PLEASE PRINT

Please Fax Page 1 of New Patient forms to (253) 661-9190

Paul Croft LMHC

1010 South 336th Street, Suite 208
Federal Way, WA

NEW PATIENT REGISTRATION

Today's Date:__/__/__

Patient Last Name:_____ First Name:_____ Middle Initial: ___
Check one: Mr _ Miss _ Mrs _ Ms _ Sex: male__ Female__ Other __ Birthdate: ___/__/___ Age: ___
Address:_____ City:_____ State____ Zip:_____
Home Phone:_____ Work Phone:_____ Cell: _____
SS#_____ Patient Email:_____
I prefer Telehealth appointment invitation by (check one) Email____ Text_____
Marital Status: single married___ Widowed___ separated___ Divorced___ Referred by:_____
Patient's relationship to person responsible for bill: self___ spouse___ child___ dependent___
Patient's Employer: _____ Spouse's Name:_____
Address:_____ Spouse's Employer: _____
City/State/Zip:_____ Address: _____
Occupation: _____ Occupation: _____

In case of emergency, local friend or relative to be notified (Not Living at same address) Name: _____
Home Phone: _____ Relationship to Patient:_____ Work Phone: _____

PERSON RESPONSIBLE FOR BILL (if not patient)

Name:_____ Home Phone:_____
Address:_____ Spouses Name: _____
City/State/Zip:_____ Spouse's Employer:_____
Work Phone:_____ Spouses Employer Address:_____
Occupation:_____ City/State/Zip:_____
Employer:_____ Spouse's Work Phone:_____
Employer Address:_____ Spouses Occupation:_____
Employer City/State/Zip: _____

INSURANCE INFORMATION

Insurance:_____ Other Insurance: _____
Subscriber's Name:_____ Subscribers Name:_____
Subscriber Date of Birth:_____ Subscriber Date of Birth: _____
Group #_____ Group # _____
ID #_____ ID # _____
Patient's relationship to subscriber: self_ spouse_ child_ dependent_ Patient's relationship to subscriber: self_ spouse_ child_ dependent_
Subscribers Employer:_____ Subscriber's Employer:_____

Assignment and Release: I hereby authorize my Insurance benefits be paid directly to the clinician. I am financially responsible for any balance due. I also authorize the clinician or insurance company to release any information required for this claim.

Signed: _____ Date: _____

Witness: _____ Date: _____

PAYMENT INFORMATION

Please bill my balance due to (check one) Visa___ MC___ Am Ex___ Card Number: _____-_____-_____-_____
Expiration Date: MM:_____ YY:_____ CVN:_____ Zip Code:_____
I understand that the charges will appear on my statement as a charge from Paul Croft LMHC. Please bill this card for my copay / outstanding charges each visit. I also understand a 24 hour notice is required for cancellation, and any "No Show" or late cancellation fees of $120 per missed or "late cancelled" appointment will be billed to this card

Signed: _____ Date: _____

I hereby authorize Paul Croft LMHC to render counseling services to _____
This authorization constitutes informed consent without exception. I hereby acknowledge receiving a copy of the "Contract for Services" (pages 2-3 of this document) "Notice of Privacy Practices" (p 4, 5, 6) and "Telehealth Informed Consent" (page 7 of this document)

Signed: _____ Date: _____

Paul Croft, L.M.H.C.
CONTRACT FOR SERVICES

Fee Schedule

The first session is specifically for the purpose of evaluation, and the fee for this initial evaluation session is $205. The fee for each regular session thereafter is $180. All appointments are 50 minutes, unless otherwise arranged.

Billing Policies

Clients are responsible for payment in full upon completion of each session. Clients with insurance will be responsible for the copayment only.

Cancellations/Rescheduling

Reschedules or cancellations must be done **24 hours prior** to the appointment. "No-Shows" or cancellations with less than 24 hours notice are billed to you at $120 per session.

Counseling Approach

Paul Croft, L.M.H.C. is a Licensed Mental Health Counselor with the State of Washington, number LH00003665. His masters degree is in Counseling from Seattle Pacific University, 1976. He has provided therapy in a variety of settings, including 40 years of providing therapy to children, individuals and families. The therapeutic approach used is both pragmatic and eclectic, using a variety of psychological approaches, including cognitive, behavioral, psychodynamic, solution-focused and systemic. The initial session focuses on assessment of the nature and scope of the problems.

