CEDAR CREEK ASSOCIATES
PATIENT INFORMATION

Date: _____ Clinician/Provider: _____

Patient Information

Name: _____ Date of Birth: _____ Age: _____

Local Address: _____

Permanent Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Sex: _____ Marital Status: _____ Social Security Number: _____

Employer: _____ Address: _____

Student: _____ Full Time: _____ Part Time: _____ Not in School: _____

Insurance Company Information

Name: _____

Mental Health Phone: _____ Customer Service Phone: _____

Policy Holder Name: _____ Relationship to patient: _____

Policy ID Number: _____ Group Number: _____

Employer Name: _____ Employer Phone: _____

Emergency Contact:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Family Physician: _____ Phone: _____

Guarantor of Payment or Responsible Party

Name: _____ Relationship: _____

Address: _____

Phone: _____

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a. ☐

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. _____ 3. _____

2. _____ 4. _____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN ☐ ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CONSENT TO TREATMENT

By signing the document below, you assert that you have read and understand this page, and that you consent to treatment for yourself, your minor child, or your family. I will be happy to discuss any questions or concerns you may have.

CONFIDENTIALITY

What we talk about, and even the fact that you are coming here for treatment, is private information and cannot be disclosed except under the following circumstances:

- If you give me a signed authorization to release the information;
- If I have reason to think you may be an immediate danger to yourself or to others;
- If a court orders me to release the information;
- In order to collect fees, information can be released to the third party payor;
- To other professionals for consultation (in which case your identity will not be disclosed);
- To qualified personnel for management or financial audits (an insurance company audit, for example).

THE NATURE OF PSYCHOTHERAPY

I will use traditional verbal techniques in providing therapy to you, or traditional play therapy techniques with your child. Treatment planning requires an assessment and diagnosis. If you have questions about the diagnosis or the diagnosis process, please ask me.

Some questions that I will ask will be very personal and may cause you more anxiety. Please feel free not to answer, or to talk to me about our feeling about the issue. I may ask you to carry out an assignment outside of the therapy hour. If so, the assignment is intended to help you, but if you feel uncomfortable with it or think it may be harmful in any way, please do not carry it out and do talk with me about your concerns.

I will see you by appointment in my office. If I see you outside the office, I will be friendly, but will not discuss your issues nor indicate the nature of our relationship unless you make it clear that you want the relationship known.

Psychotherapy is not an exact science. It involves a cooperative effort between us. I encourage your questions and an open participation. Please discuss with me any questions or concerns about our work, the staff, or the facility. Psychotherapy is intended to address the problems you present and that we agree to work on together. There is a possibility that therapy can make problems worse or even create new problems. Usually, this is a stage toward getting better, but if you do not understand how what we are doing can help, please talk to me about it.

DUTY TO REPORT

I have a legal obligation to report to authorities if I believe a child, a disabled person, or elderly person is being abused or neglected. I have a legal obligation to report to authorities if I believe you are an imminent physical danger to someone else, or an imminent physical, mental, or emotional danger to yourself.

TERMINATION

It is usually most beneficial for therapist and client to discuss the termination process and I encourage you to do so. However, if I have had no contact with you for two months, I will automatically terminate the case. It is always easy to re-open a case, so we can do so if you contact me again.

Name of Patient Date

Signature of Responsible Party Name of Responsible Party

Thank you for choosing me as your therapist. Your treatment involves payment for services as my work is not government subsidized. Please read this statement of my financial policies carefully, and sign it to show that you have read and understand it.

Fees are charged for the following:

- Therapy sessions (individual, family, couples, or group)
- Non-cancelled appointments or those missed without 24 hour prior notice my be charged at a rate of $50 per hour
- Preparing/copying records, reports, and letters
- Telephone consultations
- Returned checks
- Interest may be added to accounts due for 90 days
- Court appearances, depositions, travel and preparation time (ask for my legal policy)
- If an account is sent to collection, the fee will be what the collection agency charges plus any legal fees necessary to collect.

Please note:

- Payment is expected at the time of service by cash or checks payable to me
- Payment plans are available with prior notice

About Cedar Creek Associates: Cedar Creek Associates is an office-sharing cooperative only. It is not a group clinical practice. Each associate maintains his or her own independent practice. No other professional relationship exists among the clinicians.

