Gordon A. Harris Ph.D. & Associates, Inc.
5400 N. Main St., Dayton, Oh 45415; (937) 274-2226

Enclosed are several forms which need to be completed for the scheduled appointment on_____________ at _________

CLIENT REGISTRATION – CHILD/ADOLESCENT/YOUNG ADULT FORM
CONSENT FOR TREATMENT
FINANCIAL AGREEMENT
CONTINUITY OF CARE
YOUR RIGHT OF CONFIDENTIALITY (HIPPA)
PATIENT RIGHTS AND RESPONSIBILITIES

This acknowledgement and the forms marked with an * should be completed and brought to your appointment. The others should be retained for your reference.

ACKNOWLEDGEMENT

My signature below acknowledges that I have been given a copy of the forms listed above.

I agree and consent to participate in the psychological services offered and provided by GORDON A. HARRIS PH.D., & ASSOCIATES, INC. I agree to be bound by the terms in their policies. I have had the opportunity to ask questions about the policies and those have been answered to my satisfaction.

I understand that I am consenting and agreeing only to those services that the above-named provider is qualified to provide within the scope of their license, certification, and training; or the scope of license, certification, and training of the psychologist directly supervising the services received by the patient.

____ ________________________________
Name of Client Birth date

____ ________________________________
Signature Date
(Parent/guardian to sign, if client is a minor)

CLIENT REGISTRATION – CHILD/ADOLESCENT/YOUNG ADULT

FULL NAME___________________________ SEX _____ BIRTH DATE_____/_____/_____

LEGAL GUARDIAN OF CHILD____

WITH WHOM DOES CHILD RESIDE____

STREET ADDRESS____

CITY, STATE, ZIP____

SCHOOL NAME ____

GRADE ________________________ TEACHER _____________________________________

EMERGENCY CONTACT____
(NAME, RELATIONSHIP, PHONE)

WHO REFERRED YOU TO US?____

CHILD'S PHYSICIAN____

FATHER'S NAME______________________________BIRTH DATE______/_____/________

ADDRESS (if different than child's)____

PHONE (HOME)______________________________ (CELL) ___________________________
OK/NOT OK (circle one) to leave msg OK/NOT OK (circle one) to leave msg

SSN (REQUIRED)_____________________________EMPLOYER________________________

WORK PHONE_________________________ OCCUPATION ___________________________

MOTHER'S NAME______________________________BIRTH DATE _____/_____/________

ADDRESS (if different than child's)_______________________ ____________________________

PHONE (HOME)_______________________________ (CELL) ___________________________
OK/NOT OK (circle one) to leave msg OK/NOT OK (circle one) to leave msg

SSN (REQUIRED)_____________________________EMPLOYER________________________

WORK PHONE_________________________ OCCUPATION ___________________________

STEPFATHER'S NAME____________________________BIRTH DATE_____/____/______

ADDRESS (if different than child's)__________________ ______________________________

PHONE (HOME)___________________________ (CELL)___________________________
OK/NOT OK (circle one) to leave msg OK/NOT OK (circle one) to leave msg

SSN (REQUIRED)____________________________EMPLOYER______________________

WORK PHONE________________________ OCCUPATION__________________________

STEPMOTHER'S NAME____________________________BIRTH DATE ____/____/______

ADDRESS (if different than child's)____

PHONE (HOME)___________________________ (CELL) __________________________
OK/NOT OK (circle one) to leave msg OK/NOT OK (circle one) to leave msg

SSN (REQUIRED)____________________________EMPLOYER______________________

WORK PHONE_______________________ OCCUPATION___________________________

PERSON COMPLETING FORM____

RELATIONSHIP TO PATIENT____

BEST PHONE NUMBER TO REACH ME AT? [ ] HOME [ ] CELL [ ] WORK

INSURANCE INFORMATION

INSURANCE COMPANY____

SUBSCRIBER'S NAME________________________DOB__________SSN______________

ADDRESS (IF DIFFERENT FROM PT'S)____

____

EMPLOYER_________________________RELATIONSHIP TO INSURED______________

ID NUMBER_________________________GRP NUMBER____________________________

IF YOU HAVE ADDITIONAL INSURANCE, PLEASE INFORM THE FRONT DESK

PATIENT BACKGROUND & HISTORY

List all other children and adults living in the home:

