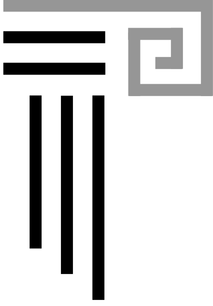


Coastal Center for Cognitive Therapy, PA
1101 Johnson Avenue, Suite 200 Myrtle Beach, SC 29577 P 843.839.9028 F 843.839.9029

New Patient Packet for One-Time Assessment (Testing)

Please ensure that you have read through the material contained on the website www.coastalcognitive.com before you proceed. Important information about my policies regarding insurance and my fee schedule is contained on the "New Patient" page on the website. Please be sure to read this if you have not already done so.

After you have read the information on the website, please call me, if you have not already, at 843.839.9028 to schedule a brief phone interview. This will allow me to assess whether or not I would be an acceptable provider of assessment services for you. If so, I will:

1. Schedule the assessment session with you, and;
2. Ask that you print out and complete all the forms in this New Patient Packet to bring with you to the assessment session. (If you cannot print them out, we will arrange for you to come to the session 30 minutes early to complete, in the waiting room, copies my receptionist will give you.)

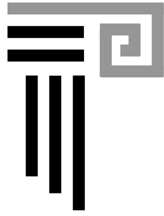
If I do not determine that there is a good match between your assessment needs and my services, I will suggest referrals to other providers in the area who may better serve you.

PLEASE NOTE: If your insurer is MEDICARE you will be asked to sign a short contract with me that MEDICARE requires of all healthcare providers who have opted-out of MEDICARE. This contract states that you will assume responsibility for paying the fee for your service and that neither you nor I will submit the charge to MEDICARE for reimbursement.

I know there are many forms in this packet and it may seem like quite a lot to do. Much of this is required by state and federal law and I must comply with these legal requirements. Some of the other forms are designed to give me the most information possible at the very beginning so I can best serve you. Your time spent providing this information will allow us to spend more time in our session completing your assessment rather than addressing, in detail, each of the questions asked here. Providing this information and bringing it all with you to the session helps me focus on you during that session.

Thank you,

Michael M. Grant, PhD



Coastal Center for Cognitive Therapy, PA

1101 Johnson Avenue, Suite 200 Myrtle Beach, SC 29577 P 843.839.9028 F 843.839.9029

Registration Sheet 2010 for Assessment

Date: ____

Patient Name: ____
Last First M.I.

Date of Birth: ____ /____ /______ Age: _____ SSN: _______-_____-_______

Gender: [ ] Male [ ] Female Last School Grade Completed: ____________

How do you prefer to be addressed (Name/Nickname)?_____________________________

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

Ethnicity:_____________________________ Religion:______________________________

Address: ____

City: ____ State: __________ Zip: _________

Home Phone: (___) ____-______ can a message be left at this number?_____yes_____no

Work Phone: (___) ____-______ can a message be left at this number?_____yes_____no

Ext.: ______________

Mobile Phone: (___) ____-______ can a message be left at this number?_____yes_____no

Pager : (____) _____-_______ Other ______________________________________

How do you prefer to be contacted? ____

Occupation: __________________________ Employer: ___________________________

Referred by: ____

In Case of Emergency, Contact:

Name: _____________________________ Relationship: ___________________________

Phone: _____________________________

<u>If patient is a minor:</u>

	Legal Guardian #1	Legal Guardian #2
Name:	______________________________	____________________________________
Address:	______________________________	____________________________________
	______________________________	____________________________________
	______________________________	____________________________________
(H) Phone:	______________________________	____________________________________
(W) Phone:	______________________________	____________________________________
Mobile Phone:	______________________________	____________________________________
Relationship To Patient:	______________________________	____________________________________

Who has legal custody of this child?____

Child's current school: ____ Grade: ___________

Ages that child: Crawled: ______ Walked: ______ Talked: ______ Potty Trained: _______

Coastal Center for Cognitive Therapy

Medical/Mental Health History Self Report

Patient's Name: ____ Date of Birth: ___________________________

Allergies to Food, Medication, Other:____

Current Family Physician: ____ Date of Last Physical Exam: ______________

Are there currently or have there previously been problems with any of the following?

