Laura L. Saviola, PsyD, LLC

(831) 295-8884 laura@drsaviola.com

Adult Patient Information Form

Today's date: _____

Patient's name: _____ Date of birth: _____ Age: _____

Social Security Number: _____ Gender: _____

Home street address: _____Apt.: _____

City: _____ State: _____ Zip: _____

Home/cell phone: _____ Okay to leave message?_____

e-mail: _____Guardian (if minor): _____

Marital Status: _____

Referred by: _____

EDUCATION

Level of education: _____

Current school: _____ Location: _____

Teacher: _____ Phone number:_____

EMPOLYMENT

Employer: _____ Occupation: _____

Phone: _____ Address: _____

EMERGENCY CONTACT

Name: _____ Phone: _____

Address: _____

Relationship: _____

LEGAL

Are you involved in any legal activities (civil, criminal, custody, probation/parole, etc.)? _____

Please describe: _____

History of felony/misdemeanor charges? _____

DUII/DWI, etc.:_____

MILITARY EXPERIENCE

____Yes ____No

Branch of Service: _____ Date enlisted/drafted: _____

Discharge Date: _____Type of discharge: _____Rank at discharge:_____

Combat experience? ____Yes ____No

Other stressors experienced: _____

MEDICAL INFORMATION

Physician's name: _____ Phone: _____

Address: _____

Most recent medical examination: _____

Do you have a history of any of the following medical conditions?

___A serious accident	___Surgery	___Allergies
___A head injury	___Meningitis	___Hospitalizations
___High fevers	___Hearing problems	___Headaches
___Vision problems	___Asthma	___Loss of consciousness
___Ear infections	___High blood pressure	___Pregnancy/miscarriage
___Stomach aches	___Diabetes	___Speech/language problems
___Abortion	___Chronic pain	___A sexually transmitted disease
___Cancer	___Heart problems	___Thyroid problems
___Seizures	___Other _____	

Please describe any checked items, noting your age at the time of onset:

Current Medications: ____ None

Medication	Dosage	Date First Prescribed	Prescribed by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current over-the-counter medications: (please include vitamins, herbal remedies, etc.)

Allergies and/or adverse reactions to medications

Are you currently or plan to apply for disability?

CHEMICAL USE HISTORY

Substance Type	Current Use (within the last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
PCP/LSD								
Heroin/opiates								
Methamphetamines								
Inhalants								
Other								

Have you ever had withdrawal symptoms when trying to stop using any substances? ___Yes ___No

PREVIOUS MENTAL HEALTH TREATMENT:

Type of Treatment	No	Yes	Start/End Dates	Provider name Primary Reason for treatment
Counseling or Psychiatric Care				
Drug/Alcohol Treatment				
Medication for mental health problem				
Self-help/support group				

Have you ever had thoughts or made statements of wanting to hurt yourself or seriously hurt someone else? ___Yes _____No

Have you ever purposely hurt yourself or another? ___Yes ___No

Please describe what brought you here today: _____

_____

_____

What are your goals for therapy?_____

_____

_____

What has helped this in the past? _____

_____

_____

Please check behaviors and symptoms that occur to you more often than you would like:

___Aggression/fighting
___Alcohol abuse
___Angry outbursts
___Arguments/conflicts
___Anxiety
___Avoiding people
___Chest pain
___Computer addiction
___Depression
___Disorientation
___Distractibility
___Dizziness
___Drug abuse
___Eating disorder
___Elevated mood
___Fatigue
___Gambling
___Hallucinations
___Heart palpitations
___High blood pressure
___Hopelessness
___Impulsivity
___Irritability
___Judgment errors
___Loneliness
___Memory impairment
___Mood swings
___Panic attacks
___Phobias/fears
___Recurring thoughts
___Sexual addiction
___Sexual difficulties
___Frequent illness
___Sleeping problems
___Speech problems
___Suicidal thoughts
___Thoughts disorganized
___Trembling
___Withdrawing
___Worrying
___Other (specify):

Do you have any family history of mental health problems?

___Depression ___Anxiety ___Sexual Abuse ___Attention deficit

___Alcohol abuse ___Drug abuse ___Schizophrenia ___Manic-depression

___Imprisonment ___Suicide ___Eating disorders ___Obsessive/compulsive

Have you suffered any of the following types of trauma?

___Neglect
___Sexual abuse
___Teenage pregnancy
___Violence in the home
___Parental illness
___Multiple family moves
___Emotional abuse
___Loss of a loved one
___Parental substance abuse
___Parents separated or divorced
___Homelessness
___Other
___Physical abuse
___Natural disaster
___Crime victim
___Financial problems
___Lived in foster home

To which cultural or ethnic group do you belong?