Name	Age	Relationship
____________________________	_____	________________
____________________________	_____	________________
____________________________	_____	________________
____________________________	_____	________________

Are any of the children adopted or foster children? Y N If yes, explain:______________

____

Current marital status of parents:____

Has either parent been previously married? Y N If yes, explain:____________________

____

Any complications during the mother's pregnancy? Y N If yes, explain:______________

____

Any difficulties reaching developmental milestones (walking, talking, etc)? Y N

If yes, explain:____

____

List any current medical problems and names of treating healthcare providers:

____

____

Current Medications (including over-the-counter):___________________________________

____

Previous mental health treatment providers and dates:________________________________

____

Has any family member (including grandparents) had problems with school learning, behavior, serious illness, emotional problems or hospitalization for psychiatric care? Y N

If yes, explain:____

____

Why are you seeking help now?____

____

____

Any additional comments you would like to make:____________________________________

____ _____________________________
Parent/Legal Guardian's Signature Date

06/20/2014

GORDON A. HARRIS, PH.D., & ASSOCIATES, INC.

CONSENT FOR TREATMENT FOR ADULT AND/OR CHILD

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist or counselor, the patient, and the particular problems you are experiencing. There are many different methods used to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, it has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, but there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, we will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion. If psychotherapy is started, we will usually schedule one 45 minute session per week, at a time we agree on. Sometimes sessions may be longer or more or less frequent.

You have the right to ask questions at any time and to be fully informed about the treatment process. The information related to evaluation and treatment is confidential and I cannot release information without written consent. There are exceptions to this right to confidentiality. According to Ohio law, there are times when a therapist must legally break such confidentiality and the client's written permission is not required. Please refer to the handout you were given "Your Right of Confidentiality" for more information regarding confidentiality.

Part of your investment in therapy is financial. You are responsible to pay for services at the time of appointment. If a payment is forgotten, it can be paid at the time of the next session. However, **if two consecutive payments are missed, no additional appointments will be scheduled until the balance is paid**.

Your signature below indicates that you have read the information in this document and agree to abide by its' terms during our professional relationship.

____ ________________________
Client/Guardian Date

____ ________________________
Witness Date

06/20/14

GORDON A. HARRIS, PH.D., & ASSOCIATES, INC.
FINANCIAL AGREEMENT – EFFECTIVE 2/6/17

This policy applies to all clients, but may vary, depending on your particular health insurance coverage at the time services are rendered.

The initial appointment fee is $125. Subsequent standard 45-minute appointments are $120. I understand **payment is required at the time of service**, unless otherwise agreed or unless my insurance coverage requires another arrangement. **If I am unsure of my co-pay, a minimum of $20 will be due at each session.** Once my co-pay is established, the office will make any necessary adjustments to my account. If payment is forgotten, it can be paid at the time of the next session. However, **if two consecutive payments are missed, I understand that no additional appointments will be scheduled until the balance is paid.**

I understand certain charges cannot be billed to my insurance company. These include, but are not limited to, phone calls to clinical staff in excess of 5 minutes (5 – 15 minutes = $30.00, 15 – 30 minutes = $60.00); report writing/forms completion; testing materials fee ($30, due prior to start of testing); return check fees ($35); consulting with other professionals (with my permission); preparation of records or treatment summaries; and time spent performing any other services I may request. If my case involves legal proceedings, I am expected to pay for time, including preparation, and transportation costs. Legal consultation case fees are $175 per hour. Charges for court appearances may vary.

