GREENVILLE Psychology

Helping you learn about yourself

Welcome to Greenville Psychology and thank you for allowing us to assist you in navigating life's challenges and demands. Here at Greenville Psychology we recognize you are special and unique and your treatment is tailored to your individual needs. The practice is dedicated to helping individuals identify and improve their mental and physical well being. Our goal is much more than symptom relief. We will provide you with tools and strategies to take control of your life through positive changes that will last. As needed, we will also collaborate with your other health care providers to give you the most effective care possible.

Along with our welcome, this package contains several pieces of information that will help you have the best possible experience as a new patient here at Greenville Psychology. Please complete all forms and bring them with you to your initial appointment. They are necessary for a complete evaluation. If you have any questions, please call our office at (401) 949-2906.

We look forward to working with you and hope you have a pleasant experience at our office.

NEW PATIENT QUESTIONNAIRE

In order to provide the best assistance to patients, it is important that each person being evaluated complete the following questionnaire prior to being seen. All information is kept strictly confidential in your file. It will not be made available to any person or agency without your written consent. You have the right to refuse to answer any question.

Name _____ Date of Birth _____ Age _____

Address _____

Telephone Number: Home (____)_____ Work (_____)_____

Social Security Number: _____

INSURANCE INFORMATION

Name of Insurance Company _____ Name of Insured Person _____

Insurance Company Billing Address _____

Member Number _____

DEMOGRAPHICS

Sex _____ Race _____ Religious background _____ Current religion _____

Where did you attend high School? _____ Highest Level of Education _____

Current Occupation _____ Employer _____

Length of time at current job _____ If you are unemployed, when did you last work? _____

Marital Status (Check all that apply):

Never married _____ Married _____ Divorced _____ Widowed _____

Number of marriages (including current marriage) _____ Length of current marriage _____

Name of person who referred you _____

Name and address of your primary care doctor _____

Describe in your our words the major problems or difficulties causing you distress at this time:

_____

_____

_____

MEDICAL HISTORY

Height: _____ Weight: _____

Physical Condition: Excellent Good Fair Poor

What type and amount of exercise do you do each week? _____

Date of last complete physical exam _____

Please list types and dates of any surgeries or accidents, including automobile accidents, and your age at the time.

_____

_____

Please list any current acute or chronic health problems.

_____

Describe any childhood health problems

_____

Please list all medications both prescription and non-prescription that you are now taking.

Name	Dose	Frequency	Reason	How long have you used

Please list previous psychiatric medication.

Name	Dose	When did you take this?	Reason for discontinuing?

FAMILY HISTORY

Please list all people living in your home. If you have children who do not live in your household at this time, please list them and indicate where they live.

Name	Relationship	Age	Occupation/Grade Level	Health Problems

Please list all members of the family in which you grew up. (If this is the same as above, please omit this section)

Name	Relationship	Age	Occupation	Health Problems (If deceased, give age, cause of death and your age at time of relative's death)

Place of birth _____ Where did you grow up? _____

Please indicate major separations from your parents or guardians (For example: divorce, foster care, living with relatives)

Age		Lived with	Reason for change or separation
From	To		

Have you been physically or sexually abused in the past? If yes, by whom and at what age were you?

_____

SUBSTANCE USE

Do you smoke cigarette? _____ Yes _____ Never _____ Ex-smoker

How many packs per day? _____ For how long? _____ How many times have you tried to quit? _____

Number of cups/glasses **with caffeine** per day of Coffee _____ Tea ____ Soda _____

During the average week, how much do you drink? (please indicate the number of drinks of each type)

_____ Beer _____ Wine _____ Hard Liquor/Mixed Drinks

Have you ever had significant problems with alcohol use? If yes, please explain _____

Have you ever used any illegal drugs. If yes, please list the drugs and how often you used it. _____

_____

MENTAL HEALTH HISTORY

Have you ever seen a counselor for any reason or sought help for an emotional problem or alcohol or drug problem (Include A.A. or N.A. programs)?

_____ Yes _____ No If yes, please complete the following:

Dates of Treatment	Name of therapist and/or clinic	Diagnosis	Name of any medication used

Have you ever been suicidal? _____ Yes _____ No If yes, was there an attempt? _____ Yes _____ No

Have any of your relatives had any emotional problems or alcohol or drug problems? (Please list)

Name/Relationship	Dates and Place of Treatment	Diagnosis (if known)

Has any family member ever been suicidal? _____ Yes _____ No If yes, was there an attempt? _____ Yes _____ No

Have you ever been arrested (including D.W.I.)? If yes, please explain. _____

Have you ever been in a physical fight causing injury to another person? If yes, please explain. _____

_____

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between you, _____, and me (Dr. Mark S. Schneider).

