Thrive Psychological Services, Inc

3200 E. Guast Rd. #100
Ontario CA 91761
www.thrivepsychservices.org

Telephone: 909.295.5805
Facsimile: 909 . 295 . 5011
referrals@thrivepsychservices.org

NEW CLIENT INFORMATION

Today's date:_____ Today's appointment is with _____

Client's Name _____ **SS#**_____

Reason for visit: _____

Date of Birth_____ Age_____ Referred by_____

☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Home Address_____ Home #_____

City_____ State_____ Zip_____ Years at this address _____

Employer_____ Occupation_____

Work Address_____ Work #_____

E-mail*:_____ Mobile #:_____

Person Responsible for payment _____

Relationship to Client:_____ SS#_____

Address _____ Home # _____

Employer _____ Date of Birth_____

Work Address_____ Work # _____

Insurance Co._____ Subscriber # _____

Name of subscriber Group # _____

Subscriber relationship to client_____ Auth. # _____

Current Medications:_____

Personal Physician_____ Office #_____

Previous Therapist_____ Office #_____

Allergies_____

Emergency Contact: _____Tel: _____ Relationship: _____

Please indicate which modes you would prefer we NOT use to contact you:

☐ US Mail ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ E-mail

* Please remember that confidentiality cannot be ensured over the Internet. Please do not communicate private or time-sensitive information by email.

New Patient Agreement

I, the undersigned, understand that the procedures that I will receive in the course of this evaluation or treatment will consist of diagnostic and psychotherapeutic interviews conducted/facilitated by the employees and contractual staff of Woodbridge Psychological Associates, PC (the Practice). Although the Practice's employees and contractual staff may also have professional roles or affiliations with other organizations (e.g., the Community Services Board, or The University of Virginia), services rendered by the Practice are offered independently, and are not provided under the auspices of these other affiliations and organizations.

I understand that 1) payment is due at the time of service, unless other prior arrangements are made, 2) I am financially responsible for all charges, whether or not covered by insurance, and 3) I will be charged for missed appointments and for cancellations made less than 24 hours before a scheduled appointment.

In the event that the Practice participates and/or accepts assignment of benefits with my insurance plan, I realize that I am responsible for all co-payments/co-insurance, deductibles, and non-covered services, as determined by my insurance plan. I also understand that it is my responsibility, and not the responsibility of the Practice, to seek out and obtain current information about my insurance coverage, including information that might affect my financial obligation for services rendered by the Practice, such as information about co-payment/co-insurance amounts, deductibles, non-covered services, and pre-authorizations.

I understand that I am financially responsible for all services rendered to me by the Practice. In the event of nonpayment of my account within sixty (60) days after an invoice is rendered, I agree to pay interest at the rate of 1 percent (12 percent per year) on the unpaid balance until the account is paid in full. If the account is delinquent, and if the account is referred for collection, I agree to pay all expenses incurred in collecting the same, including without limitation, a reasonable attorney's fee equal to 25 percent of the amount owed at the time the account is referred, and all court costs.

I authorize payment directly to the Practice for services for which the Practice accepts assignment. I also authorize the Practice to release to my insurance carrier(s) any clinical or treatment information necessary to obtain reimbursement. I permit a copy of this authorization to be used in place of the original.

_____ _____

Signature of Patient Date Parent (if Pt. is a Minor) Date

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health 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 surgical 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 understand and have been provided with a *Privacy Notice* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

☐ I consent (with restrictions noted above, if applicable)

☐ I do not consent

Signature_____ Date: _____

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ON-GOING CREDIT CARD AUTHORIZATION FORM

Patient Name: _____

I, _____, authorize Thrive Psychological Services, Inc (the Practice) to charge my credit card as stated:

My signature below indicates my knowledge, acceptance, and authorization that my credit card, listed below, is to be charged on an on-going periodic basis to process all outstanding charges for services rendered to the above-named patient by the Practice. I also acknowledge that this authorization will remain in force until revoked by me in writing to the Practice, or until all outstanding charges have been paid in full following termination of treatment.

Credit Card Information

Credit Card: ☐ **M/C** ☐ **Visa**
(please circle one)

Credit Card Number: _____

Expiration Date: _____/_____/_____
(month) (day) (year)

Credit Card Bill To Address: _____

City State: _____

Bill To Zip Code: _____

Security Code: _____
(MC/VISA 3 Digit on Back of Card)

Cardholders Name: _____
(exactly as it appears on the card)

X
_____ **Date:** _____
(signature of cardholder)

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PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Woodbridge Psychological Associates, P.C. (the PRACTICE) is required by the Health Insurance Portability and Accountability Act (HIPAA), a federal law, to maintain the privacy of your health information and to provide you with this notice. The PRACTICE is required to meet all procedures and standards defined in this notice.

