Kortanek Psychological Services, Inc.
Client Information Form

Identifying Information

Name_____ Date_____

Parent/Guardian Name(s) (if client is a minor) _____

Address_____

City_____ State _____ Zip Code_____

Date of Birth_____ Gender _____

Social Security Number_____ Relationship Status_____

Cell Phone (_____)_____ Home Phone (_____)_____

Work Phone (_____)_____ Email_____

Which of the above phone numbers is your preferred method of contact?_____

May we have permission to contact you and leave a message? Y N (circle)

In case of emergency, we should notify?_____

Relationship to the client_____Phone Number_____

How were you referred to this office?_____

Medical Information

List all Medications (if applicable)_____

List all Allergies (if applicable)_____

Family/Primary Care Physician_____

Insurance Information

Name of Policy Holder_____

Relationship to Client (if policy holder is not the client)_____

Policy Holder's Date of Birth_____

Policy Holder's Employer_____

Insurance Carrier_____Phone Number_____

Subscriber ID #_____Group Number_____

Self-Assessment Questionnaire

Name: _____ Date: _____

Please indicate the purpose of your visit:

_____

_____

Please describe why you scheduled an appointment with Kortanek Psychological Services:

_____

_____

Please list all Physical Symptoms/Health Concerns:

_____

_____

Please list all previous Psychotherapy/Hospitalizations:

_____

_____

Self-Assessment Questionnaire (Part 2)

Please mark your experiences of each of the following items:

	None	Mild	Moderate	Severe
Depression				
Anxiety				
Panic				
Mania				
Anger/Frustration				
Low Self-Esteem				
Excessive Fear/Phobia				
Lack of Pleasure/Enjoyment				
Guilt				
Sleep Disturbances				
Issues related to Food/Eating				
Social Withdrawal				
Unpleasant/Confusing Thoughts				
Irritability				
Academic/Work Dysfunction				
Legal Problems				
Relationship/Marital Problems				
Separation/Divorce				
Child Custody Problems				
Sexual Dysfunction				
Financial Difficulties				
Gambling Problems				
Grief/Loss				
Thoughts of Harming Yourself				
Thoughts of Harming Someone Else				
Substance Abuse				
Physical Abuse				
Emotional Abuse				
Sexual Abuse				
Domestic Violence				

Statement of Clients' Rights and Responsibilities

Statement of Clients' Rights:

- Clients have the right to be treated with dignity and respect.
- Clients have the right to fair treatment regardless of race, religion, gender, sexual orientation, ethnicity, age, disability, or source of payment.
- Clients have the right to have their treatment and other client information kept private.
- Only in an emergency, or if required by law, can records be released without client permission.
- Clients have the right to information from staff/providers in a language they can understand.
- Clients have the right to have an understandable explanation of their condition and treatment.
- Clients have the right to know all about their treatment choices.
- Clients have the right to get information about their insurance's services and role in the treatment process.
- Clients have the right to information about their providers.
- Clients have the right to know the clinical guidelines used in providing and/or managing their care.
- Clients have the right to provide input on their insurance company's policies and services.
- Clients have the right to know about the compliant, grievance, and appeal process.
- Clients have the right to know about State and Federal laws that relate to their rights and responsibilities.
- Clients have the right to know of their rights and responsibilities in the treatment process.
- Clients have the right to share in the formation of their treatment plan.

Statement of Clients' Responsibilities:

- Clients have the responsibility to give providers information they need to deliver the best possible care.
- Clients have the responsibility to let their provider know when the treatment plan no longer works for them.
- Clients have the responsibility to follow their medication plan. They must tell their provider about medication changes, including medication give to them by other providers.
- Clients have the responsibility to treat those giving them care with dignity and respect.
- Clients have the responsibility to keep their appointments. Clients should call their providers as soon as possible if they need to cancel visits.
- Clients have the responsibility to ask their providers questions about their care, so they can clearly understand their care and their roles in that care.
- Clients have the responsibility to let their providers know about problems with paying fees.
- Clients have the responsibility to follow plans and instruction for their care. The care is to be agreed upon by the client and the provider.