Insurance Information

Company: _____

Address: _____

City, State, Zip:_____

Phone: _____

ID Number: _____

Group Number: _____

Insured: _____DOB_____

****

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize Laura L. Saviola, PsyD to:

- Furnish my insurance company with any/all information requested concerning my present claim(s).
- Bill my insurance company and accept payment from that company on my behalf for all services from time to time relating to my case.

I acknowledge that I am responsible for all charges not covered by my insurance. I agree that if costs or fees are incurred in connection with the collection of this account, I will pay all such costs and fees, including, but not limited to, collection costs, attorney's fees and all court costs. I understand that failure to resolve any outstanding balance may result in my account being referred to a collection agency if it remains delinquent without a response from me.

NOTICE OF INFORMATION PRACTICES

Notice: We keep a record of the health-care services we provide you. You may ask us to see and copy that record. You may also ask us to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it from our office staff. The fees for copying records, searching for records or editing records are as follows:

Copying	$0.65 per page for the first 30 pages
	$0.50 for each additional page
Searching	$15.00 per search

All copies will be released upon receipt of payment.

_____ _____ _____

Patient's signature (if 18 or older) Date Responsible party signature (if for a minor)

Laura L. Saviola, PsyD, LLC

(831) 295-8884 laura@drsaviola.com

Informed Consent and Office Policies

Please read the following information carefully and initial after each section. If you have any questions, please wait to initial and sign this form and we can discuss it together. Your signature at the bottom of this sheet signifies you have read, understood, and agree to abide by these policies, and that you have received a copy of the policies for yourself.

Appointments: Your appointment time is held exclusively for you and cannot usually be filled on short notice. If you fail to keep an appointment, you may be charged for the time as though you attended. For appointments canceled with less than 24 hours notice (not including weekends or major holidays) we may charge the full session fee, no matter what the reason. Please note that insurance companies will not cover this charge and you will be responsible for covering this fee in full.

INITIAL HERE _____(Patient/and or responsible party)

Insurance: We will bill your insurance for our services. We will assist you but you are responsible to check with your insurance company regarding your coverage and to track this coverage as treatment progresses. Some things to keep in mind are: Are you currently covered? Am I a provider whose services are paid under this plan? What is your annual deductible? What is the percent of coverage? What is the maximum benefit for outpatient mental health coverage? Remember: You are responsible for bills whether insurance pays or not.

INITIAL HERE _____(Patient/and or responsible party)

Fees: My rates are as follows: $250 for an initial evaluation and $200 for subsequent 50-minute sessions, $175 an hour for testing and assessments, and $100 an hour for other professional services (report writing, telephone conversations, meetings/consultations with other professionals). Participation in legal proceedings are $300 an hour and $180 an hour for preparation and travel time. Payment (or co-payment) is expected at the time of the visit unless other arrangements are made. These rates are subject to change.

INITIAL HERE _____(Patient/and or responsible party)

Billing: You will be billed monthly for any outstanding balance. Payment by the 15th of the month, according to our written agreement, is appreciated. Should the bank return your check, there will be a $25.00 returned check charge. As a last resort, your account may be turned over to an attorney or a collection agency for collection and you will be held responsible for any legal or collection costs incurred.

INITIAL HERE _____(Patient/and or responsible party)

Medicare: I am not a Medicare provider. Because of that, Medicare will not allow me to bill them for your claims, even with the intent of billing your secondary insurance. You have the choice to pay privately or find a Medicare provider to serve you.

INITIAL HERE _____(Patient/and or responsible party)

Confidentiality and the Release of Information: Your participation in treatment and all information about you is confidential and will not be disclosed to anyone without your written consent. The only exceptions are: a) cases of suspected abuse or neglect of a child or vulnerable adult, b) cases where I believe the client presents a clear and imminent danger to him/herself or to another person, c) cases where a court subpoenas me to testify or subpoenas my records, d) cases of medical emergency, or e) cases where an insurance company is helping to pay your fee and requires information about diagnosis and/or reports about treatment.

INITIAL HERE _____(Patient/and or responsible party)

HIPAA Notice of Policies and Practices: We are committed to preserving the privacy of your personal health information. Additionally, we are required by Federal law (Health Insurance Portability and Accountability Act, known as HIPAA), and by State law to protect the privacy of your personal information and to offer you a Notice that describes (a) how clinical information about you may be used and disclosed and (b) how you can get access to this information. Please ask for a copy of the *HIPAA Notice of Policies and Practices* should you wish to have a complete copy for your records.