	Yes	No		Yes	No
Skin problems	□	□	Eating	□	□
Wounds not healing/easy bruising	□	□	Alcohol	□	□
Glaucoma/Vision	□	□	Street drugs	□	□
Gum(s)/Teeth	□	□	High blood pressure	□	□
Hearing	□	□	Heart disease/Chest pain	□	□
Headaches	□	□	Rheumatic fever	□	□
Head injuries	□	□	Nausea/Vomiting	□	□
Black outs/Fainting	□	□	Ulcers	□	□
Numbness/Tingling	□	□	Liver disease or jaundice	□	□
Thyroid problems	□	□	Kidney/Bladder problems	□	□
Blood sugar	□	□	Pregnancy (if pregnant, due date ____________)	□	□
Sickle cell	□	□	Sexual function	□	□
HIV/AIDS	□	□	Difficulty walking/standing	□	□
Fatigue	□	□	Pain	□	□
Anemia/Low blood count	□	□	Sleeping too much	□	□
Breathing/shortness of breath	□	□	Sleeping too little	□	□
Fever	□	□	Lead/Chemical exposure	□	□
Gallstones	□	□	Seizures	□	□
Cancer	□	□	Change in weight	□ Gain	□ Loss
			If change in weight: _______ lbs. In _______ time		

Please describe:

____

____

Have any family members had any of the following?

	Yes	No	Who
Depression	□	□	____
Bipolar Disorder	□	□	____
Suicide or Suicide Attempt	□	□	____
Schizophrenia	□	□	____
Eating Disorder	□	□	____
Anxiety Disorder	□	□	____
Alcohol/Drug Problems	□	□	____
ADHD	□	□	____
Thyroid Problems	□	□	____
Asthma	□	□	____
Diabetes	□	□	____
Stroke	□	□	____
Dementia/Senility	□	□	____
Stomach Problems	□	□	____
Seizures (what kind)	□	□	____
Heart Problems	□	□	____
Cancer (what kind)	□	□	____
High blood pressure	□	□	____
Abnormal heart rhythm	□	□	____
Sudden cardiac death	□	□	____
Tics	□	□	____

Have there been **hospitalizations for any medical reasons** such as illness, accidents, operations, or tests?

Reason for Hospitalization	Date	How Long?

Continue on back of this sheet, if needed.

Current Medications (including any *over the counter* or *herbal preparations*):

Name of Medication	Dosage	For what reason?	How Long?	Side effects(if any)

Continue on back of this sheet, if needed.

Mental Health Care in the past? (such as psychiatrist, psychologist, social worker, nurse, counselor, or psychological testing)

By Whom?	When?	Diagnosis	Type of Treatment	Were you hospitalized?

Continue on back of this sheet, if needed.

Currently using caffeine? □ Yes □ No If yes, how much, how often_________________ If no, past use?___________

Currently using cigarettes? □ Yes □ No If yes, how much, how often_________________ If no, past use?___________

Currently using alcohol? □ Yes □ No If yes, how much, how often_________________ If no, past use?___________

How often do you have the following problems?

Problem	Never	Rarely	Frequently	Always
Talking, thinking, and more active than normal; Can't be still or quiet				
Talking, thinking, and less active than normal; Can't do things				
Loss of interest in activities; Hard to have a good time				
Feeling sad or depressed; Feeling like crying				
Wishing I was dead				
Planning ways to kill myself or attempting to kill or harm myself				
Low energy, fatigue				
Trouble making decisions or concentrating				
Feeling worthless or guilty				
Eating and appetite more than normal or gained weight				
Eating and appetite less than normal or lost weight				
Trouble falling/staying asleep or early morning wakening				
Racing heart or chest pain (circle which)				
Lightheadedness, dizziness				
Nausea, vomiting, or diarrhea (circle which)				
Sweating or breathing fast and shallow (circle which)				
Tingling in hands, face, feet				
Hot or cold flashes (circle which)				
Trembling or shaking				
Racing thoughts				
Feeling "I'm going crazy" or losing control (circle which)				
Excessive worrying, fear, dread, feeling out of control				
Dream-like sensations or distortions in vision, hearing, etc.				
Frightening flashbacks to an earlier traumatic event				
Nightmares or frightening dreams (circle which)				
Having lots of aches/pains/physical complaints				
I have to do/say something to prevent bad things from happening				
Frequent, unwanted thoughts or images (circle which)				
Being afraid of certain things such as _______________ (fill in blank)				
Mood swings: really down for a time and then really up for a time				
Decreased need for sleep or can't sleep—too wound up				
People telling me "slow down, you are talking too fast"				
Feeling overjoyed with life/ on top of the world/like I can do anything				
Spending or giving away too much money for my financial situation				
Hearing things or voices other people don't hear (circle which)				
Seeing things other people don't see				
Smelling/tasting odd things others don't; things crawling on me				
Feeling that other people are controlling my thoughts				
Being physically or sexually abused (circle which)				
Getting into verbal and physical fights (circle which)				
Thinking about harming others				
Drinking alcohol or using drugs to relax, for pleasure, recreation				

What is the reason you are seeking a psychological assessment/evaluation at this time?

