NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND PATIENT CONSENT FORM
Jerry N. Duncan, Ph.D., ABPP

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out my treatment, payment of health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Signature: _____ Date: _____

Patient Name: _____

Signature: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

IMPORTANT INFORMATION FOR CLIENTS

Welcome to the Association of Christian Therapists. We ask that you read the following information and bring any questions you might have to our attention.

Fee – The fee for a 45 minute session is $200. We request that payment for all services be made at the time of services are rendered. It is the policy of this office to turn delinquent accounts over to a collection agency. Only information which is non-clinical in nature will be given to the collection agency for this purpose.

Telephone Calls – Our office is open Monday through Friday from 8:00 – 5:00 pm. We are closed daily from 12:00 – 1:00 pm for lunch. After hours you may leave a message on the answering machine. If your therapist determines that it is necessary for you to be able to contact him/her, special arrangements will be made.

Appointments – When you make an appointment, a specific time is reserved for you. If you should have to be late, you will be seen for the remaining portion of your reserved time. Every effort will be made to see you on time, however, in some unusual circumstances you may have to wait before being seen. In such cases you will be seen for your full visit.

If you must cancel an appointment, please do so at least 24 hours in advance.
If not, you will be charged $200.00 for the full session time reserved for you.

Insurance – Services in this office may be covered by medical insurance plans. However, few policies cover 100% of the cost. If you request, the office staff will assist you with insurance filing, but collection of insurance claims is ultimately the insured client's responsibility. You will be responsible for any co-payment amounts at the time of each visit.

Please understand that you are fully responsible for the payment of all fees for services provided regardless of the extent of any insurance coverage you may have. It is not our policy to accept the amount an insurance company may pay as payment in full if the amount is less than the regular fee. **ACT will be notified of any personal address change or changes in insurance coverage.**

Psychological Testing – In order to better understand a client's problems and to facilitate treatment, psychological tests are frequently utilized. In such cases the purpose of taking the tests will be explained and the results will be reviewed with you. Fees for testing are separate from fees for regular visits and vary according to the test used. Estimates of the cost of testing will be furnished upon request and in advance of test administration.

Confidentiality – All information which you reveal to your therapist, including test results, notes and records, is confidential and will not be released to any outside person or agency without your written authorization. When more than one family member is seen during a session, each of these legally competent individuals must sign such authorization. There are several limitations to this which include: 1) if, in the therapist's opinion, revealing the information would be necessary to prevent a person's death or serious injury, 2) insurance company requests for a diagnosis and general description of services rendered, and 3) other circumstances where it is legally required, such as the physical or sexual abuse of a minor.

I have read and understand the above policies and client information. I am responsible for any unpaid balance on my account.

Client Signature _____ Date _____

Spouse/Parent/Guardian Signature _____ Date _____

Office of Jerry N. Duncan, Ph.D., ABPP

Date _____

CLIENT

Last Name _____ First Name _____ MI _____

Address _____ City, State _____ Zip _____

Date of Birth _____ Age _____ Social Security # _____

Employer _____ Occupation _____

Highest Education Completed _____ Church Affiliation _____

Phone: Home _____ Work _____ Cell _____

Email: _____

SPOUSE/PARENT/GUARDIAN

Last Name _____ First Name _____ MI _____

Address _____ City, State _____ Zip _____

Date of Birth _____ Age _____ Social Security # _____

Employer _____ Occupation _____

Highest Education Completed _____ Church Affiliation _____

Phone: Home _____ Work _____ Cell _____

Email: _____

Marital Status

____ Single, Never Married
____ Single, Widowed (How Long:_____)
____ Single, Divorced (How Long:_____)
____ First Marriage (How Long:_____)
____Married, Separated (How Long:_____)
____Remarried (How Long:_____)
(Circle) Husband's: 1st, 2nd, 3rd, 4th
Wife's: 1st, 2nd, 3rd, 4th

Emergency Contact person (other than household member)

Name _____ Address _____

Phone: Home _____ Work _____ Relationship _____

Additional Family Members (List all children by any marriages whether living at home or not)

Name	Sex	Age	DOB	Education	Occupation	Living @ Home?
Child						
Child						
Child						
Child						
Child						
Child						

Anyone Else Ever Living In The Home:

Please list any recent stressful events or changes which have occurred in the last year (deaths of friends or relatives, marriages, divorces, changes in work, school, residence, church, etc.).

_____

_____

_____

Medical History:

Family Member	List Any Recent Illness, Tests, or Hospitalizations	List All Medications Taken	Physician

Who referred you here? _____

Have you been in counseling/therapy previously? _____

When? _____ By Whom? _____ How Long? _____

In what way would you like the counselor/therapist to assist you?

_____

_____

_____

Do you consider your Christian faith to be an important resource? ____Yes ____No

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I authorize Jerry N. Duncan, Ph.D. __ to disclose to; __ to obtain from

Person(s) _____

Organization _____

Address _____

City _____ State _____ Zip _____ Phone _____

the following information:

___ Progress Notes ___ Psychosocial History ___ Psychological Report
___ Psychological Testing ___ Treatment Plan ___ Psychiatric Evaluation
___ Medical History ___ Discharge Summary ___ Other (specify) _____

Patient(s) _____; _____

Signature of Patient _____ Date _____

Signature of Patient _____ Date _____

Parent/Guardian _____ Relationship to Patient _____
(if patient is a minor)

Therapist _____ Date _____

This consent is valid until _____.

This information is disclosed from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR Part 2) prohibit any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is <u>not</u> sufficient for this purpose. Such release may include information which may be considered a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also know as acquired immune deficiency syndrome (AIDS).