CHILD
PATIENT INFORMATION FORM

PATIENT'S NAME: ______________________________

DOB: ____________ AGE: ________ SSN_____-____-____

HOME ADDRESS (NO P.O. BOX):

____
ADDRESS

____
CITY STATE ZIP

MAILING ADDRESS IF DIFFERENT: ______________________________

PARENT'S NAMES AND DATE OF BIRTH:

MOTHER: ______________________________
DOB: ______________ AGE: ______

FATHER: ______________________________
DOB: ______________ AGE: ______

PARENT'S MARITAL STATUS: ______________________

CHILD'S PRIMARY RESIDENCE: ______________________

HOME PHONE NO: MOTHER: ( )____________________
FATHER: ( )____________________

CELL NO: MOTHER: ( )____________________
FATHER: ( )____________________

 # TO CALL FOR APPT. REMINDERS: ______________
EMAIL: ______________________________

___ Please initial if permission is granted to email statements, bills and/or other communication to above email address

TODAY'S DATE: ______________________________

INSURANCE POLICY HOLDER NAME:

____

DOB: ____________________ SSN: _____-____-_____

BUSINESS OR PLACE OF EMPLOYMENT:

MOTHER: ______________________________
NAME OF BUSINESS OR EMPLOYER

____
ADDRESS

____
CITY STATE ZIP

PHONE: ______________________________

FATHER: ______________________________
NAME OF BUSINESS OR EMPLOYER

____
ADDRESS

____
CITY STATE ZIP

PHONE: ______________________________

NEAREST NON-PARENTAL RELATIVE:

______________________ ______________________
Name Phone

Reason for requesting appointment (Chief symptoms/complaints/concerns) ______________________________

____

____

Approximate date or time problem began: ______________________________
Previous therapy or counseling (list approximate dates, places and therapist's name)

____

Child's Medical Doctor is: ______________________________

Referred by (Please specify names):
(a) Doctor: ____________________ (c) Friend: ____________________ (e) Public/Private Agency: __________
(b) Attorney: ____________________ (d) Yellow Pages: ______________ (f) Other: ____________________

List all medical conditions for which your child is currently being treated or medications child is currently taking:

____

FAMILY INFORMATION

List other minor children's name, ages, dates of birth and schools they attend

Name	*Gender*	*Age*	*Date of Birth*	*School*	*Grade*

The parent who initiates treatment is financially responsible for payment. I agree to pay for all charges not reimbursed by my insurance or not reimbursed by any other payment source, including **DEDUCTIBLES AND CO-PAYMENTS**.

______________________________ ______________________________
PARENT SIGNATURE **DATE**

Silver Psychology Center
4461 Camino Real Way
Fort Myers, FL 33966
(239) 936-1336
Fax (239) 936-4927

INFORMED CONSENT
FOR FINANCIAL RESPONSIBILITY & PRACTICE POLICY FOR PSYCHOLOGICAL SERVICES
GUARANTEE OF PAYMENT

WELCOME!

INTRODUCTION

The following is intended to inform you of the conditions governing the psychological services you are requesting. We wish to thank you in advance for your patience regarding all of this paperwork necessary in order to be in compliance with federal laws, state laws and regulations, and professional ethical standards. Also, we consider it important to clarify all financial matters beforehand to avoid misunderstanding.

PARTICIPATING INSURANCE PLANS

This practice participates in a few select insurance plans. The largest plans in which we participate are:
BEECH STREET
FIRST SERVICE ADMINISTRATORS (Charlotte County Sheriff's Office Employees)
MULTIPLAN
MEDICARE
WEB-TPA (Lee Memorial Health System Employees)
For these plans this practice will bill your insurance carrier and you only need pay your co-pay or deductible. However, please keep in mind the fact that no matter what payment information your carrier provides, this information is ADVISORY and not a guarantee of coverage or payment. You will only know your coverage for sure after your insurance claim is processed: Please be aware that not all services are covered by your insurance policy (e.g. school visits, phone calls, legal or court related services and sometimes educational testing or marital counseling). Medicare patients are advised that you will be responsible to pay half the cost for psychotherapy. Also, Medicare places limits on the amount and type of services for which Medicare will pay. If your psychologist believes Medicare will not pay for the services provided, you will be told of this and asked to sign a form accepting payment responsibility.

