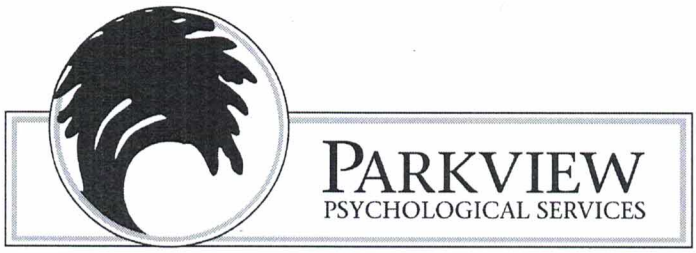


Please read before completing the included forms.

The materials in this file have been made available to you in advance so that you may print and complete them comfortably and thoughtfully prior to your first appointment at Parkview Psychological Services, P.C. All of the forms have been prepared to provide you with information about our practice and its' policies as well as providing us with the information we need to be of most help to you. This packet should contain the following; **Patient Registration, Patient History/Information, Therapist/Patient HIPPA Agreement, Therapist/Patient HIPPA Agreement Authorization, Consent & Acknowledgement, and a Release of Information**. The Therapist/Patient HIPPA Agreement contains information about our professional services and business policies as well as information about the Health Insurance Portability and Accountability Act (**HIPPA**) along with a form to indicate that you have read and agree to the terms of the professional services agreement and acknowledge that you have received the HIPPA notice. While we have prepared these materials to be as concise and clear as possible, you may find you have questions that are not answered. If you do have questions, feel free to call before our first meeting or ask when you meet with your therapist. Your attention to these materials will help us to use your time well.

Please remember to read the enclosed materials carefully and bring all the completed forms and insurance info. with you to our first meeting.

Sincerely,

Parkview Staff

2910 Hamilton Blvd., Ste. 100 • Sioux City, Iowa 51104 • Phone 712-239-1111 • Fax 712-239-1199

PATIENT REGISTRATION FORM

PLEASE PRINT CLEARLY

2910 Hamilton Blvd., STE. 100 • Sioux City, IA 51104 • 712-239-1111 • 712-239-1199

PATIENT INFORMATION

PATIENT NAME (First, MI, Last)	BIRTHDATE SEX PATIENT RELATIONSHIP TO INSURED _____/_____/_____ ❒ FEMALE ❒ MALE ❒ Self ❒ Spouse ❒ Dependent ❒ Other _____
PATIENT ADDRESS	MARITAL STATUS
PATIENT ADDRESS	EMPLOYER NAME TELEPHONE EMPLOYMENT STATUS ❒ Full Time ❒ Retired ❒ Part Time ❒ Not Employed
TELEPHONE (HOME) TELEPHONE (WORK/OTHER)	EMPLOYER ADDRESS CITY STATE
Social Security Number	STUDENT STATUS IF 19 YEARS OR OLDER: *PERSON TO CONTACT IN CASE OF EMERGENCY*: NAME: _____ PHONE : _____
EMAIL ADDRESS	

RESPONSIBLE PARTY FOR BILLING (IF DIFFERENT THAN PATIENT)

RESPONSIBLE PARTY NAME (First, MI, Last)	BIRTHDATE SEX LEGAL REPRESENTATIVE _____/_____/_____ ❒ MALE ❒ FEMALE ❒ YES ❒ NO
RESPONSIBLE PARTY ADDRESS	REFERRING DOCTOR
RESPONSIBLE PARTY ADDRESS	EMPLOYER
CITY STATE ZIP	EMPLOYER ADDRESS
TELEPHONE	EMAIL ADDRESS