____

____

____

How long have you had these problems or symptoms?

____

____

____

How often do they occur?

____

____

____

What have you tried, in the past, to help yourself?

____

____

____

____

Who lives with you at home?

Name of person	Relationship to you	Age	Occupation/School

____________________________________ ____________________________________

Signature **Date**

Coastal Center for Cognitive Therapy

CONTACT & EMERGENCY INFORMATION

I usually return phone calls within the same business day if the message is left during normal business hours. Otherwise, I will review and return my messages on the following business day.

If *your call involves a mental health emergency* and I cannot return your call promptly, please go to the nearest emergency room or call 911 immediately and then attempt to contact me again, if needed.

Even the best voice mail systems and attempts to return calls fail at times so please remember that the *emergency room is another resource*.

Please realize that if you are calling with a mental health emergency my response is likely to include use of the local emergency services and the nearest emergency room.

I have carefully read all the terms of the above guidelines and have had an opportunity to discuss any questions.

___________________________________ ___________________________________

Signature **Date**

You will receive a signed copy of this to keep for future reference.

Coastal Center for Cognitive Therapy

ASSESSMENT FEE SCHEDULE AND PAYMENT AGREEMENT 2010
FINANCIAL AND INSURANCE INFORMATION and INFORMED CONSENT

Service	Fee
Standardized Intelligence Assessment*	$400
Standardized Academic Achievement Assessment*	$400
Behavioral/Emotional Functioning Assessment for Children*	$100
Attention Deficit Hyperactivity Disorder Assessment*	$100
Learning Disorder Assessment (Psycho-Educational Assessment) (This includes Data Scoring, Computation, Analysis, Complete Report Generation)	$1,300
Beck Inventories (Depression, Anxiety, Hopelessness, Suicidal Ideation) Price each:	$20
Pre-Surgery Assessments (This includes generation and submission of report to your physician) ▪ Chronic Pain (Pre-Spinal Cord Stimulator or Intrathecal Pump Implant) ▪ Bariatric (Weight Loss Surgery)	 $300 $300
Phone Consultation (for each 10 minute period after the 1st 5 minutes. No charge for 1st 5 minutes)	$35
Generation of Specially Requested Report/Correspondence (Per hour prorated at $3/minute)	$180

** Price includes written tabular summary of findings and administrative time establishing file but not complete report.*

Please initial

_______If Dr. Grant **does not** accept my insurance, I understand that fees are due as stated and are payable *at the beginning of the assessment or evaluation session* (this allows him to focus entirely on my problems, needs, and concerns during the session). If Dr. Grant **does** accept my insurance, I understand that I am responsible for paying my **co-pay** amount at the time the service is rendered and that, if I cannot pay the correct amount at the time of service, my credit or debit card will be charged that amount at that time to ensure that payment has been received. If my insurance company refuses to pay Dr. Grant the amount allowed by them per his contract with them (because, for example, I have not yet met my insurance **deductible**) I agree that I am responsible for payment of that amount and agree that he can bill my credit card/debit for it. *This is to ensure that Dr. Grant receives the full amount contracted for and allowed him by my insurance company and is not punished financially because I have not fulfilled a portion of my contracted agreement with my insurer.*

_______I agree to accept financial responsibility for any missed appointment and my insurance company will not be billed for nor reimburse me for missed appointments. **To avoid a fee, 24 Business hours advance notice is required for all cancelled or rescheduled appointments.**

_______Accounts which are not settled within a 45-day billing period will be charged a monthly service charge of 10%.

***Payment in the form of cash, personal check, debit card, *Visa*, *MasterCard*, or *Discover* is expected at the time services are rendered unless I accept your insurance in which case you will need to pay your co-pay portion at the time of service. If I accept your insurance I will file the claim for the portion beyond your co-pay. If I do not accept your insurance, I will provide you with the documentation you need to file your own insurance claim. *At this time I am a participant in some but not all insurance plans* and, if I am not a participant in yours at the time I see you, your insurance plan will consider me "out-of-network." You may use the **Insurance Worksheet** at the end of this *New Patient Packet* to help you contact your insurance company ahead of time to determine if they will reimburse you for any portion of my services.