I understand that I am financially responsible for the payment of ALL charges rendered to me or to any family members. If I have insurance, this is an agreement between my insurance company and me. **I am responsible for reporting any changes to my insurance coverage to office staff. If I receive a new insurance card, I will present it to the office so they can copy it.** The office will file my claims to my insurance. However, **if insurance does not pay, I am responsible for the total amount of the bill**. My insurance company can provide me with my benefits, such as whether I have met my deductible (if applicable) and, if I have a co-pay or co-insurance.

By signing this form, I agree that the office can provide requested information to my insurance company. I assign all payments for services rendered to myself or my dependents to Gordon A. Harris, Ph.D., & Associates, Inc.

CANCELLATION/NO-SHOW POLICY: I understand that my appointment is reserved exclusively for me and the FULL FEE ($120) will be charged for missed appointments or those not cancelled with 48 hours notice or by noon on Friday for a Monday appointment. These charges are not reimbursable by insurance. The clerical staff does not have the authority to remove these charges from any account. Exceptions may be made for emergencies or extenuating circumstances. If there are questions about a charge, I will discuss this matter with my psychologist/therapist at my next session. This will not be discussed over the phone. I understand that if I miss more than two sessions for any reason, I may be terminated from therapy. INITIAL HERE __________________________

I understand that it if my account has not been paid for more than 45 days and payment arrangements have not been agreed upon, the office may use legal means to secure payment. This may include placing my account with a collection agency or going through civil or small claims court, which will require the office to disclose otherwise confidential information. In most collection situations, the only information that will be released is the patient's and/or parent/legal guardian's name, demographic information, nature of services provided, and amount due. In the case of collection or legal action, collection fees (currently 40% of the balance due) will be included in the claim and become my responsibility.

WHEN PARENTS ARE DIVORCED: As the parent/legal guardian requesting treatment, I acknowledge I am responsible for payment. It is my responsibility to collect reimbursement due me from the other party. **THE OFFICE WILL NOT BILL A PARENT WHO HAS NOT BEEN IN THE OFFICE AND SIGNED AN AGREEMENT TO ASSUME FINANCIAL RESPONSIBILITY.**

I HAVE READ THE ABOVE STATEMENTS AND AGREE TO BE BOUND BY THE TERMS IN THIS POLICY. I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE POLICY AND THOSE HAVE BEEN ANSWERED TO MY SATISFACTION.

SIGNATURE: ______________________________________ DATE: ______________________

2.6.17

GORDON A. HARRIS, PH.D., & ASSOC., INC.
5400 N MAIN ST., DAYTON, OH 45415
(937) 274-2226; (Fax) (937) 274-2074

CONFIDENTIAL EXCHANGE OF INFORMATION FORM
(CONTINUITY OF CARE TO FAMILY PHYSICIAN)

Patient Name: ____ **Birth Date** _______________

CHOOSE ONLY ONE:
[ ] I DO NOT give my authorization to release any information to my Primary Care Physician.

[ ] I give authorization to the office of Dr. Gordon Harris, Ph.D. & Associates to release any mental health/substance abuse information to my PCP.

[ ] I do not have a family physician

Physician Name: ____________________________________ Phone: _______________________

Complete Address: ___________________________________ Fax: _________________________

____

Required Patient or Guardian's Signature_____________________________ Date: _________________
Relationship to patient: ____

This information shall expire in six months or can be revoked in writing any time prior to that time, except for information which has already been shared prior to revocation.
****

TO BE COMPLETED BY OFFICE

TREATING CLINICIAN: [ ] Gordon Harris, Ph.D. [ ] G. Jane Shirley, MS, LPCC

Patient Clinical Information

Date of Initial Consultation: ___________________________ Next Appointment: ___________

Diagnosis: ____

Reason seen: ____

____

Medications: ____

Expected length of treatment: [ ] <3 months [ ] 3-6 months [ ] 6-12 months [ ] >1year

Coordinating care issues/other significant information impacting behavioral care:

____

____

*****THIS IS NOT A REQUEST FOR MEDICAL RECORDS*****
COPY IS BEING SENT/FAXED TO PCP – ORIGINAL REMAINS IN PATIENT'S FILE

06/20/14

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YOUR RIGHT OF CONFIDENTIALITY
The following is provided in accordance with the Federal HIPPA Requirements