Regarding Insurance: I may accept assignment of benefits once you provide needed information. This means that you would pay co-pays and deductibles at the time of service and the staff will bill the insurance company for the balance. When we tell you what the benefits and authorizations for sessions are, we cannot guarantee that the information is correct. I am providing you with an estimate of your share of the cost treatment as provided to me by your managed care company, insurance company, or employee assistance program. Sometimes this information is not consistent with alter information we receive from the insurance company and I have no way of determining that in advance. Your actual share may be more than this estimate and I have no way of determining that in advance. Your actual share may be more than this estimate. You are ultimately responsible for the charges incurred as I am not a part of your contract with the insurance company. Remember to please let the staff know if you change insurance or managed care companies.

Managed care companies: Many insurance companies contract with a managed care company to manage the benefits and care. The managed care company may require that I obtain prior authorization for sessions and I usually am required to submit clinical information about you to do so.

Consultation: In order to serve you better, I may seek professional consultations. If I seek consultations, there will be no fee to you. Confidentiality will be maintained and your identity will not be disclosed.

Thank you. If you have any questions or concerns about these policies, please speak with me or with one of the office staff.

Name of Patient Date

Signature of Responsible Party Name of Responsible Party

631 MILL STREET, SUITE 101
SAN MARCOS, TEXAS 78666

THE PURPOSE OF THIS RELEASE IS TO ALLOW YOUR THERAPIST TO BILL YOUR INSURANCE COMPANY AND OBTAIN AUTHORIZATION FOR TREATMENT.

Patient's Name (print): _____ Date of Birth: _____

1. I authorize the following person: _____ **(name of therapist)**

2a. To use or disclose the information below from the initial date of service until financial liabilities are satisfied.

- ✓ Inpatient or outpatient treatment records for physical or psychological, psychiatric, or emotional illness.
- ✓ Admission and discharge summaries.
- ✓ Psychological, psychiatric, and or medical evaluations, reports, histories, assessments, treatment notes, treatment planes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or documents received from other medical and mental health providers.
- ✓ Billing records.

3. Name of your insurance company and/or Employee Assistance Program: _____
4. I understand and agree that this Authorization will be valid and in effect until service with this provider is completed and payment benefits have been collected. I understand that after this date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization.
5. I understand that I can revoke or cancel this authorization at any time by sending a letter to my provider. If I do this, it will prevent any disclosures after the date it is received but cannot change the fact that some information may have been sent or shared before that time.
6. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the Provider named above, nor will it affect my eligibility for benefits. **However, I may not be able to have further sessions authorized other than those contained in the initial authorization of services and I will assume financial responsibility for all subsequent services.**
7. I understand that I may inspect and have a copy of the health information described in this authorization. There may be a cost for this copy or other services.
8. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
9. I have discussed the issues above with the Provider and I understand the terms of this authorization.

_____ _____
Signature of client or his or her personal representative Date

_____ _____
Printed name above Relationship to the client

_____
Description of the personal representative's authority

_____ I acknowledge that I received a copy of this completed form.

_____ I do not want a copy of this completed form.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

1. PURPOSE:

As an independent mental health practitioner, I follow the privacy practice described in this Notice. I keep your mental health information in records that will be maintained and protected in a confidential manner, as required by law. Please note that in order to provide you with the best possible care and treatment, all employees involved in the health care operations of this practice may have access to some of your records.

2. WHAT ARE TREATMENT AND HEALTH CARE OPERATIONS?

Your treatment includes sharing information among health care providers who are involved in your treatment. For example, if you are seeing both a physician or psychiatrist and a psychotherapist, they may share information in the process of coordinating your care. Treatment records may be reviewed as part of an on-going process directed towards assuring the quality of care.