I have carefully read all the terms of the above guidelines and have had an opportunity to discuss any questions.

______________________________________ ______________________________

Signature of Patient or Responsible Party **Date**

I have **consented** to psychological assessment or treatment by Michael M. Grant, PhD, and understand that if he is NON-PARTICIPATING in my insurance plan I agree to undertake full responsibility for payment of the fees incurred at the time of the assessment/treatment. I am seeking an assessment/treatment from Dr. Grant understanding that if he does not accept my insurance I will be given the necessary billing codes for the type of assessment or treatment I receive which I may then submit to my insurance provider for any reimbursements for which I am contractually eligible. If Dr. Grant is "out-of-network" with my insurer and I submit his invoice to my insurer, I understand that there is a possibility that I may receive no insurance reimbursement for this assessment/treatment.

______________________________________ ______________________________

Signature of Patient or Responsible Party **Date**

You will receive a signed copy of this to keep for future reference.

Coastal Center for Cognitive Therapy

<u>Transmission of Completed Psychological Evaluation</u>

The assessments for your psychological evaluation will be scored and the report describing all your results will be prepared within 24-48 hours after the time of your evaluation.

Your evaluation will be held in your file for release until payment is received for it.

You have several options available to you regarding the payment/release of your evaluation to your referring physician/surgeon. Please read through these options and indicate your choice by initialing in the space next to the option you choose and signing below, where indicated.

<u>Please initial</u>

____________ **<u>Option A: Immediate Release</u>**. If I am not using insurance I agree to pay the standard rate listed on the previous page of this packet. If I am using insurance, I understand that I may pay for the evaluation, fee-for-service, at the *exact rate contracted for by my insurer and Dr. Grant*. Dr. Grant will inform me of the contracted rate and, if I choose, I can call my insurer to verify it (when you complete the *Insurance Worksheet* at the end of this packet, you will take care of this). *Once I pay the contracted rate to Dr. Grant, I understand that he will mail the evaluation that same day or the next*. I understand that if I choose this option I will receive a reimbursement check from Dr. Grant when/if my insurer pays the contracted allowed rate (sometimes called the "covered amount") to Dr. Grant. I also understand that if my insurer chooses to further discount their payment to Dr. Grant below the contracted or "covered amount", that I will not expect him to refund me that discounted amount. I understand that if I paid for the evaluation myself at the "covered amount" rate agreed to by Dr. Grant and my insurer, *he will reimburse me for the exact amount paid to him by my insurer on my behalf*. I understand that Dr. Grant will send me a copy of my insurer's notification of payment to him along with my reimbursement check for that payment amount. This is to ensure that Dr. Grant is not "punished" by my insurer paying less than their contracted amount to him and/or combined with an expectation on my part that he would write-off the difference.

____________ **<u>Option B: Delayed Release</u>**. I understand that I may pay only my insurance-required copay at the time of the evaluation and may wait for my insurer to pay for the remainder of the evaluation fee at their contracted rate with Dr. Grant. *Once the insurer has paid <u>in full</u> (the full "covered amount"), the evaluation will be mailed the same day the full insurance payment was received.* If there is a discrepancy between the amount billed to my insurer and the amount they paid, Dr. Grant will contact my insurer *one time* to attempt to resolve the matter. If my insurer continues to fail to pay the "covered amount", Dr. Grant will inform me of that and will offer me the option of paying the difference owed. *If I choose to do this, I agree that I will work out the matter with my insurer*. Once Dr. Grant receives my payment of the remaining fee owed (totaling the full "covered amount"), he will mail the evaluation that same day or the next. I also understand that, if I choose Option B at the time of the evaluation and later decide I would like to choose Option A, above, I may do so by contacting Dr. Grant and arranging for payment of the evaluation as described in that option and I agree to follow the provisions of Option A.