FINANCIAL RESPONSIBILITY

For all those patients not covered by the above mentioned plans you are expected to pay for each office visit at the time the service is rendered. By signing this form you indicate you understand and agree to pay the following charges for any direct or indirect professional service rendered on your behalf.

First Diagnostic Interview (60 min)	$185
Subsequent Interview/Therapy Session (55 min)	$170
Subsequent Interview/Therapy Session (45 min)	$139
Subsequent Extended Therapy Session (75 min)	$230
Therapy Session, per 30 minutes	$ 93
Psychological Evaluation, per hour *(includes scoring, analyzing and preparation of a written report)*	$185
Any consultation or other service performed on behalf of the patient, per hour	$ 185
Record review or preparation of any documents or forms, 15 minute increments	$ 45
Telephone Consultations longer than 5 minutes will be billed per quarter hour	$ 45

Our charges reflect the cost of maintaining a pleasant office environment, support staff, testing equipment, and continuing professional education which enables us to provide the most up-to-date, competent care possible.

Because direct fee-for-service payment saves this practice administrative and clerical costs we can offer a 19% prompt payment discount to all patients who pay at the time of service.

DESCRIPTION OF SERCIVES PROVIDED

TESTING

Psychological testing is sometimes necessary and can be extremely helpful in understanding the nature and extent of academic, learning, emotional, and/or psychological difficulties. This practice also conducts neuropsychological evaluations (e.g. assessment of how brain conditions affect understanding, reasoning, thinking, memory, learning and performance). An adequate evaluation is quite involved and usually requires five to ten hours broken up into a number of sessions. Following the evaluation, the results and conclusions will be discussed in detail with you during a feedback session. It is important to note that for every hour of direct testing, another hour is required for scoring, analyzing, and interpreting the results. The per hour rate for a psychological evaluation is $185. The overall cost of the psychological evaluation may range from $750 to $2,500. The cost of a psychological evaluation is determined by the amount of time and testing required to provide the necessary information for adequate diagnosis and treatment. In addition to the verbal feedback, an **optional** comprehensive report can be prepared at your request. However, in our experience, insurers do not usually pay for this service so you will have to be responsible for the cost. The hourly cost for report preparation is $185 and this usually requires a minimum of two hours or more.

SPECIAL SERVICES

One specialty area of this practice is conflict resolution services which involve working with parties to resolve disputes, particularly these related to sharing children after a marital or relationship break-up. Because of the special skills required and the stressful demands of solving disputes the fee for this service is $200 per hour. Furthermore, this service is not considered “medically necessary” or related to treatment for a mental disorder by insurance carriers, so this service is not covered by insurance. It is our policy to require a non-refundable retainer to engage our services for addressing and managing parental disputes.

FORENSIC SERVICES

The fee for expert legally related services is $240 per 60-minute hour. Billable forensic services may include but are not limited to: expert testimony, office depositions, case review, preparation of documents, and time out of office for courtroom appearances. Billable services may also include (but are not limited to) any or all of the following indirect services: reviewing hospital charts or medical records; obtaining history and background information; and the administration, scoring and interpretation of psychological tests. Forensic services are more costly due to the precision necessary, the added stress of the adversarial system and the legal exposure attendant to providing such services. The fee for expert legal testimony or deposition is $250 per hour.

Forensic psychological services are not considered medically necessary and therefore are not billable to insurance. Forensic services must be **self-paid**. Psychological services initiated for any legal or administrative purpose are considered NON-CONFIDENTIAL and you thereby give up any claim to privacy. Please keep in mind that forensic evaluations by their very nature are much more intrusive in terms of questioning about sensitive personal matters (e.g. sexual matters, abuse, arrests) and may therefore cause a degree of personal discomfort.