Confidentiality

I am bound by both my professional ethics and by the laws of the State of Washington to protect Client rights to confidential communications in regard to their participation in counseling. I have provided you with a copy of my Notice to Privacy Practices which describes how I may use and disclose your health information. If you want me to release information about this participation to anyone, I will require you to sign a "Release of Confidential Information" to that person, or the Form HCFA-1500 insurance form, which allows me to communicate with your insurance company or managed care firm. Exceptions to this law include:

1. To report suspected child abuse, abuse of a developmentally disabled person, or of a dependent adult.
2. To interrupt potentially suicidal behavior.
3. To intervene against harm to another (this may include knowledge that a client is HIV positive but is unwilling to inform others with whom he/she is intimately involved)
4. When required by court order or other compulsory process.

Disclosures may also be made if you sign a written authorization permitting disclosure, or in the event that you file a complaint against me.

Subpoenas:

Occasionally, my records or myself are subpoenaed by the court. I will immediately contact you directly, with every effort made to find your correct address, in the following circumstances.

1. Upon receipt of a notice of intent to obtain health care records.
2 Upon receipt of a subpoena for records.
3. Upon receipt of a subpoena for the clinician's deposition.
4 Upon receipt of a subpoena for the clinician's testimony at a hearing or trial.

Contractual Obligations:

If you are using a 3rd party payor (insurance company) to pay for services, I may be required to provide access to counseling information and/or my file by that payor for the purpose of fulfillment of my contract to them.

I hereby authorize Paul Croft, L.M.H.C. to render counseling services to:

_____

This authorization constitutes informed consent without exception. I have read and understand the policy statement and received a copy for myself.

_____ _____
Signature Date

_____ _____
Witness Date

Paul Croft, L.M.H.C.
1010 South 336th Street, Suite 208, Federal Way, WA
(253) 952-4147

"Counselors practicing counseling for a fee must be registered or certified with department of licensing for the protection of the public health and safety. Registration of an individual with the department does not include a recognition of any practice standards, nor necessarily implies the effectiveness of any treatment" WAC 246-810-031

Paul Croft L.M.H.C.
1010 South 336th Street, Suite 208
Federal Way, WA
253-952-4147 Phone - 253-661-9190 Fax

NOTICE OF PRIVACY PRACTICES

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

Your health record contains personal information about you and your health. State and Federal law protects the confidentiality of this information. "Protected health information" (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Your rights regarding your PHI

You have the following rights regarding PHI that I maintain about you:

Right of Access to Inspect and Copy. You have the right, which may be restricted only in certain limited circumstances, to inspect and copy PHI that may be used to make decisions about your care. I may charge a reasonable, cost-based fee for copies.

Right to Amend. If you feel that the PHI I have about you is incorrect or incomplete, you may ask me to amend the information although I am not required to agree to the amendment. The original record will not change, but the amendment will be added.

Right to an Accounting of Disclosures. You have the right to request a copy of the required accounting of disclosures that I make of your PHI.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.

Right to Request Confidential Communication. You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. I will accommodate reasonable requests and will not ask why you are making the request.

Right to a Copy of this Notice. You have the right to a paper copy of this notice.

Right of Complaint. You have the right to file a complaint in writing with me or the Secretary of Health and Human Services if you believe that I have violated your privacy rights. I will not retaliate against you for filing a complaint.

My uses and disclosures of PHI for treatment, payment and health care operations

Treatment. Your PHI may be used and disclosed by me for the purposes of providing, coordinating, or managing your health care treatment and any related services. This may include coordination or management of your health care with a third party, consultation with other health care providers or referral to another provider for health care services.

Payment. I will not use your PHI to obtain payment for your health care services without your written authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities.

Healthcare Operations. I may use or disclose, as needed, your PHI in order to support the business activities of my professional practice. Such disclosures could be to provide quality assurance (such as with managed care companies), financial services (if I chose to use a billing service) provided that I have a written contract requiring them to safeguard the privacy of your PHI. I may also contact you to inform you of treatment alternatives and/or health-related products or services that may be of interest to you.

Other uses and disclosures that do not require your authorization or opportunity to object

Required by Law. I may use or disclose your PHI to the extent that the use or disclosure is required by law, made in compliance with the law, and limited to the relevant requirements of the law. Examples are public health reports and law enforcement reports. I also must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirements of the Privacy Rule.

Health Oversight. I may disclose PHI to a health oversight agency for activities authorized by law, such as professional licensure. Oversight agencies also include government agencies and organizations that provide financial assistance to me (such as third-party payors).

Abuse or Neglect. I may disclose your PHI to a state or local agency that is authorized by law to receive reports of abuse or neglect of children or elders. However, the information I disclose is limited to only that information which is necessary to make the initial mandated report. I may disclose PHI regarding deceased patients for the purpose of determining the cause of death, in connection with laws requiring the collection of death or other vital statistics, or permitting inquiry into the cause of death.