I have carefully read all the terms of the above guidelines and have had an opportunity to discuss any questions. By signing below I indicate that I am in full agreement with the process outlined in the payment/release of evaluation option I have chosen. By signing below I also indicate that I understand that insurance payment matters are often confusing and agree to work in a friendly way with Dr. Grant should a problem, miscommunication, or other confusion arise.

_______________________________________ _______________________________

Signature of Patient or Responsible Party **Date**

Coastal Center for Cognitive Therapy

CREDIT CARD INFORMATION & AUTHORIZATION

******<u>REQUIRED INFORMATION:</u> Please note I will only charge fees to your credit card if this is your preferred payment method, if you fail to keep an appointment without 24 business hours advance notice, or if you use insurance, I need to collect a copay from you and you have not arranged to pay it in some other way******

Patient Name: ____

Card holders Name (as it appears on card):____

Card holders Address:____

____

☐ VISA ☐ MasterCard ☐ Discover

Card #:

Expiration Date:

Security Code:

Please charge this credit card for: $ _________________________.

_______________________________________ _______________________

Signature **Date**

Please charge future visits to this account and send a receipt for each charge.

_______________________________________ _______________________

Signature **Date**

*****<u>I understand that if I miss an appointment without 24 hours prior notice my credit card will be charged for the full appointment fee.</u>**

_______________________________________ _______________________

Signature **Date**

Coastal Center for Cognitive Therapy

NOTICE OF PRIVACY PRACTICES Page 1 of 4

As of April 14, 2003, the federal government requires us to disclose our privacy policies to all patients (HIPPA 04/14/03). 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.

We are required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice which describes the health information privacy practices of our psychologist private practice and its staff. A copy of our current notice will always be available in our office. You will also be able to obtain your own copy by calling our office at (843) 839-9028 or by asking for one at the time of your next visit. If you have any questions about this notice or would like further information, please contact our privacy officer at (843) 839-9028.

WHAT HEALTH INFORMATION IS PROTECTED

We are committed to protecting the privacy of information we gather about you while providing you with healthcare. Some examples of protected health information are:

- information indicating you are a patient of our practice;
- information about your health condition (such as diagnosis);
- information about health care products or services you have received or may receive in the future (such as an operation or diagnostic imaging);
- information about your health care benefits under an insurance plan

When combined with:

- demographic information (such as your name, address, insurance status);
- unique numbers that may identify you (such as social security number, phone number, or drivers license number); or
- other types of information that may identify who you are.

REQUIRED PERMISSION TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

We will obtain a one-time general written consent (at the end of this Notice of Privacy Practices) to use and disclose your health information in order to treat you, obtain payment for that treatment, and conduct our business operations. This general written consent will be obtained the first time we provide you with treatment or services. This general written consent is a broad permission that does not have to be repeated each time we provide treatment or services to you.

We will generally obtain your written authorization before using your health information or sharing it with others. You may also ask that we transfer your records to another person by completing a written authorization form. If you provide us with written authorization, you may revoke that written authorization at any time, except to the extent that we have already relied upon it or taken action to do what you previously requested. To revoke a written authorization, please write our Privacy Officer at:

Coastal Center for Cognitive Therapy, PA
1101 Johnson Avenue, Suite 200
Myrtle Beach, SC 29577

INITIAL________

NOTICE OF PRIVACY PRACTICES Page 2 of 4

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

1. Treatment, Payment, and Business Operations

With your general written consent, we may use your health information or share it with others in order to treat your condition, obtain payment for that treatment, and run our business operations. In some cases, we may also disclose your health information for payment activities and certain business operations of another healthcare provider or payor. Below are further examples of how your information may be used and disclosed for these purposes.

Treament. The psychologists and other staff of our practice may share your health information with each other for the purpose of treating you. A psychologist from our practice may also share your health information with a doctor or other professional outside of this practice to determine how best to diagnose or treat you. Your doctor may also share your health information with another doctor or professional to whom you have been referred for further heath care.

Payment. If you use third party reimbursement, we are required to provide the insurer with a clinical diagnosis and sometimes a treatment plan or summary. We may use your health information or share it with others so that you can get payment for your health care services. For example, we may share information about you with your health insurance company in order to help you obtain reimbursement after we have treated you, or to determine whether it will cover your treatment. We might also need to inform your health insurance company about your health condition in order to obtain approval for treatment. Finally, we may share your information with other health care providers who have treated you so that they may also have accurate information to seek payment from your health insurance company.