Service	Fee
Special Services-Conflict Resolution	$200
Forensic (court or legal related) services, per hour** ***An advanced retainer is required of which a $500.00 minimum is charged and is **NON-REFUNDABLE***	$240
Courtroom Testimony and/or Deposition, per hour** ***An advanced retainer is required of which a $500.00 minimum is charged and is **NON-REFUNDABLE***	$250
Telephone Consultations longer than 5 minutes will be billed per quarter hour or any portion thereof	$ 60

STANDARD POLICIES

CANCELLATIONS & CHECK RETURNS

I understand and agree that appointments cancelled or broken without 24-hours advance notice do not allow the Silver Psychology Center to offer my reserved time to another patient. This, in turn, exacts a financial toll on the Silver Psychology Center's practice. As such, you will be charged a fee of $35 for any appointments cancelled or broken without providing 24-hours advance notice. I understand that my insurance plan does not cover such charges.

For returned checks you will be charged the current bank fee. Returned checks must be picked up within three (3) business days and the full amount due must be paid in cash.

BILLING AND COLLECTIONS

I understand and agree that professional services are rendered and charged to me and not to an insurance company. I agree that it is my responsibility to understand my insurance plan and to keep the Silver Psychology Center informed of any changes. **I agree that it is my responsibility to know whether precertification is required and if so to obtain such precertification and have it submitted to this office prior to appointments.** As a courtesy we can submit your
claims to your insurance carrier or provided you with a statement that has all the necessary information to file yourself for reimbursement. However, we **cannot** follow up on any disputed claims. We will nonetheless attempt to help you recover your costs by providing advice and guidance on securing insurance reimbursement.

If Robert B. Silver, Ph.D., P.A. D/B/A Silver Psychology Center is a participating provider with my insurance plan, I understand and agree that co-payment and/or deductible amounts are due at the time of service and I will pay them.

SEPARATION/DIVORCE POLICY

For separated or divorced families, the person who initiates the service or who comes or brings a child for the service is financially responsible. We will not bill another person or the other parent unless that individual informs us in advance in writing of his/her willingness to pay for the services. Should another party be willing to assume financial responsibility for our services they may download the FINANCIAL RESPONSIBILITY form and return it by email, fax or mail.

Whenever possible our goal is to promote a better relationship between children and their parents. Privacy is especially important in securing and maintaining the trust necessary to successful treatment. We will not necessarily share with you what your child has disclosed unless safety is an issue. We will, though try to discuss general concerns, the progress being made and what needs to be done. Unless the divorce settlement agreement prohibits it or we believe the child's safety requires it, the other parent is entitled to participate in whatever way is considered beneficial and also is entitled to the same information (with the limitations just discussed).

ACKNOWLEDGMENT OF RESPONSIBILITY

In consideration of the services rendered, I promise to pay Robert B. Silver, Ph.D., P.A. D/B/A the Silver Psychology Center all charges minus authorized discounts and to make full payment at the time of service. In lieu of this, I will guarantee full payment with a credit card. In the event that the undersigned patient is a subscriber to an insurance plan in which Dr. Silver is a participating provider and is entitled to benefits, I hereby assign any insurance benefits to Robert B. Silver, Ph.D., P.A. D/B/A the Silver Psychology Center. I understand and agree that the Silver Psychology Center may not know all of the particulars of my specific insurance policy and that the Silver Psychology Center is not responsible for actions taken by my insurance company. **If Robert B. Silver, Ph.D., P.A. D/B/A the Silver Psychology Center is an in-network provider for my insurance plan I understand and agree that I will be responsible for payment for any charges or services that are not covered by my insurance company**. Any problems that may occur with insurance reimbursement remain my responsibility to solve with my insurance carrier.

If Robert B. Silver, Ph.D., P.A. D/B/A the Silver Psychology Center is an out-of-network provider with my insurance plan I understand and agree that I am the responsible party for settling my account directly with the Silver Psychology Center. I authorize Robert B. Silver, Ph.D., P.A. D/B/A Silver Psychology Center to charge any visits for which I do not pay directly by cash or check to my credit card.

