ORLANDO PSYCHOLOGY ASSOCIATES
1630 HILLCREST ST., ORLANDO, FL. 32803
PH: (407) 447-5437 FAX: (407) 447-4543

PATIENT INFORMATION

PLEASE PRINT Date: _____

Name: _____ DOB: _____

AGE: _____ Sex: [ ] M [ ] F Gender Identity: _____ Race: _____ First Language: _____

Relationship Status: [ ] Single [ ] Living Together [ ] Married [ ] Divorced [ ] Widowed

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (____) _____

Cell Phone: (_____) _____ Email: _____

Patient SS #: _____ Driver's Lic. # : _____

Parent(s)/Guardian (if child) _____

Contact #: _____

Parent SS#: _____

Please List Your Primary Concerns/Reason for Appointment:

1)_____

2)_____

3)_____

Referral Source: [ ] online [ ] Psychology Today [ ] current patient [ ] insurance company
[ ] physician/clinician – name: _____
[ ] other: _____

Primary Medical Care Provider (Family Doctor/Pediatrician):_____

Phone #:_____

I verify that this information is correct and accurate: _____ Date:_____
Signature

FINANCIAL RESPONSIBILITY

If patient is a child, Guarantor information must be filled out in this section

Name: _____ Relation: _____

Address: _____ DOB: _____

City: _____ State: ____ Zip: _____ SS #: _____

Driver's Lic. #: _____ Home Phone: (____)_____

Employer: _____ Work Phone (____)_____

Address: _____ City: _____ State: ___ Zip: _____

Occupation: _____

INSURANCE INFORMATION

Primary

Type: [ ] Self Pay [ ] PPO [ ] HMO

Company: _____

Policy # : _____ Group # : _____

Name of insured:_____

DOB:_____ SSN:_____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the release of any medical/psychiatric information acquired in the course of my examination/treatment to my health and hospital insurance companies to facilitate payment for services rendered.

Parent/Guarantor_____ Date:_____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment of medical benefits to John Grbac, Psy.D., if any, due to me under my insurance policies.

Parent/Guarantor_____ Date:_____

Office Administrative and Payment Policies 2023

Please read the following office policies that will apply to administrative operations, as well as policies related to private payment and payment by insurance companies and managed health care. **Please initial each paragraph**.

- ___I fully understand and accept that regardless of my method of payment for services, I am fully responsible for the payment for services rendered the day of service.

- ___Please understand that we file insurance as a courtesy to our patients. If you choose to have our office file for your insurance, all insurance information must be presented prior to your session. Our office will not backdate any claims. Please bring your insurance cards with you and be aware of your insurance contract information. Your insurance benefits, deductibles, copays and coverage are not determined by our office. We can only assist you in estimating your portion of the cost of treatment. **You are responsible for unpaid balances due to a lack of information or for services provided but not covered by your plan.**

- ___If you choose to have our office file your insurance, you accept our assistance in managing claims, while you maintain full responsibility for all unpaid claims. We will file claims by mail or electronically on a regular basis; therefore, we will not be responsible for delays and denials. It will be your responsibility to ensure we receive prompt payment from your insurance company. We will re-file unpaid claims (usually every 45 days).

- ___Our office expects that all deductibles, co-payments, co-insurance, or fees not covered by your insurance carrier will be paid **at the time** services are rendered. Although we will verify your insurance for you, it is your responsibility to be aware of insurance coverage limits, and we encourage you to monitor the number of sessions and type of services approved. **Please remember that any benefits quoted by your insurance company are not a guarantee of payment.** Our office will bill only one responsible party. It is your responsibility to arrange payment at the time services are rendered.

- ___Sessions may range from 15-60 minutes. Sessions may be billed at different rates based on time, persons present and the type of service. Any court related services are billed at a higher rate, which may be outlined in a separate contract for services. If you would like a full, detailed account of each provider's rates, please contact the office and request your provider's specific fees for services or to request a "good faith estimate." Please note that all fees for services may be adjusted or changed at the onset of the new year.

- ___**Phone contact and consultations, case management services, preparation of letters or written reports, after hours calls and reviewing of records, documents and emails** for the purpose of assisting a patient are billed per 15-minute increments at the providers per hour rate as listed above. Please be advised that while you may send information via email, our providers do not send or respond by email. Email should **not** be used for immediate, time sensitive or emergency situations. In addition, the providers do not engage with clients on social media in an effort to maintain the therapeutic relationship and protect patient privacy and confidentiality. Please note, our office strictly prohibits recording of any nature, audio, or video, while on property, in the office or in session.

