Dr. Gary Grogan
Licensed Psychologist
Phone (208) 724-0489
Fax (844) 247-3478

Lewiston Psychology Associates

307 19th Street Suite A1
Lewiston, ID 83501

REGISTRATION FORM

(Please Print)

Today's date:	Physician:

PATIENT INFORMATION

Patient's last name: First: Middle:	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Email address:	Birth date: / /	Age:	Preferred Gender: ❑ M ❑ F

Street address:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Website
❑ Family ❑ Friend ❑ Close to home/work ❑ Internet Search ❑ Other

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance

Subscriber's name:	Subscriber's Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

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Informed Consent for Children/Adolescents

This form is designed to answer some frequently asked questions about the practices at Lewiston Psychology Associates, so please read all of it, sign it at the end. We ask that you read and sign this form in order to indicate your understanding of office procedures, as well as your willingness to abide by these policies. Upon request, you will receive a copy of this form so you can refer to it later.

Informed Consent

Clients need good information about psychotherapy in order to make the best choice for themselves and/or their family members. Informed consent means that you are (1) capable of understanding the information you read and we discuss, (2) provided with information of what will occur in therapy, (3) initiating therapy voluntarily, (unless you are being treated under a court order) with the understanding that you may withdraw your consent at any time.

Psychotherapeutic Treatment

The initial assessment of a minor child will involve meeting with you as the parent(s) or guardians, and the child; you may also be asked to complete some forms to provide additional information. After a few sessions, the therapist should be able to give you his or her clinical impressions and recommendations for treatment. With older children and adolescent, they are often concerned with the amount of information about sessions that is offered to parents. In general, we have found it best to provide parents with general information about the treatment and progress. In order to encourage trust on the part of minor clients, we typically do not provide parents with specific details about what they tell us. However, if the therapist is concerned that the child may be in jeopardy of hurting himself/herself or someone else, you will certainly be informed. In addition, if the therapist has reason to believe there is abuse or neglect occurring, we are required by law to report to the appropriate authorities.

Psychotherapy is not like visiting a medical doctor, as it requires both the parent and the child's very active involvement and efforts to change thoughts, feelings, and behaviors. It will be important for you and your child to offer your feelings about the treatment and progress you're making. Offering your views and responses when they are important to you or your child is one of the ways you are an active partner in this process. You and your child will have work to do both in the therapy office and many other times not spent in the therapeutic situation. There may be "homework" assignments and will certainly be time spent working on your personal relationships. Change will sometimes be easy and swift, but more often it will be slow, frustrating, and requiring a need for repetition.

Parents and guardians have the right to ask about other treatments for your child's condition, as well as potential risks and benefits. When difficult issues arise in therapy, it is not unusual to feel angry, sad, or guilty. If any of these feelings become evident, please mention them to their therapist. Please encourage your child to discuss their feelings about their sessions with their therapist and to ask any questions they may have about treatment.

Appointments

For the most part, appointments will last for 45-50 minutes, once per week, at a mutually agreed upon time. Our policy recognizes the importance of your time as well as ours. If you are unable to keep a scheduled appointment, please notify the office. Upon three no shows, services may be suspended if there is no communication about rescheduling. If no one is available to take your call, the answering system will record the date and time of your call. You may call Dr. Grogan at (208) 724-0489. If you are in a crisis situation after business hours, call 911.

Professional Records

Both law and the standards of the psychological profession require that we keep appropriate treatment records. If you are interested in the content of your child's mental health records, your therapist will share them in summary format

(either verbally or in written format) upon an in-person or written request (please allow up to 5 business days for processing).

Confidentiality

We regard all information shared in therapy with the greatest respect so we want to be as clear as possible about how it will be handled. In general, the information provided is confidential. The privacy and confidentiality of our conversations, and this agency's records, is a privilege of yours and is legally protected by federal and state law and by the ethical principles of the psychological profession, in all but a few rare circumstances. In the following situation, confidentiality may be broken:

(1) When there is actual or suspected abuse and/or neglect of a child or elder.
(2) When there is reason to believe that the client may harm himself/herself or someone else.
(3) When the court subpoenas records.

Other than the above described situations, we do not and will not give information regarding the treatment, diagnosis, history, or identity of a client, without the full knowledge and signed release of information form.

Additional Points

First, parents are expected to be available while their children are in session, and agree to bring their children to session and to pick them up directly after the session is over unless prior arrangements are made. We assume no liability for children left alone after their scheduled meeting time. Second, termination of the therapeutic relationship is inevitable. It should never be done casually and can be the most valuable part of the therapeutic process. Either party may terminate therapy; however, prior to termination, we suggest that a meeting be scheduled to discuss further recommendations. Finally, like any health care professional, we have ethical responsibilities and fully abide by the Ethical Principles of our discipline and of the state of Idaho.