INITIAL HERE _____(Patient/and or responsible party)

Patient Consent to Treatment: Your signature below indicates that you have read this agreement and agree to its terms. You consent to the use of a diagnosis in billing, and to release of that information and other information necessary to complete the billing process. You agree to pay the stated fees. Your signature also serves as an acknowledgment that you have received the *HIPAA Notice of Policies and Practices* described above.

_____ _____
Signature Date

_____
Please print patient name

_____ _____
Signature of financially responsible party if not patient Date

_____
Please print your name and relationship to patient

Laura L. Saviola, PsyD, LLC
laura@drsaviola.com
(Revised 8/2013)

HIPAA NOTICE OF PRIVACY PRACTICES

This notice describes how medical and psychological information about you may be used and disclosed, and how you can get access to this information.

Laura L. Saviola, PsyD, LLC is required by federal and state law to maintain the privacy of your health information, and to provide you with a description of our privacy practices. This notice will tell you how your provider will use medical information here in this office, when and how it can be shared with other professionals and organizations, and how you can see it. If you have any questions, your provider will be happy to help you understand our procedures and your rights.

I. What Is Protected Health Information?

Protected health information (PHI) is information in your treatment record that identifies you (i.e. name, date of birth, etc.). Each time you visit Laura L. Saviola, PsyD, LLC information is collected about you and your health, and recorded in your health care records. In this office, PHI is likely to include information such as your personal history, reasons for coming to treatment, your diagnoses and treatment plan, progress notes for each session, records or reports from other providers or agencies who have treated or evaluated you, psychological test scores, information about medications you took or are taking, and billing and insurance information.

II. Privacy And The Laws About Privacy

Your provider is required to tell you about privacy because of a federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA requires your provider to protect the privacy of your PHI, to tell you about your rights and your provider's legal duties in regard to your PHI, and to tell you about our privacy practices. Your provider is obligated to obey the rules described in the most current version of this notice.

III. Uses And Disclosures With Your Consent

Your provider may use and disclose PHI for purposes of treatment, payment, and health care operations. "Use" applies to activities within Laura L. Saviola, PsyD, LLC office that help to manage the services we provide. "Disclosure" applies to activities outside the office, such as releasing, transferring, or providing access to other individuals or organizations. "Consent" refers to your agreement to the policies described in this document, which you indicate through your signature on the "Acknowledgment of Receipt of Notice of Privacy Practices."

Treatment. Your provider will use your medical information to provide you with psychological treatments or services such as individual, family, or group therapy; psychological or educational testing; treatment planning; or measuring the benefits of services provided. Your provider may share your PHI with others who provide treatment to you, such as your physician, or if/when your provider refers you to other healthcare professionals. Your provider may also receive PHI from other healthcare professionals involved in your care, which will go into your records here.

Payment. Your provider may use your information to bill you, your insurance, or others, so that your provider can

be paid for the treatments provided to you. Your provider may contact your insurance company to find out what services your insurance plan covers. Your provider may have to tell your insurance company about your diagnoses, the treatments you have received, treatment plan, and your progress in order to be reimbursed for services.

Healthcare operations. Your provider may use your PHI for activities related to the performance, operation, and maintenance of the practice, such as quality assessments, business-related matters such as audits and administrative services, and for case management or care coordination. For example, your provider may hire a billing service to submit bills to insurance companies. Under the law, providers of such services are called "business associates." To protect your privacy, any business associates will agree in their contract with Laura L. Saviola, PsyD, LLC to safeguard your information, and they will receive only the PHI required to do their job. Your provider may also use and disclose PHI to schedule appointments with you or to provide you with appointment reminders

IV. Uses And Disclosures That Require Your Authorization

Your provider may use and disclose your PHI for purposes outside of treatment, payment, and healthcare operations with your written authorization. An authorization is specific, written permission above and beyond general consent. When information is disclosed for purposes other than treatment, payment, and healthcare operations, such as consulting with a child's teacher, Your provider will obtain an authorization form from you before releasing the information. You may cancel your authorization in writing at any time. Your provider would then stop using or disclosing your information for that purpose. Of course, your provider cannot take back any information already disclosed or used with your permission.

V. Uses And Disclosures That Do Not Require Your Consent Or Authorization

Your provider may use or disclose your PHI without your consent or authorization under circumstances such as those described below. If any of these situations arise, your provider will attempt to discuss it with you before taking action, and will disclose only necessary information.

Abuse or neglect: If your provider has reasonable cause to believe that a child, elderly person, or other vulnerable adult has been abused, exploited, or neglected, (s)he is required to report their suspicion to law enforcement and to the Department of Social and Health Services.

Legal proceedings: If you are involved in a lawsuit or legal proceeding, and your provider receives a subpoena, discovery request, or other lawful process, they may have to release PHI.