INSURANCE INFORMATION

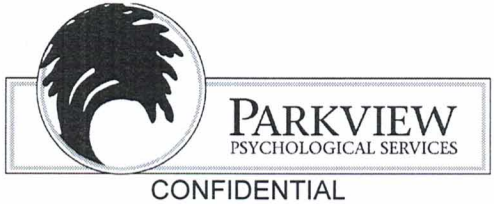
PRIMARY INSURANCE CARRIER NAME	GROUP NAME EMPLOYER NAME OF INSURED
INSURANCE CLAIM CENTER ADDRESS (STREET, SUITE NO.)	EMPLOYER ADDRESS OF INSURED (STREET, SUITE NO.)
CITY STATE ZIP	CITY STATE ZIP
INSURED POLICYHOLDER NAME (FIRST, MI, LAST	GROUP NUMBER POLICY ID NUMBER
INSURED POLICYHOLDER ADDRESS (STREET, APT. NO.)	INSURED SOC SEC NUMBER PATIENT RELATIONSHIP TO INSURED ❒ Self ❒ Spouse ❒ Dependent ❒ Other
CITY STATE ZIP	EMPLOYER PLAN COVERAGE IF CHAMPVA: ❒ Active ❒ Retired ❒ Deceased ❒ YES ❒ NO BRANCH OF SERVICE:
SECONDARY INSURANCE CARRIER NAME	GROUP NAME EMPLOYER NAME OF INSURED
INSURANCE CLAIM CENTER ADDRESS (STREET, SUITE NO.)	EMPLOYER ADDRESS OF INSURED (STREET, SUITE NO.)
CITY STATE ZIP	CITY STATE ZIP
INSURED POLICYHOLDER NAME (FIRST, MI, LAST	GROUP NUMBER POLICY ID NUMBER
INSURED POLICYHOLDER ADDRESS (STREET, APT. NO.)	INSURED SOC SEC NUMBER PATIENT RELATIONSHIP TO INSURED ❒ Other ❒ Self ❒ Spouse ❒ Dependent
CITY STATE ZIP	EMPLOYER PLAN COVERAGE IF CHAMPUS: ❒ Active ❒ Retired ❒ Deceased ❒ YES ❒ NO BRANCH OF SERVICE:

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed amounts for certain services, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. IN ORDER TO CONTROL YOUR COST OF BILLING, WE REQUEST THAT OUR CHARGES FOR OFFICE VISITS BE PAID AT THE CONCLUSION OF EACH VISIT. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection.

I hereby authorize the release of information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf, I assign the benefits payable to which I am entitled including Medicare, private insurance and other health benefits to: Parkview Psychological Services, P.C.

This assignment shall remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize assignee to release all information necessary to secure payment.

Signed _____ Date _____



CONFIDENTIAL

PATIENT HISTORY/INFORMATION

Note

The information you disclose on this form is for use by your therapist to aid in better understanding your problems and developing an appropriate plan for assisting you. This information will be released to no other parties outside of Parkview Psychological Services without your explicit consent or very exceptional circumstances. If you have any concerns about this please discuss this with your therapist.

Today's date:_____

Name:_____ Age:_____ Date of Birth _____

Sex:_____ Place of Birth:_____ SS #:_____ ____ _____

Phone: home(_____)_____ _____work(_____)_____ _____

RESIDENCE:

Address:_____ City:_____ State:_____

Zip:_____

By whom were you referred?_____

EMPLOYMENT:

Employer (name,address,phone) Title or Duties

_____

_____

How long employed there?:_____

INSURANCE:

Will any part of your fees be paid by insurance or other "third party"?
Yes:_____ No:_____ Not sure yet_____

If you answered yes or not sure please provide the following information:

Group Policy_____ Individual_____

Insurance Company_____ Policy #_____

MARITAL STATUS:

single_____,widowed,_____,divorced,_____,separated_____
If currently married, when?_____ If separated or divorced when?_____
If married more than once, give dates of prior marriages, how they ended, and number of children:
_____

_____

EDUCATION:

School(s) and Location(s) Dates

_____

_____

_____

OTHER TRAINING:

Form and place Dates

_____

_____

MILITARY:

Service:_____ Branch:_____

Rank:_____ Dates:_____

CHILDREN:

Names Sex Age School and Level

_____

_____

_____

_____

_____

(place a check beside those living with you)

IMPORTANT PEOPLE in your life:

Name Age Educ. Occupation Comments (e.g.,health)

Father_____

Mother_____

Sisters _____

IMPORTANT PEOPLE (CON'T)

and Brothers _____

_____

Spouse
Other _____
Important
People _____

CHILDHOOD:

Were your parents ever separated?_____ If so for how long? _____

Did you ever live with anyone other than your parents while a child ?_____
With whom? _____
How old were you?_____

MEDICAL:

Physician:_____ Address/Phone:_____

_____

Date last seen:_____ Last Physical:_____

Current and/or chronic medical problems, diseases, conditions etc.: ❑ None

_____

_____

_____

SUBSTANCE ABUSE HISTORY:

Substance	Amount	Frequency	Duration	1st use	Last Use	
Caffiene						
Tobacco						
Alcohol						
Marijuana						
Narcotics						
Amphetamines						
Cocaine						
Hallucinogens						
Other						

Allergies: ❑ None _____

Current prescription medications: ❑ None_____

_____

_____

_____

PREVIOUS COUNSELING, PSYCHOTHERAPY, MENTAL HEALTH SERVICES:

Names Profession City Dates Type

_____

_____

_____

_____

What are the main concerns that bring you to us?