This practice is dedicated to maintaining the privacy of your personal health information (PHI). You, as the client, have the right to have your communications and records held in confidence by your therapist. This is called confidentiality. With certain exceptions, your therapist may release confidential information only with your written authorization. Authorization may be revoked at any time, provided this is done in writing; however, this may not be done to the extent this office has relied on that authorization or if the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under the policy. Your (PHI) may be used or disclosed for:

Treatment – when used to provide, coordinate or manage your health care and other services related to that care (i.e., when another health care provider is consulted, such as your family physician or another psychologist). Psychotherapy notes kept separate from the rest of the medical record (therapist notes which may have made about your conversation during a counseling session and may include particularly sensitive information that is not required to be included in your clinical record) are given a greater degree of protection than PHI and authorization would need to be obtained before releasing them.

Payment – when reimbursement is obtained from your healthcare (i.e., when your PHI is disclosed to your health insurer to determine eligibility or coverage or obtain reimbursement).

Health care operation – activities related to the operation of this practice (i.e., quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination).

Use – applies only to activities within this office and practice group, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

Disclosure – applies to activities outside of this office and practice group (i.e., such as releasing, transferring, or providing access to information about you to other parties).

There are instances in which your therapist has the legal obligation to share information with others without your written consent. These circumstances include:

Clear and imminent danger to yourself or society. In a valid emergency or life threatening situation, only relevant information would be revealed to the appropriate professionals or organizations who are able to help prevent or reduce that threat. This helps insure your safety and the safety of others. In any such instance, your therapist will try to work in cooperation with you. The law protects the therapist who must disclose information about an individual who presents a danger to himself or others.

Under law, your therapist is required to immediately notify the appropriate agency or the police in incidents of suspected abuse or neglect of a child or an adult. If your therapist knows or suspects that abuse or neglect has occurred, there is a lawful obligation to report it.

When ordered by a judge to respond to particular questions or to release records, it must be answered.

If required by a law enforcement official.

For **Workers' Compensation** and similar benefit programs.

When working as the agent of another, such as court-ordered evaluation or treatment, fitness for duty evaluations, etc., your therapist provides a detailed report to the court and to the attorneys or other party (if applicable) on the findings of the evaluation or course of treatment. It is understood that this is **not** a confidential process, as the court, attorneys, or others will receive psychological information and recommendations made by the psychologist.

Non-custodial parents have rights to information about the treatment of their children.

PATIENT RIGHTS AND RESPONSIBILITIES

Patients have the right to:

- Request restrictions on certain uses and disclosures of protected health information about you. However, your therapist is not required to agree to a restriction you request.

- Request and receive confidential communications of PHI by alternative means and at alternatives locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address).

- Inspect and copy (or both) your PHI and psychotherapy notes in my mental health and billings records used to make decisions about you for as long as the PHI is maintained in the records. Your therapist may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed.

- To request an amendment of PHI for as long as the PHI is maintained in the records. Your therapist may deny your request.

- You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization.

Your therapist will discuss with you the details of each request process, should your desire.

Psychologist's Duties:

- By law, your therapist is requested to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices with respect to PHI.

- Your therapist has the right to change the privacy policies and practices described in this notice. Unless you are notified of such changes, however, your therapist is required to abide by the terms currently in effect.

- Your therapist must notify you by mail or in person when you come into the office, if these policies and procedures have been revised.

Questions and Complaints:

If you have questions about this notice, disagree with a decision your therapist makes about access to your records, or have other concerns about your privacy rights, you may contact Jennifer Thompson, our office manager, or me directly at 274-2226.

If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send your written compliant to 5400 N. Main S., Dayton, Oh 45415-3453 or to the Secretary of the U.S. Department of Health and Human Services. You have specific rights under the Privacy Rule and you will not be retaliated against for exercising your right to file a complaint.