Research. I may disclose PHI to researchers if (a) an Institutional Review Board reviews and approves the research and an authorization or a waiver to the authorization requirement; (b) the researchers establish protocols to ensure the privacy of your PHI; and (c) the researchers agree to maintain the security of your PHI in accordance with applicable laws and regulations.

Threat to Health or Safety. I may disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety to the public or another person.

Criminal Activity on My Business Premises/Against Me and My Office Partners. I may disclose your PHI to law enforcement officials if you have committed a crime on my premises or against me or my office partners.

Compulsory Process. I will disclose your PHI if a court of competent jurisdiction issues an appropriate order. I will disclose your PHI if you and I have each been notified in writing at least 14 days in advance of a subpoena or other legal demand, and no protective order has been obtained, and I have satisfactory assurance that you have received notice of an opportunity to have limited or quashed the discovery demand.

Uses and disclosures of your PHI with your written authorization

Other uses and disclosures of your PHI will be made only with your written authorization. You may revoke this authorization in writing at any time, unless I have taken an action in reliance on the authorization of the use or disclosure you permitted, such as providing you with health care services for which I must submit subsequent claim(s) for payment.

This notice

This *Notice of Privacy Practices* describes how I may use and disclose your protected health information (PHI) in accordance with all applicable law. It also describes your rights regarding how you may gain access to and control your PHI. I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this *Notice of Privacy Practices*. I reserve the right to change the terms of my *Notice of Privacy Practices* at any time. Any new *Notice of Privacy Practices* will be effective for all PHI that I maintain at that time. I will make available a revised *Notice of Privacy Practices* upon request, if the client is not currently active, or directly prior to a counseling session if they are active.

Contact information

I am my own Privacy Officer. So, if you have any questions about this *Notice of Privacy Practices*, please contact me. My contact information is listed on the top of the first page of this Notice.

Complaints

If you believe that I have violated your privacy rights, you may file a complaint in writing to me, as my own Privacy Officer, specified on the first page of this Notice. I will not retaliate against your for filing a complaint. You may also file a complaint with the U.S. Secretary of Health and Human Services.

The effective date of this Notice is April 14, 2003.

Acknowledgment

I hereby acknowledge receiving a copy of this *Notice of Privacy Practices*.

_____ _____

Client Signature Date

Paul Croft LMHC
1010 South 336th Street, Suite 208
Federal Way, WA

Please Fax Completed New Patient forms to (253) 661-9190

TELEHEALTH INFORMED CONSENT

I _____ [name of patient] hereby consent to engaging in telemedicine with Paul Croft LMHC as part of my psychotherapy.

Patient's Preferred Email address for notifications: _____

Patient's Preferred Phone# for Text Invitation & Reminder: _____

Technology: I understand that I will need to have a broadband Internet connection or a smart phone with a good cellular connection

Financial Obligations: Fees associated with telemedicine appointments are identical to in person appointments. I agree to have my credit/debit card information on file with Paul Croft LMHC.

Clients using insurance: I am responsible for contacting my insurance company, if applicable, to determine what my out-of-pocket costs may be. I authorize insurance benefits to be paid directly to Paul Croft LMHC and that Paul Croft LMHC may release any information to my insurance provider required for processing my claims. (Client Initial: _____)

Self-Pay clients: I am aware of the fees associated with telemedicine appointments and agree to pay at the time of my appointment. I understand that I am responsible for cancelled telemedicine appointments in accordance with the current Paul Croft LMHC cancellation policy (24 hours notice required). (Client Initial: _____)

I understand that using the Telemedicine platform allows access to mental health services that might not otherwise be available to me due to my mental health, and/or my physical, resource, or geographic limitations.

Scheduling: I understand that scheduling is conducted exactly as before, and is based on my provider's normal business hours. Telemedicine appointments are considered outpatient services and not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to the local county crisis line or by dialing 911.

Video/Audio Recording: As a general practice Paul Croft LMHC DOES NOT record Telemedicine sessions.

Confidentiality: The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is confidential according to the laws of the State of Washington. Paul Croft LMHC's Telemedicine platform is HIPAA compliant to protect my privacy and confidentiality. This is further explained in the Mental Health Informed Consent, which I have signed.

I also understand that in case of technology failure, I may contact Paul Croft LMHC via phone to coordinate alternative methods of treatment.

I understand that there are risks and consequences associated with telemedicine including, but not limited to the possibility, despite reasonable efforts on the part of my counselor/therapist, that the transmission of my session could be disrupted or distorted by technical failures. In addition, I understand that telemedicine-based services and care may not be as complete as face-to-face services.

I have read and understand the information provided above. I have discussed it with my counselor/therapist, and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment using this platform.

Client Signature _____Date _____

Client Guardian's Signature _____ Date _____