- ___**Cancellation Policy:** You are responsible for scheduling and attending your / your child's appointment(s) Note that insurance companies do not pay for a missed, scheduled appointment. The office requires a standard ***24-hour notification*** (business day) of appointment cancellation. We will charge a fee for our providers' time for late cancellations and/or missed appointments. No-Show appointments will be charged the full fee for service and any late cancellation (less than 24 business hour notice) will be charged a fee of $50.

- ___You agree to reimburse us fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including attorneys' fees, we incur in such collection efforts. In addition, there will be a $25.00 fee for a bounced check and/or checks returned with insufficient funds.

By signing I acknowledge that I understand the above policies and agree to them.

Patient Name: _____ (please print)

Patient/Parent Signature: _____ Date: _____

Informed Consent for Treatment

1) I understand the concepts and conditions of informed consent, privacy, and confidentiality.
2) I understand that I have the opportunity to discuss these concepts and conditions and to ask for clarification of parts, which I was concerned about or did not fully understand.
3) I understand that I will be informed of the goals, expectations, procedures, benefits and possible risks involved in an evaluation and counseling/treatment.
4) I understand that the process of counseling, psychotherapy or evaluation is an interactive process requiring self-disclosure, self-exploration, and responsible action. It has the overall purpose of promoting understanding and change. Sometimes this process can be *stressful* and emotionally *uncomfortable*, and at other times, very **fulfilling**. I understand that there are no guaranties of positive outcome for the therapy/treatment.
5) I have the right to question any procedure, intervention, rationale, or discussion that is unclear or that I do not understand.
6) I have the right to refuse or withdraw from any counseling, psychotherapy or evaluation procedure or intervention unless otherwise specified by law.
7) I understand that all communication will be private, legally privileged, and confidential unless otherwise specified in a legal order or document, by the special laws presented below, or unless I provide my written consent to a specified release of information. I understand that if my therapist is a resident or intern, then the treatment will be discussed with a supervising professional.
8) I understand that the office strictly prohibits recording of any nature, audio or video, while on property, in the office or in session.
9) I understand that office staff may call and leave a voice mail concerning clinical and/or administrative information.
10) I understand that this consent may be withdrawn by me *at any time* without prejudice and must be completed in writing.

Please note the following *exceptions* to privacy, privileged communication, and confidentiality:
Principles of confidentiality vary within the context of treatment and services which are court ordered, or agreed to in a legal agreement. In addition, there are special laws that allow for release of confidential or privileged information that have been developed in an effort to provide protection for the client and the public. In unusual circumstances information that the client discloses may be released without consent to the appropriate parties involvement, if:

1) There exists a danger of harm to the client or someone else.
2) The client needs to be involuntarily hospitalized due to the debilitating effects of mental illness or substance use.
3) The client is required to undergo a court-ordered examination.
4) The client discloses information about the abuse, neglect or exploitation of a child or of an aged/disabled adult.
5) The client's mental or emotional condition is involved in legal matters or as a legal defense.
6) A civil, criminal, or disciplinary action arises from a complaint filed on behalf of the client against a mental health professional in which case the disclosure and release of information shall be limited to that action.

Safety & Supervision Agreement: I understand that as a parent or legal guardian of my child, I am responsible for my child's safety and supervision while going to, waiting for, or leaving a service/session, including the parking lot, the lobby/waiting area, the bathroom, and any time my child is not in session with their therapist.

I hereby give my consent for service to be provided under these conditions.

Client's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

Notice of Privacy Practices

Notice
When you seek treatment from a health care provider or apply to a health plan for benefits, the provider or plan must give you a "Notice of Information Practices" that states your privacy rights and explains how they intend to use and disclose your health information. They are required to make a "good faith effort" to get you to acknowledge that you have received this notice by obtaining your signature. However, your signature is not required.

Access
You have the right to see, copy, and supplement your own medical records (Usually, this includes medical and billing records *but does* ***not*** *include psychotherapy notes*.) Copies of your records must be supplied to you within 30 days of your request. The holder of the records is allowed to charge you a reasonable fee for copying your records.

Security
Health care providers, plans, and "information clearinghouses" that collect, share and store your health information must have appropriate technical and administrative safeguards in place to protect your information.

Limits on Employers
Health care providers and health plans are barred from disclosing your identifiable health information to your employer. In various circumstances, some employers also gather health-related information on their own. In those cases when the employer is acting in the capacity of a health plan or care provider, as in the case of a self-insured company, they are covered by the new federal law. The health care information they gather can only be used for health-care-related functions and they are prohibited from sharing that information with anyone else in the company. However, if an employer gathers personal health information, but is not acting as a health plan or health care provider, then the information is not protected by the law. Examples of information that is not covered includes information collected as part of an Employee Assistance Program or through a pre or post-employment physical.