Law enforcement: Your provider may be required to release information to law enforcement officials.

Government oversight: As a health care provider, your provider is subject to oversight by federal and state agencies. If a government agency makes a lawful request, your provider may be required to disclose PHI as part of audits, inspections, or investigations.

Veterans and military personnel: Your provider may be required to disclose PHI of current or past members of the armed forces, security, or intelligence services to government authorities, or to benefit programs relating to eligibility and enrollment.

Worker's compensation: Your provider may be required to disclose PHI to workers' compensation and disability programs to the extent necessary to comply with laws relating to programs that provide benefits for work-related injuries or illness.

Threat to safety: Your provider may use or disclose PHI if they believe it is necessary to prevent a serious threat to you or someone else.

Medical emergency: In the event of a medical emergency or involuntary commitment, your provider may disclose PHI to facilitate treatment.

Healthcare providers: As a result of state regulations adopted by the Washington State Department of Health, your provider is required to report themselves of another healthcare provider in the event of a final determination of unprofessional conduct, a determination of risk to patient safety due to a mental or physical condition, or if your provider has actual knowledge of unprofessional conduct by another licensed provider. *Note: If you yourself are a healthcare provider, and we believe that your behavior is a clear and present danger to your patients or clients, we are also required to report you.*

VI. Your Rights Concerning Your Health Information

HIPAA provides you with the following rights regarding your clinical record and disclosures of your PHI. Requests must be made in writing.

Right to request restrictions: You have the right to ask your provider to limit the use and disclosure of your PHI. Although your provider is not required to agree to a restriction you request, if they do agree, they will honor the request except when it is against the law, an emergency situation, or when the information is necessary to treat you.

Right to confidential communications: You have the right to ask your provider to communicate with you about your health and related issues in a particular way, or at a certain place that is more private for you. For example, you can ask your provider to call you to schedule appointments at home, rather than at work, or to send mail to someplace other than your home address.

Right to inspect records: You have the right to look at the health information your provider has about you, such as your medical and billing records. You can get a copy of these records, but your provider may charge you for postage and a state-determined rate for copying. Your provider may deny access to PHI under some circumstances. If they do so, they will explain any options you may have for a review of that decision.

Right to amend: If you believe that the information in your records is incorrect or missing something important, you can ask your provider to make additions to your records to correct the situation. This request must be made in writing, and include the reasons you want to make the changes. If your provider does not approve your request, they will tell you why, and explain any right you may have to file a written statement of disagreement.

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

Right to an accounting: You have the right to request an accounting of disclosures of PHI to which you did not consent or provide authorization. Your provider is not required to account for disclosures of PHI for treatment, payment, or healthcare operations, or for which you provided consent or authorization.

VII. If You Have Questions Or Problems

If you need more information or have questions about the privacy practices described above, please speak to your provider. If you have concerns about how your PHI has been handled, or if you believe your privacy rights have been violated, please contact your provider immediately so they can address your concerns together with you. If this does not resolve your concerns, you have the right to file a complaint with the Secretary of the U.S.

Department of Health and Human Services. Your provider can provide you with the form for the complaint. Filing a complaint will not limit your care here, and your provider will not take any actions against you if you complain. Complaints may be filed with:

Health and Human Services Region X – Seattle (Alaska, Idaho, Oregon, Washington)
Linda Yuu Connor, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
2201 Sixth Avenue - M/S: RX-11
Seattle, WA 98121-1831
Voice Phone (206)615-2290 FAX (206)615-2297 TDD (206)615-2296

VIII. Effective Date, Restrictions, And Changes To Privacy Practices

The effective date of this notice is July 18, 2011. Your provider can reserve the right to change the terms of this notice. All changes will be consistent with state and federal law. The revised notice will be effective for all PHI that your provider maintains, including for PHI collected previously. Your provider is not obligated to tell you when the notice changes, but will post the revised notice in the front office. You are entitled to request a paper copy of the current notice at any time.

Laura L. Saviola, PsyD, LLC
laura@drsaviola.com

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Your signature below acknowledges that:

1. You have had an opportunity to review and ask questions about the Notice of Privacy Practices, and have been offered a paper copy.

- You agree that protected health information (PHI) may be used and disclosed by Laura L. Saviola, PsyD, LLC to conduct treatment, payment, and health care operations as described in the Notice of Privacy Practices.

_____ _____
Printed Patient Name Date Of Birth

_____ _____
Patient Signature (if patient is age 14 or older) Date

_____ _____
Printed Name Of Parent/Legal Guardian Relationship To The Patient

_____ _____
Parent/Legal Guardian Signature (if patient is a minor) Date