Business Operations. In the course of providing treatment to you or your family member, we may use your health information to contact you with a reminder that you have an appointment for treatment or services at our facility. We may use your health information in order to recommend possible treatment alternatives or health-related benefits and services that may be of interest to you. At times we may use a **cellular phone** to contact you or return your calls. Please be aware that I will not notify you when I am using such a device. If the information you are discussing requires a more secure level of confidentiality, please let us know so arrangements can be made to contact you in another way. We generally discourage **e-mail** as a mode of communication due to confidentiality concerns. We may reply to e-mails but when doing so make an effort to limit the type of information discussed. However, we must stress that e-mail is not a confidential mode of communication. We routinely use a **fax machine** in communications with other agencies. We will only release information that you have authorized to release and do send these with a cover sheet that includes a confidentiality statement. However, the cover sheet cannot ensure that the fax is received in the proper place or handled in a confidential matter once it is received. You may pick up and hand-carry documents to agencies if you wish. We will also mail documents on special request. We can do all of these things if you have signed a general written consent form. <u>Once you sign this general written consent form, it will be in effect indefinitely until you revoke your general written consent</u>. You may revoke your general written consent at any time except to the extent that we have already relied upon it. To revoke your general written consent, please write to:

Coastal Center for Cognitive Therapy, PA
1101 Johnson Avenue, Suite 200
Myrtle Beach, SC 29577

INITIAL_______

2. Emergencies or Public Need

We may use your health information and share it with others in order to treat you in an emergency or to meet important public needs. We will not be required to obtain your general written consent before using or disclosing you information for these reasons. We will, however, obtain your written authorization for, or provide you with an opportunity to object to, the use and disclosure of your health information in these situations when state law specifically requires that we do so.

Emergencies. We may use or disclose your health information in order to treat you, to obtain payment for that treatment, and to conduct our business operations if you need emergency treatment or if we are required by law to treat you but are unable to obtain your general written consent as soon as we reasonably can after we treat you.

Law Enforcement. We may disclose your health information to law enforcement officials for the following reasons:

- to comply with a court order or law that we are required to follow;
- to assist law enforcement officers with identifying or locating a suspect, fugitive, witness, or missing person;
- if you have been the victim of a crime and we determine that: (1) we have been unable to obtain your agreement because of an emergency or incapacity; (2) law enforcement officials need this information immediately to carry out their law enforcement duties; (3) in our professional judgment disclosure to these officials is in your best interest;
- if necessary to report a crime that occurred on our property;
- if we believe that a patient is threatening serious harm to self or another, we are required by South Carolina law to take protective action which may include notifying the police, warning the intended victim, and/or seeking the patient's hospitalization.

Victims of Abuse, Neglect, or Domestic Violence. We may release your health information to a public health authority that is authorized to receive reports of abuse, neglect, or domestic violence. For example, we may report your information to government officials if we reasonably believe that you have been a victim of such abuse, neglect, or domestic violence. We will make every effort to obtain your permission before releasing this information, but in some cases we may be required or authorized to act without your permission.

Health Oversight Activities. We may release your health information to government agencies authorized to conduct audits, investigations, and inspections of the practice. The government agencies monitor the operation of the health care system, government benefit programs, and compliance with regulatory programs and civil right laws.

Lawsuits and Disputes. We may disclose your health information if we are ordered to do so in a court or administrative tribunal that is handling a lawsuit or other dispute. In most judicial proceedings you have the right to prevent us from testifying. However, in child custody proceedings, adoption proceedings, and proceedings in which your emotional condition is an important element, a judge may require our testimony if it is determined that resolution of the issues before the court requires it. If you are involved in litigation, or are anticipating litigation, and you choose to include your mental or emotion state as part of the litigation, we may have to reveal part or all of your treatment or evaluation records. If you are called as a witness in criminal proceedings, opposing counsel may have some limited access to your treatment records. Our testimony may also be ordered in other cases including legal proceedings relating to psychiatric hospitalization, malpractice and disciplinary proceedings, court-ordered psychological evaluations, and certain legal cases following the death of a client. Under current South Carolina law, in group and family therapy and in marital therapy all participants are required to consent to the release of information. One marital partner may not waive privilege for another. In cases of marital therapy, therefore, the record may be released only if both parties waive privilege or release of the record is court ordered.