Psychotherapy Notes
Mental health providers can refuse to disclose psychotherapy notes to health plans without first obtaining a patient's voluntary authorization. Health plans may not condition the delivery of benefits or enrollment on obtaining an authorization from an individual.

Hospital Directories
You have the right to opt-out of having your name and health status publicly available in a hospital's directory. You may also limit the hospital form sharing medical information with family members.

Law Enforcement
In most cases, law enforcement officials must present some form of legal process—warrant, subpoena, summons—before a health care provider or health plan can disclose your health information to them.

If you believe that your health privacy rights or protections have been violated, there are several actions you can take:

Contact a Privacy Officer
Every health care provider and health plan covered by the federal health privacy law must appoint someone on their staff as a privacy officer. If you experience a problem related to the privacy of your medical records or access to them, you might want to contact this individual in an effort to resolve the problem.

File a Federal Complaint
You may also choose to file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights, the federal agency charged with enforcing the federal health privacy law. This office has the authority to impose civil and criminal penalties if they find a violation of the law. Your complaint must be filed within 180 days of the incident.

The complaint process is outlined at www.healthprivacy.org. A standard complaint form is also available on the website. You can also go directly to www.hhs.gov/ocr/hipaa/. Please be sure to send copies of your complaint to the Health Privacy Project, so that complaints and follow-up can be monitored.

Seek State-level Recourse
There are officials in your state who may be willing to help you address violations of the federal privacy law and additional state privacy laws. Among those likely to help are your state attorney general [www.naag.org], your state insurance commissioner [www.naic.org], and a state medical board [www.fsmb.org]. See the websites to find your state's officials.

Lawsuits
You do NOT have the right to sue a health care provider or health plan for a violation of the federal privacy law, but a documented violation of the federal law may strengthen a privacy case you bring in state court.

If you would like to view all of the privacy laws in their entirety, more information may be found at www.healthprivacy.org and www.hhs.gov/ocr/hipaa/ or ask anyone in the office staff for a copy.

**** By signing below, you have read and understand all of the privacy laws and have also had the opportunity to review the full "Notice of Privacy Practices."**

_____ _____
Signature Date

INFORMED CONSENT FOR TELEPSYCHOLOGICAL SERVICES

In addition to all agreements made in the Contract for Services signed at your first visit, the following additions need to be agreed upon before starting video/phone conferencing services:

- There are potential benefits and risks of telepsychology services that differ from in-person sessions. Benefits include being able to continue treatment when obstacles prevent in-person services. Risks include limits to patient confidentiality, as someone may be able to overhear our conversation if you are not in a private location.
- Confidentiality still applies for telepsychology services. We will not record any session, nor are you permitted to record any portion of a session.
- It is important to be in a quiet, private space that is free of distractions (including cell phones, television, or other devices) during the session and using a secure internet connection (rather than public/free Wi-Fi). We will not proceed with the session if you are driving/operating a motor vehicle. For children, they must be in a space alone, which does not include in a car with a parent/sibling/etc.
- You agree to use the telepsychology platform our office has selected for our virtual sessions and we will explain how to use it. You will need a webcam, tablet, or smart phone during the session.
- If we have technical difficulty, the provider will call you at the number you provided on this form. If we have significant difficulty connecting, you will not be charged for the session.
- Once it is determined that the circumstances related to the COVID-19 outbreak have changed, in-person sessions will resume.
- Our office will make every effort with your insurance provider to ensure that these emergency telepsychology appointments will be covered. However, in the event insurance does not provide payment, you will be responsible for the full contracted rate of the session.
- In the event of a crisis situation, you authorize a safety plan that includes our provider being permitted to call your emergency contact and the closest emergency room to your location, both listed below.

By signing below, I am consenting to telepsychology services with a provider at Orlando Psychology Associates and agree to all the above office policies. I understand that any of the points mentioned above can be discussed and may be open to change at any time.

_____	_____	_____
Printed Client Name	Signature of Client	Date

_____	_____
Best Phone Number	Preferred email

_____	_____	_____
Emergency Contact Name	Emergency Contact Phone	Nearest Emergency Room

Please make sure the information above, especially the email, is legible. Please return this form prior to your appointment by faxing to 407-447-4543, dropping off in person, or emailing to OrlandoPsychologyAssociates@gmail.com ATTN: Telehealth ***(Please note: email is only for this use and cannot be used to make/change/cancel appointments, ask clinical questions, etc).***

Call 407-447-5437 with any concerns.