I have read and understand my client rights and responsibilities.

Client Signature _____ Date _____

Provider Signature _____ Date _____

Financial Agreement

Clients are responsible for providing accurate information about their insurance benefits. Failure to complete this section or inaccurate information will make clients fully responsible for all charges. Clients are responsible for notifying Kortanek Psychological Services, Inc. (the office) of any insurance changes within 30 days, otherwise you may be responsible for payment in full. In most cases, the office may obtain insurance benefit information. Information quoted is not a guarantee of benefits or payment by your insurance company. The office does not accept Medicare, Medicaid and its subsidiaries. Clients are responsible for all charges.

I request that Kortanek Psychological Services, Inc. as the agent for the Clinician, submit bills to the insurance company that I have listed, and I grant permission to the Clinician and Kortanek Psychological Services, Inc. to release such confidential information as necessary to obtain payment from the insurance company. In the event that my insurance company fails to observe Ohio prompt payment standards or otherwise fails to adhere to relevant rules and standards, I grant permission to Kortanek Psychological Services, Inc. to share information related to my insurance claim with the Ohio Department of Insurance.

I understand that I am financially responsible for the cost of the mental health service to me or my child and for any portion of the fees not reimbursed or covered by my health insurance. If my mental health care is provided under the terms and condition of a managed mental health care program to which the Clinician is contracted, my financial responsibilities may be limited by the terms of that contract. I understand that my failure to pay these bills may result in collection procedures being taken against me by the Clinician or a collection agency contracted by Kortanek Psychological Services, Inc. to collect these bills. I also understand that if my account is placed in collections, neither I nor any other client for whom I am the guarantor will be able to schedule appointments with any other Clinician. Any fee associated with the collection of this debt is the responsibility of the client or guarantor, including attorney and filling fees.

Any fees for testing and materials will be billed at a separate rate and may not be covered by insurance. I authorize the release of any medical information necessary to process my claim. Fees may be different for alternative or additional services such as psychological testing, legal consultation/testimony, etc. and will be explained to me if these services are necessary.

My signature below indicated that I have agreed to the above terms.

Name (Please Print) _____

Signature of Client/Guardian _____ Date_____

Financial Responsibility (if other than the client)

Name (Please Print) _____ Date _____

Address (if different from client) _____

Phone Number _____ SSN_____

DOB _____

Signature of Financially Responsibility Party _____

PROFESSIONAL SERVICES AGREEMENT

OUR OFFICE IS HIPPA COMPLIANT. This information sheet has been prepared to inform you with policies affecting issues that frequently arise over the course of treatment. The ethical standards of our profession demand that we respect the dignity and integrity of those who seek our help regardless of race, gender, sexual orientation, ethnicity, age, disability, or source of payment. Your signature on this document will indicate you have read and understood it and agree to its provisions. If at any point, you have further questions we are always willing to discuss our office policies with you.

_____(initial) I understand that the effectiveness of mental health services depends on efforts of the patient as well as those of the Clinician and I promise to make my best effort to comply with these procedures. The best efforts will include open and honest discussion of my thoughts, feelings, and behaviors, as well as an effort to perform any exercises or homework assignments that may be recommended. I also agree to return, undamaged, any materials that have been loaned to me as part of the procedures and understand that I am liable for the cost of these materials. I understand that the effectiveness of the procedures cannot be guaranteed and that the Clinician has sole professional responsibility for all services provided.

_____(initial) I understand that regular attendance will produce the maximum benefits but that I am free to discontinue treatment at any time. If I decide to do so, I will notify the Clinician at least two weeks in advance so that effective planning for continued care can be implemented. I also agree to notify the Clinician **at least 24 business hours in advance** if I will be unable to attend any session. I understand that if I fail to make such notification, I may be charged for the **full** cost of the session, which will not be reimbursable by my insurance company. I agree to be responsible for these charges. I understand that tardiness 15 minutes past the start time of my session without notification to the clinician may be considered a "no show" (failure to cancel at least 24 hous in advance) and I may be charged for the **full** cost of the session, which will not be reimbursed by my insurance company.