When I examine, diagnose, treat, or refer you, I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information here in this office to decide upon what treatment is best for you, and to provide that treatment to you. I may also share this information with others who provide treatment to you, or need it to arrange payment of your treatment, or for other business or government functions.

I would like your permission to contact your referring physician and your primary care physician to discuss your treatment. Please provide me with the name, address and phone number of your physicians:

Primary Care Physician: _____

Referring Physician (if different from above): _____

If you do not want me to be in contact with your doctor please indicate that here: _____

By signing this form you are agreeing to let me use your information here in this office and to send it to others. Paperwork pertaining to the Health Insurance Portability and Accountability Act (HIPAA) are hanging in my office. These explain in more detail your rights and how I can use and share your information. The Therapy Agreement in your intake packet gives further information about how my practice works. ***Please read the HIPAA forms and the Agreement before you sign this consent form***. Your signature indicates that you have read the HIPAA forms and the Agreement, understand them, and agree to them.

If you do not sign this consent, **I cannot treat you.**

In the future, I may change how I use and share your information and, therefore, may change the forms. If I do change it, you will get a copy of the new forms from me.

If you are concerned about some of your information, you have the right to ask me not to use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if I do agree, I promise to comply with your wishes.

After you have signed this consent, you have the right to revoke it (by completing the form to revoke your consent). I will comply with your wishes about using or sharing your information from that time on. However, I may already have used or shared some of your information and cannot change that. If you revoke consent, I will no longer be able to treat you.

_____ _____

Signature of patient, or his/her personal representative Date

_____ _____

Printed name of patient or personal representative Relationship to patient

THERAPY AGREEMENT

Welcome to my practice! This agreement contains information about my professional services and business policies.

The **"Health Insurance Portability and Accountability Act" (HIPAA)**, a federal law that protects your privacy and rights as a patient, requires me to explain the use and disclosure of your personal health information regarding treatment, payment, and health care procedures. **HIPAA** requires that I provide you a **Notice of Privacy Practices**. This notice is posted in my waiting room. Although these documents are long and sometimes complex, it is important that you read them thoroughly; we can discuss any questions you may have. The law also requires me to obtain your signature acknowledging that I have given you this information by the end of the first session.

When you sign the last page of this therapy agreement, you are affirming that you have read, understood, and agree to all my office policies. ***This document represents an agreement between us, revocable in writing by you at any time.***

PSYCHOLOGICAL SERVICES:

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the clinician and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like visits to a medical doctor. Instead, it calls for an active effort on your part. For therapy to be most successful, you must 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, psychotherapy 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. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will help you set up a meeting with another mental health professional for a second opinion.

INSURANCE COMPANIES, YOU & THIS OFFICE:

You must provide us with accurate information about your insurance coverage, including any changes. If and/or when you are covered by more than one policy, we must know this right away. Otherwise, you will be responsible for any fees for which payment is denied by any insurance carrier.

Your insurance policy ***does not guarantee*** coverage for mental health services! You should ***know the limits of your benefits***. It's your responsibility to know your co-payment fees, deductibles, and maximum coverage limits. You will be billed directly, after you have reached your maximum coverage.

Your insurance carrier ***will pay*** for mental health services that are ***medically necessary*** – those that focus on alleviating symptoms of a specific mental illness or disorder. Your insurance carrier ***will not pay*** for mental health services that are not medically necessary; such as focusing solely on interpersonal problems, phase of life difficulties, personal

growth, enrichment, or enhancement. You will be financially responsible for these charges.

Your insurance carrier ***will not pay*** for failed appointments or for sessions cancelled with less than 24 hours' notice. You will be financially responsible for these charges.

APPOINTMENTS:

Routine office visits are **45 minutes** long. I do my best to start and finish on time, and I ask that you do the same. Please understand that when clinical crises occur, they demand my immediate attention, and may either interfere with starting a session on time, or interrupt a session that's already underway. Current state licensing laws ***do not permit me*** to conduct psychotherapy sessions in states where I am not licensed therefore all appointments will take place in Rhode Island.