3. HOW WILL THIS PRACTICE USE MY PROTECTED HEALTH INFORMATION?

Your personal mental health record will be retained by me for approximately ten years after your last clinical contact; or, in the case of a child, for ten years after the 18th birthday. After that time has elapsed, the record will be shredded or otherwise destroyed in a way that protects your privacy. Until the record have been destroyed, they may be used, unless you ask for and agree to restrictions on a specific use or disclosure for purposes of treatment, payment or other health care operations including, but not limited to:

- Appointment reminders;
- Notification when an appointment is cancelled or rescheduled;
- As may be required by law;
- For public health purposes such as reporting of child or elder abuse or neglect; reporting reactions to medications; infectious disease control; notifying authorities of suspected abuse, neglect, or domestic violence (if you agree or as required by law); administration and management of this practice;
- Mental health oversight activities (e.g., audits, inspections, or investigations of administration and management of this practice);
- For billing and collections;
- Lawsuits and disputes (I will attempt to provide you advance notice of subpoena before disclosing information from your record);
- Law enforcement (e.g., in response to a court order or other legal process) to identify or locate an individual being sought by authorities; about a victim of a crime under restricted circumstances; about a death that may be the result of criminal conduct; about criminal conduct that occurred on the premises; when emergency circumstances occur relating to a crime;
- To prevent a serious threat to health or safety;
- To carry out treatment and health care operations functions through medical transcription services;

- To military command authorities if you are a member of the armed forces or a member of a foreign military authority;
- National security and intelligence activities;
- Protection of the President or other authorized persons or foreign heads of state, or to conduct special investigations;
- Alcohol and drug abuse information has special privacy protections. I will not disclose any information identifying an individual as being a client or provide any mental health or medical information relating to a client's substance abuse treatment unless: (i) the client consents in writing; (ii) a court order requires the disclosure of the information; (iii) medical personnel need the information to meet a medical emergency; (iv) qualified personnel use the information for the purpose of conducting research, management audits, or program evaluation; (v) it is necessary to report a crime or a threat to commit a crime or to report abuse or neglect as required by law.

4. YOUR AUTHORIZATION IS REQUIRED FOR OTHER DISCLOSURES.

Except as described previously, I will not use or disclose information from your record, unless you authorize (permit) it in writing for me to do so. You may revoke your permission, which will be effective only after the dates of your written revocation.

5. YOU HAVE RIGHTS REGARDING YOUR PROTECTED MENTAL HEALTH INFORMATION.

You have the following rights regarding your mental health information, provided that you make a written request to invoke the right:

- Right to request restriction. You may request limitations on your mental health information I may disclose, but I am not required to agree to your request. If I agree, I will comply with your request unless the information is needed to provide you with emergency treatment.
- Right to confidential communications. You may request communications in a certain way or at a certain location, but you must specify how or where you wish to be contacted.
- Right to inspect and copy. You have the right to inspect and copy your mental health information regarding decisions about your care. I may charge a fee for copying, mailing, and supplies. Under limited circumstances, your request may be denied; you may request review of the denial by another licensed mental health professional. I will comply with the outcome of the review.
- Right to request clarification of record. If you believe that the information I have about you is incorrect or incomplete, you may ask in writing to add clarifying information. I am not required to accept the information that you propose.
- Right to accounting of disclosures. You may request a list of disclosures of your mental health records, for the purposes other than treatment, payment, or health care operations during the last six years, but not prior to April 14, 2003.

6. REQUIREMENTS REGARDING THIS NOTICE.

I am required to provide you with this notice that governs my privacy practices. I may change policies or procedures in regard to privacy practices. If and when changes occur, the changes will be effective for mental health information I have about you as well as any information I receive in the future. Any time you come in for an appointment, you may ask for and receive a copy of the Privacy Notice that is in effect at the time.

7. COMPLAINTS.

If you believe your privacy rights have been violated, you may file a complaint with me, the appropriate state regulatory agency (see the list below) or the Secretary of the U.S. Department of Health and Human Service. You will not be penalized or retaliated against in any way for making a complaint.

CONTACT: CALL THIS OFFICE IF:

- You have a complaint;
- You have any questions about this notice;
- You wish to request restrictions on uses or disclosures for health care treatment or operations; or
- You wish to obtain additional information or forms to exercise your individual rights described above

STATE REGULATORY AGENCIES:

- For psychologist: Texas State Board of Examiners of Psychologist (512-305-7700).
- For social workers: Texas State Board of Social Worker Examiners (800-232-3162).
- For licensed professional counselors: Texas State Board of Examiners of Professional Counselors (512-834-6658).
- For marriage and family therapists: Texas State Board of Examiners of Marriage and Family Therapists (800-942-3162).

Print Patient Name	Date
Patient or Parent/Guardian Signature	Date
Provider Name	Date