_____

_____

_____

_____

COMMENTS(please provide any other information about yourself which may be helpful):

_____

_____

_____

_____

_____

Parkview Psychological Services, P.C.

THERAPIST / PATIENT HIPPA AGREEMENT

Welcome to our practice. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the *Health Insurance Portability and Accountability Act* (**HIPAA**), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your *Protected Health Information* (**PHI**) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with a *Notice of Privacy Practices* (**the Notice**) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that we obtain your signature acknowledging that we have provided you with this information by the end of your first session. Although these documents are long and sometimes complex, it is very important that you read them carefully before your next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred with Parkview.

THE LIMITS OF CONFIDENTIALITY

The HIPPA law protects the privacy of all communications between a patient and a psychotherapist. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPPA and/or Iowa law. *However, in the following situations, no authorization is required*:

- ✓ If a patient threatens to harm himself/herself, your therapist may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

- ✓ If you are involved in a court proceeding and a request is made for information concerning the professional services that we provided, such information is protected by the psychologist/patient privilege law. We cannot provide any information without your written authorization or a court order. If you are involved in or are contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information about your therapy or evaluation.

- ✓ If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.

- ✓ If a patient files a complaint or lawsuit against a Parkview employee, we may disclose relevant information regarding that patient in order to defend our interests.

- ✓ If a patient files a worker's compensation claim, we must, upon appropriate request, provide any information concerning the employee's physical or mental condition relative to the claim.

- ✓ Your therapist may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our clients. The other professionals are also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together. We will note formal consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).

- ✓ You should be aware that Parkview is a practice with other mental health professionals, and we employ administrative staff. In most cases, your therapist will need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling and billing. All of the mental health professionals in our practice are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- ✓ Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations in which we may be legally obligated to take actions, which we believe are necessary to attempt to protect others from harm, and in such cases, we may have to reveal some information about a patient's treatment. These situations are unusual. If such a situation should arise, we will make every effort to fully discuss it with you before taking any action, and we will limit our disclosure to what is necessary. These situations may include:

- ✓ If we have reasonable cause to believe that a minor we have provided professional services to have been abused or if we suspect that a dependent adult has been abused, the law requires that we file a report with the appropriate government agency, usually the Department of Human Services. Once such a report is filed, we may be required to provide additional information.

- ✓ If a patient communicates an imminent threat of serious physical harm to an identifiable victim, we may be required to disclose information in order to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

- ✓ If a patient communicates an imminent threat of serious physical harm to him/herself, we may be required to disclose information in order to take protective actions. These actions may include initiating hospitalization or contacting family members or others who can assist in providing protection.

THERAPIST / PATIENT HIPPA AGREEMENT

- ✓ While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, your therapist may keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances such as those that involve danger to yourself and others or that make reference to another person (unless such other person is a health care provider) and in which your therapist believes that access is reasonably likely to cause substantial harm to such other person or where information has been supplied to us by others confidentially, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in the presence of your therapist, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, Parkview is allowed to charge a copying fee of a minimum of $20 or greater and may charge for reviewing the records with you. The exceptions to this policy are contained in the attached Notice Form. If your therapist refuses your request for access to your Clinical Records, you have a right of review, except for information supplied to us confidentially by others, which he or she will discuss with you if your request it.

In addition, your therapist may also keep a set of Psychotherapy Notes. These notes are for the therapist's own use and are designed to assist him or her in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of patient/therapist conversations, the therapist's analysis of those conversations, and how they impact on your therapy. They may also contain particularly sensitive information that you may reveal to your therapist that is not required to be included in your Clinical Record, as well as information from others provided to your therapist confidentially. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without your written, signed authorization. Insurance companies cannot require your authorization to release Psychotherapy Notes as a condition of coverage nor penalize you in any way for your refusal to provide such authorization.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with 'regard to your Clinical Records and disclosures of protected health information. These rights include requesting that we

amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and requesting a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. Your therapist will gladly discuss any of these rights with you upon your request.