I understand and agree that the Silver Psychology Center may refer accounts past due to a collection agency, or to an attorney chosen by the Silver Psychology Center, with information released as necessary for collection purposes. I specifically authorize the Silver Psychology Center to release information to the collection agency, and/or attorney as necessary for billing and collection purposes. I understand that if I do not settle my account within thirty (30) days, and if my account is assigned to an attorney or collection agency, this may adversely affect my credit. I hold the Silver Psychology Center harmless for any adverse consequences that may occur as a result of the assignment of my account to a collection agency or attorney.

CONFIDENTIALITY AND CONSENT INFORMATION

RELEASE OF INFORMATION

I understand and agree that the Silver Psychology Center may communicate by phone and in writing with my insurer if Dr. Silver is a participating provider for the purpose of conducting utilization reviews. I understand and agree that utilization reviews may require the written or telephonic release of confidential information such as progress notes, treatment reports and psychological reports.

When asked, I direct the Silver Psychology Center to exchange information regarding my case, including release of a psychological report, to agencies, doctors, therapists, or to anyone whom I so authorize in writing.

By authorizing a release of information, I understand that I am waiving the confidential nature of the patient-psychologist relationship. I also authorize the release of information as necessary for the purpose of the Silver Psychology Center obtaining consultation regarding my evaluation and/or treatment. If Robert B. Silver, Ph.D., P.A. D/B/A the Silver Psychology Center is an in-network provider for my insurance plan I authorize the release of any and all information requested by my insurance carrier for the purpose of processing my insurance claim and obtaining payment for services. In authorizing the release of information to any insurance company or other third party, I understand that the information may become part of the third party's records and that the Silver Psychology Center can no longer control any subsequent release of that information. It is important to note here that **THE ONLY WAY YOU CAN ABSOLUTELY ASSURE THE CONFIDENTIALITY OF YOUR TREATMENT IS TO PAY FOR THE SERVICES YOURSELF**. As long as a third party is involved, your confidentiality will be compromised to some degree.

Should you desire written records of your treatment, you must sign an authorization and a summary of treatment will be provided.

CONSENT FOR PSYCHOLOGICAL SERVICES

I hereby voluntarily apply for and give my consent to psychological services provided by the Silver Psychology Center. This consent applies to myself, my child, and/or my family. Because I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent.

LIMITATIONS OF SERVICES

I understand that the Silver Psychology Center provides outpatient psychological, consultation and educational services only. This practice is not geared to the provision of emergency services. While the practice maintains an after-hours answering service, this is not a guarantee of the availability of emergency coverage. Should you require emergency services after hours, please dial 911 or call the Lee Mental Health Center at (239) 275-3222.

ASSUMPTION OF RISKS

I understand that the potential benefits of undergoing psychological or other consultative professional services may include improvement in psychological functioning of myself or child and/or an increased understanding of myself and/or my child or help in resolving conflicts. I understand that the potential risks may include possible disagreement with the opinions offered to me, and possible emotional distress concerning my situation. I understand that alternative procedures include services provided by another psychologist, psychiatrist, or mental health professional.

I understand that while the evaluation and/or treatment will be based upon known psychological principles and research, the practice of psychology is not an exact science. I acknowledge that no guarantees have been made to me concerning the results of evaluation or treatment provided by the Silver Psychology Center.

LIMITS OF CONFIDENTIALITY

I understand and agree that my disclosures and communications are considered privileged and confidential, except to the extent that I authorize a release of information. I understand that state law requires a psychologist to disclose the following without consent or authorization:

(1) Known or reasonably suspected abuse or harmful neglect of children, the elderly, or disabled or incompetent individuals; (2) immediate threats of physical violence against a readily identifiable victim; (3) an immediate threat of self-inflicted damage. (4) Also, where a patient or client, by alleging mental or emotional damages in litigation, puts his or her mental state at issue or files a malpractice claim, records may be released without consent or authorization. Where a patient is examined pursuant to a court order, confidentiality may not apply. Under such circumstances, I acknowledge that I hold the Silver Psychology Center harmless for releasing information under any of the above conditions.