Your Privacy is Important

The PRACTICE understands your privacy is important. The PRACTICE will handle information about you only as allowed by federal and state law and PRACTICE policy.

If at any time you believe your privacy rights have been violated, you may verbally or in writing contact:

1. PRACTICE Privacy Officer
2. United States Secretary of Health and Human Services

Addresses and phone numbers to use for this contact are listed at the end of this notice. You will not suffer change in your services or retaliation for filing a complaint.

Each time you receive services from the PRACTICE, your therapist/psychologist makes a record of the visit. Typically, this record contains your assessment, service plan, progress notes, diagnoses, treatment, and plan for future care or treatment.

Your Federally Defined Rights under HIPAA

There are several rights concerning your health information in the medical record that the PRACTICE wants you to be aware of:

1. You have the right to request access to your medical record in order to inspect, copy, amend, or correct it. This right is not absolute. In certain situations, such as if access would cause harm, the PRACTICE can deny access. You must make this request in writing to your therapist/psychologist.
2. You have the right to receive at any time an accounting of the PRACTICE's disclosure of your medical record. You have the right to receive information from the PRACTICE through the means you prefer (e.g., telephone, mail).
3. You have the right to request a restriction with regards to the use or disclosure of your medical record. This request will be given serious consideration and you will be informed promptly whether the PRACTICE will be able to use the restriction and still offer effective services, receive payment, and maintain health care operations. Legally the PRACTICE is not required to abide by any restrictions you request.

Use and Disclosure of Your Information

The PRACTICE uses and discloses necessary information about you internally and with business associates in order to provide treatment, receive payment for treatment provided, and conduct day-to-day business practices. For example:

In order effectively to provide treatment, your therapist/psychologist may consult with or seek supervision from other service providers within the PRACTICE. During those consultations or supervision, health information about you may be shared.
In order to receive payment for services provided, your health information may be sent to those companies or groups responsible for payment, or that you designates as your third-party payor. In addition, the PRACTICE sends a monthly bill to the responsible party identified by you and noted on your financial form. Patient bills outstanding for more than (3) three months may be submitted by the mental health professional to a collection agency or attorney for litigation.
In day-to-day business practices, trained staff may handle your physical medical record in order to have the record assembled and available for review by your therapist/psychologist and to file documentation. Certain data elements are entered into the PRACTICE's computer system that processes most billing and insurance claims.

OVER

[illegible]

The PRACTICE is allowed by federal and state law in certain circumstances to disclose specific health information about you without your consent, authorization or opportunity to agree or object. These specific circumstances may include:

- **As required by law and limited to the relevant requirements of the law.**
- **For public health activities (to the Health Department to prevent or control disease**
- **On behalf of children or incapacitated adults who are victims of abuse, neglect, or exploitation (to report as required by law) any suspicion of abuse, neglect, or exploitation**
- **Judicial and administrative proceedings (in response to a court order**
- **Law enforcement purposes (to report criminal conduct that occurs on PRACTICE property**
- **Dead persons (to assist coroners and medical examiners to identify a deceased person or to determine cause of death**
- **To avert a serious threat to health and safety (to yourself or someone else**
- **Specialized government functions (for protection of the President of the United States**
- **Workers' Compensation (to comply with laws related to Workers' Compensation**

A more detailed explanation of all situations allowed by federal and state law is available upon request.

[illegible]

When you request information to be disclosed to another party or to yourself, the PRACTICE will respond within federal and state law.

The PRACTICE is required to obtain your authorization to use or disclose your protected health information for any reason other than treatment, payment, health care operations, and those specific circumstances outlined previously. The PRACTICE uses an Authorization to Release and Obtain Confidential Information form that specifically states what information about you will be given to whom and for what purpose. You or your legal representative signs the form. You may revoke the signed authorization at any time, except to the extent that action has been taken in reliance on it, by giving your therapist/psychologist/case manager a written statement to that effect.

[illegible]

The PRACTICE reserves the right to change any of its privacy policies and related practices at any time and to make the change effective for all health information that the PRACTICE maintains, as allowed by federal and state law.

You will receive notice of changes either by mail, discussion with a PRACTICE representative, electronically, or a combination of all three.

If you would like additional information concerning the privacy policy or the federal or state laws pertaining to privacy, please contact:

PA, PC Privacy Officer

United States Department of Health and Human Services