_____(initial) I understand that conversations with the Clinician will be of a confidential nature. I authorize my Clinician to discuss my treatment with other treatment providers to coordinate my care. As an adult, anything said in the context of psychotherapy is privileged, with these limitations:

1. If I am behaving in a way that poses a threat to the physical well-being of another person, or myself, privilege is waived. I understand that this office is bound by law to contact the person(s) involved, and warn them of possible danger.

2. If a parent or guardian is suspected of child or elder abuse, it is the Clinician's professional responsibility to report their concern to the appropriate authorities.

3. If I am using confidentiality as a means of avoiding legal punishment, privilege is waived.

4. All actions taken under these provisions will be discussed with me fully and in advance whenever possible. I understand that the Clinician will make reasonable efforts to resolve these situations before breaking confidentiality. I also understand that in order to ensure patient confidentiality and privacy, electronic recording is strictly prohibited within our offices.

_____(initial) I understand that my clinical case will be closed after a period of 6 months from the last clinical session if no correspondence has been made by me to the clinician, unless otherwise directed or agreed upon with consent from the clinician. If I choose to re-establish a clinical relationship after this period, I understand that I will be reconsidered a new patient. I understand that as a new patient, I may not be guaranteed to meet with my former clinician and that I may need to review and sign a new informed consent agreement.

As a general rule, email cannot be considered a secure way to transmit your personal health information. This office will not use email to send your personal health information to anyone in a form that allows you to be identified by name or by other unique information. We also discourage all clients from sending email to this office if the email is going to include a client's personal health information. Additionally, our therapists do not use email, texting or any other social media outlets as a means of responding to emergency situations.

Although we sincerely care for your well-being and safety, please be advised that we are not always available to assist in emergency or crisis situations. Therefore, we strongly recommend that you call 911 or proceed to a hospital emergency room if such situations arise.

Client Name: _____

Client Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICES FOR KORTANEK PSYCHOLOGICAL SERVICES, INC.

The following describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We understand that your health information is personal to you, and we are committed to protecting information about you. We rely on you to give us complete and accurate information about your condition, symptoms and health history to diagnose and treat you. We appreciate how you trust us with this information. This Notice of Privacy Practices (or "Notice") describes how we will use and disclose protected information and data that we receive or create related to your health care as well as your rights regarding your health information. We are required by law to maintain the privacy of your health information and to give you this Notice describing our legal duties and privacy practices. If you have any questions, about our Privacy Practices, including your rights and ability to voice your concerns, please call 216 245-6231.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The most common reason why we use or disclose your health information is for treatment, payment or health care operations.

Treatment: We will use and disclose your health information while providing, coordinating or managing your health care. For example, information obtained by the clinician or a member of our staff during the course of your treatment will be documented in your record. This documentation may be forwarded to other health care providers, hospitals or nursing homes that are involved in treating you. Information obtained also may be disclosed to your pharmacy to fill your prescription. Kortanek Psychological Services, Inc. may request your medical information from other health care providers previously seen to assist in your care.

Our records may contain information we receive from other sources, such as a hospital (if you have been an inpatient). If another doctor or provider (hospital or nursing home) treating you asks for your records, we may send the record, with your consent. We believe that is in the best interests of patient care and treatment. Please let us know if you have a concern about our sending the record.

Payment: We will use and disclose your medical information to obtain or provide compensation or reimbursement for providing your health care. For example, a bill will be sent to you if you have an outstanding balance or to an outside collection agency if your account becomes delinquent. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis. As another example, we may disclose information about you to your health plan so that the health plan may determine your eligibility for payment of certain benefits

Health Care Operations: We will use and disclose your health information to deal with certain administrative aspects of your health care and to efficiently manage our business; for example financial or billing audits, internal quality assurance, participation in managed care plans, defense of legal matters, business planning, and outside storage of records.