INITIAL_____

NOTICE OF PRIVACY PRACTICES Page 4 of 4

Notice to Minors. If you are under eighteen years of age, please be aware that your parents have a right to receive general information on the progress of the treatment. Your parents may also request a copy of your record.

Medical Records. I am required to maintain complete treatment records. Patients are entitled to receive a copy of these records unless I believe the information would be emotionally damaging and, in such cases, the records must be made available to the patient's appropriate designee.

Incidental Disclosures. While we will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of our otherwise permissible uses or disclosures of your health information.

Group Reporting of Assessment Data. I assess all patients using the *Beck Depression Inventory* and the *Beck Anxiety Inventory*. I sometimes also use the *Beck Hopelessness Scale* and the *Beck Scale for Suicide Ideation,* when appropriate. I aggregate data from all these instruments and report it as group, not individual data, on my website and in my office in graphic form to depict the effect of Cognitive-Behavioral Therapy for all patients, as a group, over time. I also collect and may report it in terms of pre- and post-surgical intervention outcomes. *The identity of any individual patient is completely protected since the data is reported only in group form*. Your signature, below, signifies that you understand that I collect data and report it in group form, that your identity is protected, and that you consent to my inclusion of your data in the patient group and in any graphic representations I may use in any venue (website, presentations, published articles, posted in office, etc.).

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY AND CONSENT FOR TREATMENT

By signing below, I acknowledge that I have read, initialed each page of, and have been provided a copy of this **Notice of Privacy Practices** and have therefore been advised of how health information about me may be used and disclosed by the psychologist private practice listed at the beginning of this notice, and how I may obtain this information. Finally, by signing below, I **consent** to the use and disclosure of my health information to treat me and arrange my mental health care, to seek and receive (or help me seek/receive) payment for services given to me, and for the business operations of this practice.

______________________________________ ________________________

Signature of Patient or Patient's Representative **Date**

You will receive a copy of all four pages of this Privacy Notice to keep for future reference.

Coastal Center for Cognitive Therapy

PLEASE COMPLETE THIS BEFORE OUR INITIAL VISIT

INSURANCE WORKSHEET

I file some but not all insurance claims in this practice. To determine if your insurance will cover your visit with me, you will need to call them several days BEFORE you see me. Below is a guide to help you get the information you need from your insurance company. Please document the information you are given over the phone as **I will need all of this information when I see you**. If I don't have it, I cannot submit your charges for insurance and you will be responsible for paying them yourself at the time of our visit. I have provided space in the guide for recording the answers to the questions you will ask. *Please bring this completed sheet with you since I will ask for it when we meet.* If I am not on your insurer's panel I will be considered "out-of-network" and will provide you with the documentation you need to file your insurance claim yourself.

STEP	Record Answers Here	
1. Look on your insurance card for the number to call to speak with your insurer and call them. Record the date and time of your call and write down (in the box to the right) the name of each person with whom you speak.		
2. If you are seeking to have a pre-surgery evaluation (Bariatric or Spinal Cord Stimulator) ask if the number you have called is the right one for *Medical/Surgical benefits*. If you are seeking any other psychological evaluation, ask for *Mental Health benefits*.		
3. If you are seeking a pre-surgery evaluation (Bariatric or Spinal Cord Stimulator) ask if outpatient *pre-surgery evaluations* are covered. If you are seeking any other evaluation ask if *psychological evaluations* are covered.		
4. Give them my name and ask if I am considered "in network" or "out of network". If "out of network" ask if they will pay for services provided by me. If the answer is "no" stop here and be prepared to pay for my services out of pocket. If "yes", continue to ask the following questions.	**In Network**	**Out of Network**
5. Ask if you need a referral from your physician.	**YES**	**NO**
6. Ask how much your insurer will pay Dr. Grant (the "covered amount") and *make sure you record their answer in the box to the right.* Note: For most evaluations, the insurance company will be billed for one (1) unit of each of the following four CPT codes: 90801, 96101, 90887, and 90889.	$	
7. Ask what your deductible dollar amount is *and record it in the box to the right.*	$	
8. Ask for the dollar amount you have already paid, this year, toward your deductible *and record it in the box to the right.*	$	
9. Ask when your deductible year starts *and record it in the box to the right.*	**Start Date:**	
9. Ask what your co-pay amount is *and record it in the box to the right.*	$	
10. Ask them for a preauthorization number that you can give me *and record it in the box to the right.*	#	