MINORS & PARENTS

Patients under 18 years of age who are not legally emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. However, because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, your therapist may request an agreement from parents that they consent to give up their access to their minor's records. If they agree, during treatment, we will provide parents only with general information about the progress of the minor's treatment, and his/her attendance at scheduled sessions. We will also provide parents with a summary of the minor's treatment when it is complete. Any other communication will require the minor's authorization, unless your therapist feels that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving the parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections the child may have.

Rev. 10/22

PARKVIEW
PSYCHOLOGICAL SERVICES
2910 Hamilton Blvd., Ste. 100 • Sioux City, IA 51104 • Phone: 712-239-1111 • Fax 712-239-1199

THERAPIST/PATIENT HIPPA AGREEMENT
Authorization, Consent & Acknowledgement

My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by Parkview Psychological Services for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations of Parkview Psychological Services.

I have reviewed your *THERAPIST/PATIENT HIPPA AGREEMENT* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *THERAPIST/PATIENT HIPPA AGREEMENT* from time to time and that I may contact Parkview Psychological Services at any time at the address above to obtain a current copy of the *THERAPIST/PATIENT HIPPA AGREEMENT.*

Coordination of treatment:

- ☐ I give permission for my provider at Parkview Psychological Services to release mental health information for the purpose of coordination of care with my primary care physician and any other medical practitioners who provide care for me. (If you check this box, please complete the included Release of Information).
- ☐ I decline to release information to my primary care physician or other medical providers at this time.

_____ _____

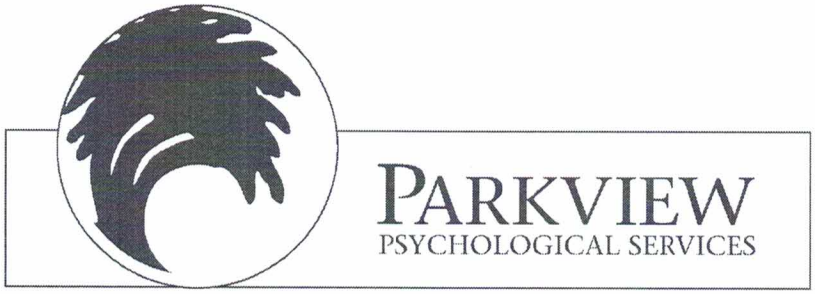
Patient, or Legal Guardian/Representative Signature Date Signed

_____

Relationship, if not Patient

_____ _____

Therapist or Witness Signature Date Signed



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Authorization to obtain or release health care information

Client name:	ID#	SS#
Date of Birth:	Parent/Guardian:	

I authorize the following individual or agency to share written and oral information (two-way or reciprocal release) about my needs and the services I receive:

Name of agency to release and receive information:_____
Address:_____
City/State/Zip_____
Phone:_____

With the following individual or agency:

Name or agency to receive and release information:_____
Address:_____
City/State/Zip:_____
Phone:_____ Fax:_____

The information released or shared may include: Face sheet Admission Status Psychological reports
Discharge summary Social history Lab results Treatment and aftercare Progress Notes
Diagnosis Team notes Medication History & Physical exam Initial assessment
School records Court documents Evaluation Consultation reports
Other (please specify):_____
Other (note exceptions or limits to this release):_____

I authorize my records to be faxed to Parkview Psychological Services _____ _____ Authorizing initials:_____

This information is being used ONLY for (state purpose)

Specific Authorization for Release	Type of Information	Authorizing initials:_____
I authorize the release of the information listed at the right, which requires specific consent under Federal Law	Mental Health evaluation/treatment_____ AIDS/HIV-related_____ Substance Abuse_____	

This authorization is valid for information already in existence and any information that may be generated while this authorization is effective. I understand that I have the right to see any information that is disclosed pursuant to this authorization for release. I understand that I can revoke my authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization shall expire on the date specified below. If I fail to specify an expiration date, this authorization will expire in **six months** after the date it is signed. I have read and understand this form.

Confidentiality of mental health information is protected by federal and state law, i.e. Chapter 228 of the Iowa Code and federal regulations governing confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR Prt.2, and cannot be disclosed without my written consent. Unauthorized disclosure may result in ivil damages and criminal penalities

Authorizing signature: Date Expiration date:

Relationship to Client: Self Legal Representative Other (specify)