Business Associates: There are some services provided in our organization through contracts with business associates. We may disclose your health information to our business associates so they can perform the job requested. However, we require the business associates to take precautions to protect your health information.

Research: Consistent with applicable law, we may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Appointment Reminders: We may call to remind you of scheduled appointments, missed appointments, or that it is time to make your appointment. We may also call or write to notify you of other treatments or services available at our office that might benefit you. Unless you tell us otherwise, we will leave you a reminder message on your home answering machine, cell phone, or with someone who answers your phone if you are not home.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse and neglect.

Health Oversight: In order to oversee the health care system, government benefits programs, entities subject to governmental regulation and civil rights laws for which health information is necessary to determine compliance, we may disclose your health information for oversight activities authorized by law, such as audits and civil, administrative or criminal investigations.

Law Enforcement: Under certain circumstances, we may disclose your health information to law enforcement officials. These circumstances include reporting required by certain laws pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises and crimes in emergencies.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Victims of Abuse, Neglect or Domestic Violence: We may disclose your health information to appropriate governmental agencies, such as adult protective or social services agencies, if we reasonably believe you are a victim of abuse, neglect or domestic violence.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Workers' Compensation: We may disclose health information when authorized and necessary to comply with laws relating to Workers' Compensation or other similar programs.

We may not make any other use or disclosure of your personal health information without your written authorization. Once given, you may revoke the authorization in writing to Kortanek Psychological Services Inc. Understandably, we are unable to take back any disclosure we have already made with your permission.

Individual Rights:

You have many rights concerning the confidentiality of your health information. You have the right:

- To request restrictions on the health information we may use and disclose for treatment, payment and health care operations. We are not required to agree to these requests. To request restrictions, please send a written request to Kortanek Psychological Services, Inc.
- To receive confidential communications of health information about you in a certain manner or at a certain location. For instance, you may request that we only contact you at work or by mail. To make such a request, send a written request of how or where you wish to be contacted to Kortanek Psychological Services, Inc.

- To inspect or copy your health information. You must submit your request in writing to Kortanek Psychological Services, Inc. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of your request. You may be charged a fee for the cost of copying and mailing in advance. If you are denied access to your health information, we will send you a written explanation. You may request that the denial be reviewed. Another licensed health care professional will then review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- To amend health information. If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. To request an amendment, you must write to Kortanek Psychological Services, Inc. You must also give us a reason to support your request. We may deny your request to amend your health information if it is not in writing or does not provide a reason to support your request. We may also deny your request if:
    1. The information was not created by us, unless the person who created the information is no longer available to make the amendment.
    2. The information is not part of the health information kept by or for us.
    3. The information is not part of the information you would be permitted to inspect or copy; or
    4. The information is accurate and complete.
- To receive an accounting of disclosures of your health information, you must submit a request in writing to Kortanek Psychological Services Inc. Not all health information is subject to this request. Your request must state a time period of no longer than six years. Your request must state how you would like to receive the report. The first accounting you request

within a 12 month period is free. For additional requests, there may be a charge. We will notify you of this cost and you may choose to withdraw or modify your request before charges are incurred.

- To receive additional copies of this Notice upon request, please send your request to Kortanek Psychological Services, Inc.

Complaints

If you believe that your privacy rights have been violated, a complaint may be made to:

Kortanek Psychological Services, Inc.

24800 Chagrin Blvd. Suite 103

Beachwood, OH 44122

216-245-6231

You may also submit a complaint to the Secretary of the Department of Health and Human Services.

Kortanek Psychological Services, Inc. will not retaliate against you for filing a complaint.

Changes to This Notice

Kortanek Psychological Services, Inc., reserves the right to change our privacy practices and to apply the revised practices to the health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, you will be notified of any such change. We will post the new notice in our office, have copies available and post it on our website.

My signature below indicates that I have agreed to these terms and have read and understand a "Notice of Privacy Practices" and information describing my rights and responsibilities as a patient or guardian of a patient.

Patient Name (please print)_____

Signature of Patient/Guardian_____

Date_____