Agreement/consent

I have read this form, discussed issues I was unclear about, and my questions answered, and understand and agree to comply with terms outlined above. I am consenting to have my child participate in therapeutic treatment with a therapist at Lewiston Psychology Associates.

I have legal authority to consent to non-emergency psychological therapy or evaluation services with a therapist at Lewiston Psychology Associates. **Please Initial** _____

In the event that custody of a child is shared with another individual, please include the following information regarding the person sharing custody:

Name: _____ Relationship to child: _____

Address: _____ Phone: _____

I give permission for Lewiston Psychology Associates to contact the person listed above. **Please Initial** _____

_____	_____	_____
Printed name of Child	**Signature** of Child	Date
_____	_____	_____
Printed name of Parent or Guardian	**Signature** of Parent or Guardian	Date
_____	_____	_____
Printed name of Psychologist	**Signature** of Psychologist	Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION: I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information ("PHI") that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a clinician were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your person health information, which is otherwise confidential, in order to assist the clinician in diagnosis and treatment of your mental health condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because therapists and other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a

subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I do keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is: a. For my use in treating you. b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy. c. For my use in defending myself in legal proceedings instituted by you. d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA. e. Required by law and the use or disclosure is limited to the requirements of such law. f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes. g. Required by a coroner who is performing duties authorized by law. h. Required to help avert a serious threat to the health and safety of others.
2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes.
3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

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VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.
2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE This notice went into effect on September 20, 2013

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By checking the box below, you are acknowledging that you have received a copy of HIPPA Notice of Privacy Practices.

Printed name of Patient _____ **Signature** of Patient _____ Date _____

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Financial Agreement

We, at Lewiston Psychology Associates, are committed to providing you the best care possible. Your clear understanding of our Financial Policy is important to our professional relationship. Therefore, we wish to clarify the following points:

Our current regular fee for **psychotherapy** is as follows:

$220- New patient evaluation

$190- Couples/Family psychotherapy appointment

$160- 60 minute psychotherapy appointment

$150- 45 minute psychotherapy appointment

$140- 30 minute psychotherapy appointment

Our current regular fee for **psychological assessment** is as follows:

$160- per hour (includes face-to-face, scoring, and report writing)

Full Psychological Assessments are typically 8-10 hours

Please note that you will be expected to pay the co-payments and / or deductible at the time of service. If your insurance has not paid your claim in full within sixty days of billing, we will require the balance to be paid by you. Please call to discuss payment arrangements, if needed. If payment arrangements cannot be agreed upon; however, your account will be turned over to a collection agency. In addition, we cannot continue to schedule appointments and any subsidies granted will be considered void.

In addition to our regularly scheduled appointments, it is my practice to charge for other professional services you may require, such as report writing, letter writing, and telephone conversations lasting longer than 15 minutes, attendance at meetings or consultations with other professionals that you have authorized, preparation of records or treatment summaries, or completion of other services you have requested of me. Court appearances are billed at $250 per hour, with a minimum of one half-day, which is equivalent to four hours.

Psychological therapy services may be partly reimbursable to you under many health insurance plans. In most cases, as a courtesy, we will bill your insurance directly for the services rendered. If your insurance requires a referral form and/or co-pay, you are solely responsible to have it with you on the day of your appointment. We are not responsible to call your insurance to inquire about your referrals, benefits, and/or co-pays. In order to process your insurance claims, we request you bring in your insurance card so that we may make a copy of

your card. If your insurance has not paid within a timely manner, you will be responsible for payment of the charges incurred. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. Typically, the insurance company will send the payment directly to our office, although this is not always the case, and you are responsible for the co-insurance payment and the deductible. If the company denies payment for any reason, you will be responsible for covering these costs. If a check is returned for insufficient funds, a $25 returned check fee will be charged to your account.

Insurance may billed electronically as a courtesy to our clients. The insurance company is provided with the dates of our appointments, charges, and a psychiatric diagnosis. All insurance companies claim to keep such information confidential, but once it is in their hands, we have no control over what they do with it. By agreeing to allow us to bill your insurance you agree to the release of this information necessary to process your claim.

Agreement/Consent

I have read this form, discussed issues I was unclear about, had my questions answered, and understand and agree to comply with terms outlined above. I am consenting to undergo psychotherapeutic treatment/ assessment with a psychologist at Lewiston Psychology Associates (Gary Grogan, PhD). I am agreeing to accept financial responsibility for this treatment. I understand and agree that if I fail to make payments for which I am responsible, after such a default and upon referral to a collection agency by Lewiston Psychology Associates. I will be responsible for all costs of collecting monies owed, including court costs, and collection agency fees. I further understand that any subsidies granted will not be applied to my account until payment is made, and default will result in loss of subsidies.

Printed name of Client (or Guardian)	**Signature** of Client (or Guardian)	Date
Printed name of Psychologist	**Signature** of Psychologist	Date