STATEMENT OF UNDERSTANDING

I certify that I have read this form or that it has been read and explained to me in terms that I understand. My questions have been answered to my satisfaction and all statements of which I do not approve have been stricken by mutual agreement. I accept the policies described. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. I understand that my consent for release of information will be considered valid for twelve (12) months after my last appointment. I acknowledge that I voluntarily consent to the preceding conditions. By signing this form, I understand and agree with the terms and conditions of this form.

____
Name of Patient (if a minor)

______________________________________ ______________________
Signature of Adult Patient or Parent/Guardian of Patient Date

GUARANTEE OF PAYMENT

This practice cannot provide loan or credit services. Therefore, we require payment at the time of service and/or a credit card guarantee of payment. I authorize Robert B. Silver, Ph.D., P.A. to charge any visit for which I do not pay directly by cash or check to my credit card listed below. I understand and agree that if Robert B. Silver, Ph.D., P.A. D/B/A Silver Psychology Center is a participating provider in my insurance plan he may charge my credit card or debit card in the event (1) my insurance carrier fails to pay within 30 days of filing (as required by State law), and (2) I have been notified by letter or phone, and (3) I have been allowed to pay my bill within 10 days, and (4) I have failed to pay within those 10 days. This guarantee of payment is valid for twelve consecutive months after my last visit unless I cancel this authorization through written notice to The Silver Psychology Center.

______________________________________ ______________________
Cardholder's Name (Please Print) Date

______________________________________ _____ ______________________
Credit Card Number (VISA, M/C, AMEX, Discover, Debit) Security Number Card Expiration Date

______________________________________ ______________________
Cardholder's Signature Office Personnel Initials

____
Cardholder's Full Billing Address (No P.O. Boxes)

Thank you

HIPPA NOTICE OF PRIVACY PRACTICES

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

This notice is effective April 14, 2003 and remains valid until changed and you are notified of the changes and agree to them.

This notice describes how this practice may use and disclose the psychological information that is gathered as a result of our evaluation and treatment of you and/or your child. We recognize this information is personal and we will comply with State and Federal regulations regarding this protected health information.

USES AND DISCLOSURE FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS:

- Robert B. Silver, Ph.D., P.A. or the Silver Psychology Center may use or disclose psychological information that is collected and referred to as *Protected Health Information* (PHI), for treatment, payment and health care operation purposes. To help clarify these terms, here are some definitions:

- **PHI** refers to psychological information that we create and obtain during the course of providing our services to you. Such information may include documenting your symptoms, your personal history, test results, diagnosis, and/or treatments, used to apply for future care or treatment.

- "Payment" means obtaining reimbursement for your mental health care. This includes all billing matters, such as the need to disclose your PHI to your health insuror to obtain payment for your mental health care or to determine eligibility or coverage.

- "Health care operations" are activities that relate to the performance and operation of The Silver Psychology Center. This includes such things as accessing quality of care necessary to improve services, business-related matters such as adult and administrative services, and case management and care coordination.

- "Use" applies to activities within the Silver Psychology Center such as maintenance of records. Disclosure applies to activities outside this clinical practice such as releasing, transferring or providing access to information about you to other parties. For example, sometimes it is necessary to consult with another specialist and share information with that specialist in order to obtain that specialist's consultative input.

YOUR HEALTH INFORMATION RIGHTS:

All mental health records, as well as billing records are securely maintained on the physical property of this office. This information will only be disclosed with an appropriate authorization. An authorization is a written permission provided by the patient, parent or guardian that gives permission to share PHI about you or your child with a specified person or agency. You have the right to:

- Request a restriction on uses or disclosures of your protected health information by delivering such a request in writing to our office. However, we are not required to agree with your request for a restriction.

