ☐No ☐Yes At home? ☐No ☐Yes *If so, what do you consider the problem to be and when and how did it begin?*____

____

Has your child ever experienced any traumatic events (e.g., death of a close relative/friend, accident, etc.)? ☐No ☐Yes *If yes, please describe*____

Has your child ever experienced any abuse such as sexual, emotional or physical? ☐No ☐Yes *If yes, please describe*

____

Has your child ever had counseling or a psychological/psychiatric evaluation (Testing)? ☐No ☐Yes *If yes, agency or name of therapist*____

Does your child have suicidal thoughts? ☐No ☐Yes Suicide attempts? ________________ Baker Acts? ___________

Does your child use or do you suspect substance abuse?☐No ☐Yes *If Yes, please explain* ________________________

____

Has your child been arrested or involved with the law?☐No ☐Yes *If Yes, please explain* _________________________

____

Do any family members have (or have had) any of the following psychological issues? (Please Check all that Apply and Specify which family member(s) in the blank)

☐ Addiction___________ ☐Anxiety___________ ☐Depression__________ ☐Bipolar Disorder___________

☐Schizophrenia____________ ☐Eating Disorder___________ ☐PTSD____________ ☐ADD/ADHD____________

☐Autism Spectrum Disorder____________ ☐Other__________________

Please list some of your child's strengths____

Please list some of your child's weaknesses____

What are the difficulties that caused your to seek professional help at this time?___________________________________

____

PHARMACY

Pharmacy name: ____

Pharmacy Phone:_______________________________ Pharmacy Fax:___________________________________

Pharmacy address: ____

____

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___________________________
Print name____ Relation to child________________

Assignment of Benefits

Patient Name: _________________________________ DOB:____/____/_____
Insurance:___________________________ Member ID:______________________

Professional Services Assignment: To the extent that fees for professional services rendered to the patient are payable, the undersigned hereby assigns to said professionals and authorizes payment directly to said professionals all insurance benefits, including major medical, for professional services rendered to the patient. The undersigned is financially responsible to the service provider for fees not paid pursuant to this agreement. Your insurance and Identification will be copied for our records today. PLEASE NOTE: WE WILL ONLY BILL THE PRIMARY INSURANCE and WE NO LONGER ACCEPT MEDICARE OR MEDICAID PLANS.

Acknowledgement: I understand and agree that Kinsler Psychology
1) May at its discretion make contact with an insurance company regarding insurance benefits.
2) Does not in any way guarantee any insurance health benefits.
3) Has not and does not guarantee that the professional services chargers are covered by insurance.

This will authorize Kinsler Psychology to release general medical as well as psychiatric, alcohol, drug abuse, HIV and/or AIDS information from my health record in accordance with Florida Statutes 394.459.90.503, 396.112, and/or 381.609 (3)(F) and Federal regulations (42 CFR Part 2) to the above-named insurance company if necessary for payment of insurance claims. I understand that I have the right to refuse this authorization. If I approve, the facility naked aboe is released from all legal liability that may arise from the release of the information requested.

Prohibition on redisclosure: This information has been disclosed from records whose confidentiality is protected by State/Federal law, which prohibits any further disclosure of such information without the specific written consent of the person to whom such information pertains, or as otherwise permitted by State/Federal law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. This consent is subject to revocation at any time except that the program which is to make the disclosure has already taken action in reliance on it. This authorization will expire one (1) year from the day signed.

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

Patient/Guardian Signature:____ Date:______/______/_______

Witness Signature:____ Date: ______/______/_______

Patient Payment Responsibility and Agreement

Text & Email Alerts

Please be advised that this service is a courtesy and it should not be the only thing you rely on to remind you and/or your family members of appointments. Immediately after scheduling the appointment, notate it in your calendar. Feel free to call either of our offices to confirm that you have the correct date or to ask for a printed copy of your upcoming appointments at your next visit.

Late Cancellations & No-Shows

Because the provider's time has been reserved exclusively for you and/or your family members, you are 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 advanced notice, I am financially responsible for the scheduled appointment and I will be charged a $100.00 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.) Fees can be waived due to emergency situations/ sickness, please contact as soon as possible so we can let your provider know.

Psychological Evaluations and Testing: (effective August 1, 2018)

- All patients are required to pay a **$100 DEPOSIT** in order to schedule testing. In instances where the deposit exceeds the amount for testing, then the remainder of the deposit funds will be refunded accordingly.
- In the event a patient needs to cancel their appointment, the patient agrees to cancel 24 hours in advance to receive a full refund. If the patient does not cancel within 24 hours of the scheduled appointment, then the patient forfeits their full deposit. Additionally, if the patient needs to reschedule their appointment, they must do so 24 hours in advance and Dr. Kinsler & Associates will transfer the deposit to the new appointment. If the patient does not reschedule within 24 hours of the scheduled appointment, then the patient forfeits their full deposit.
- 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.

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. 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 and credit cards. We do not accept checks. 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 or denies payment for any reason.

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

Patient/Parent/Guardian Signature ___________________________________Date:_______/_______/________

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 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____

Dr. Kinsler & Associates, LLC

Help…when life hurts

Release of Information

*****Please fill out if you would like a facility or person to have access to specific information regarding your medical records.*****

Patient's Name: ____ DOB: ______/______/_______

I, ___________________________________ (print name of adult patient, parent or guardian of minor), understand that Kinsler Psychology is authorized by me to use or disclose my Protected Health Information (PHI) for purposes which include treatment, evaluation and gathering information. I have read this authorization and understand what information will be used or disclosed who may use and disclose the information and the recipients of the information. I specifically authorize Kinsler Psychology to disclose my PHI as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization. It may be subject to disclosure by the recipient and may no longer be PHI.

The Information you may release subject to this signed release form is as follows:

- ☐ Psychological Evaluations/Reports
- ☐ Health/Medical/Birth Reports/Records
- ☐ Social/Developmental History Reports
- ☐ Psychiatric Evaluations/Reports
- ☐ Diagnostic Screenings/Reports/Records
- ☐ Mental Health/Psychotherapy Evaluations/Reports
- ☐ Educational/Academic Reports/Records
- ☐ Appointment Coordination (i.e. Schedule, cancel)
- ☐ Other (Specify)__________________________

Release my protected health information to the following physician/person/facility or those directly associated in my medical care:

Name: ____

Address: ____

Phone: ____

Fax: ____

For the Purpose of:____

I am aware that I have the right to revoke the authorization in writing, except to the extent that action has been taken in reliance on this authorization. All revocation must be sent to Kinsler Psychology and are not effective until received.

This authorization shall expire:

☐**Once treatment has been terminated** ☐**Has no expiration date** ☐**Date of Expiration:_______________**

After the expiration, Kinsler Psychology can no longer use or disclose my PHI without first obtaining a new authorization form. I fully understand and accept the terms of the authorization.

Patient/Parent/Caregiver Signature:____

Printed Name: ____ Date:______/______/_______