- Obtain a paper copy of this notice of Privacy Practice For Protected Health Information by making a request at our office. You have the right to inspect or obtain a copy (or both) of your mental health PHI and billing records for as long as a PHI record is maintained. You may exercise this right by delivering your request in writing to our office using the form we provide to you upon request. If you want a copy of your record we will charge you $1.00 per page up to 25 pages; thereafter you will be charged $0.25 per page.

- Request that your mental health care record be amended to correct incomplete or incorrect information. You may do this by delivering a written request to our office using the form we provide to you upon request. Robert B. Silver, Ph.D., P.A. or the Silver Psychology Center may deny your request. You have a right to file a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached to all future disclosures of your PHI.

- Receive an accounting of all disclosures of your PHI. This will include disclosures made at your request.

- Request and receive confidential communications of your PHI by any alternative means and at any alternative locations.

- Revoke any authorizations that you have made previously regarding use or disclosure of PHI, except to the extent that the information has already been released based upon prior authorization, or that action has already been taken. You may rescind an authorization by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact Robert B. Silver, Ph.D., at (239) 936-1336.

NON-RESTRICTED PHI USES AND DISCLOSURES:

There exists a number of contingencies wherein this practice may disclose certain limited PHI without prior consent. Examples of these are as follows:

BUSINESS PRACTICES

- This practice has Business Associates with whom we may share limited PHI. For example, information about payments may be shared with our accountant. Also, we may need to hire computer technicians and software vendors. In performing their duties, they may have access to your name and perhaps limited PHI data.

FAMILY

- When there is a need to communicate with family members, using our best judgment, this practice may disclose to a family member, other relatives, close personal friends, or any other person you identify, PHI relevant to that person's involvement in your care, or for payment for such care, provided you do not object, or in case of an emergency.

DISASTER RELIEF

- We may use and disclose your protected health information to assist in disaster relief efforts.

NOTIFICATION OF APPOINTMENTS

- We may contact you to provide you with appointment reminders.

WORKERS' COMPENSATION

- If you are seeking or receiving compensation through Workers' Compensation, we may disclose your PHI to the extent necessary to comply with laws relating to Worker's Compensation.

ABUSE AND NEGLECT

- As required by law, we may disclose your PHI to public health authorities to report abuse or neglect.

EMERGENCIES

- Where there is a serious threat to your health and safety or your child's, we may release PHI necessary to prevent serious harm, injury or irreparable damage.

JUDICIAL/ADMINISTRATIVE PROCEEDINGS

- If treatment or evaluation is being provided for legal purposes pursuant to a court order, you give up your right to confidentiality and all PHI will be subject to disclosure without your consent.

OTHER USE AND DISCLOSURES

- Other uses and disclosures, in addition to those identified in this Notice, will be made only as authorized by law **or with your written authorization,** you may revoke that authorization at anytime.

COMPLAINTS

If you have any questions, concerns or want to report a problem regarding the handling of your PHI, you may contact Robert B. Silver, Ph.D. (239) 936-1336 in person or by writing.

In addition, if you believe your privacy rights have been violated, you may file a written complaint at your office by delivering the written complaint to the following person: Robert B. Silver, Ph.D. (239) 936-1336.

You may also file a complaint by writing or mailing it to the Secretary of Health and Human Services.

PSYCHOLOGIST'S DUTIES

The psychologists of the Silver Psychology Center are required to:

- Maintain the privacy of your mental health information as required by law.
- Provide you with a notice of the practice's legal duties and privacy practices with respect to PHI.
- Abide by the terms of the Notice.
- Notify you if we cannot accommodate a requested restriction or request.
- Robert B. Silver, Ph.D., P.A. or the Silver Psychology Center reserves the right to change the privacy policies and practices described in this notice. Unless notified, however, this practice is required to abide by the terms currently in effect.

By signing below, I acknowledge that I have read this Notice of Privacy and I am aware I may request and be given a copy.

Signature:____ Date:__________________