PROFESSIONAL FEES:

As a ***contracted provider*** for Blue Cross/Blue Shield, UnitedHealthcare, Neighborhood Health Plan**,** and other private insurance companies, I must abide by their limits on the frequency, duration, and reimbursement of psychotherapy sessions.

If you would like additional time at the end of a routine 45-minute session, or if you want to set up an in-state psychotherapy session by telephone or voice-over-Internet to discuss a non-emergency matter, then I will arrange to do so. Because these are non-contracted services, ***you must agree to self pay for them, pro-rated at my established fee of $150 per hour. _____[Your Initials required]***

If I am ***not a contracted provider*** for your insurance carrier, then I will charge my hourly fees of:

$150.00 – Individual therapy (60 minutes)
$ 50.00 – Group therapy session with 6 to 8 individuals (90 minutes)

Whether or not I am a participating provider in your insurance carrier's network, I will charge you my hourly fee of $150 for professional services such as report writing, consulting with your attorney, preparing records or treatment summaries, and any other time spent performing tasks you may request. ***You must agree to self pay for these services, pro-rated at my established fee of $150 per hour. _____[Your Initials required]***

In cases involving legal proceedings, my fee is $200 per hour. This fee includes the time I will spend preparing your case, providing depositions, transportation to/from court, and for actual testimony time.

You will be charged a fee of **$45.00** for failed appointments or late cancellations (less than 24 hours' notice). Three failed appointments and/or late cancellations within a calendar year will be interpreted as a lack in commitment, and at that time you may be referred back to your insurance carrier and/or your physician, and given the names of three other clinicians with whom you might continue treatment.

BILLING AND PAYMENTS:

You must pay your deductible or co-payment for each session at the time it is held, unless we agree otherwise. If full payment of an outstanding balance is not possible,

please discuss this with me promptly. We can arrange a mutually agreeable installment plan. Otherwise, ***all accounts overdue 90 days will be turned over to a collection agent***. If this should happen, I will be required to disclose otherwise confidential information. In many collection situations, this information may include such items as: dates of service, patient and/or policy holder's name, address, telephone number, date of birth, Social Security number, driver's license number, and place of employment. If such legal action is necessary, its costs will be included in the claim.

Any billing disputes with this office about reimbursement of co-payments or other fees will be void 90 days after the specific date(s) of service, unless you notify us about the dispute prior to the lapse of the 90 days. Returned checks will be re-billed for the original amount of the check, plus bank service fees for receiving a check with insufficient funds, plus a **$10 office billing fee**.

CONTACTING ME:

The most appropriate time to discuss issues or concerns is during our scheduled sessions.

Telephone: A 24-hour voice mail system, including an emergency cell phone (401-286-9601) is available to handle your calls between appointments. Messages are retrieved regularly throughout the day and evening, seven days a week. Every effort will be made to return your call quickly in response to urgency. If you are experiencing a clinical crisis and cannot reach me or the "on call" clinician, then go to the nearest hospital emergency room for assistance. You should advise them that you are in treatment with me, so I can communicate with them as needed.

Frequent non-emergency telephone calls – other than brief routine contact, or to cancel or reschedule appointments – will be billed directly to you at my $150 hourly rate.

E-mail: This is not a confidential form of communication. Keep in mind that you are putting your privacy at risk unless you have an encryption program in place. This office does have the capability to send confidential information to you by encrypted e-mail.

Texting: I do not encourage the texting of any information!

LIMITS OF CONFIDENTIALITY:

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can release information about your treatment to others only if you sign a written authorization form that meets legal requirements imposed by **HIPAA**. Further information about these limitations can be found in the **Notice** posted in my waiting room.

Absolute confidentiality and privacy of your medical records cannot be guaranteed, especially when it involves third party payers, such as an insurance carrier. At the outset of treatment, and thereafter, I must submit paperwork to your insurance carrier which may include specific information about your mental health, such as diagnosis, and medical conditions. Insurance carriers frequently conduct a clinical audit which includes chart review.

There are some situations when I am permitted or required to disclose information without either your consent or authorization; for example:

- If I believe you present a risk to yourself or to another person in your family, I must warn the potential victim(s), contact the police, or get you hospitalized.
- If you are involved in a court proceeding and a request is made for information concerning my professional services such information is protected by the psychologist-patient privilege law. I cannot release any information without: your written authorization or that of your legal representative or a court order. If you are involved in, or contemplate litigation, you should consult your attorney to determine if a court would order me to disclose your record.
- If you file a complaint or lawsuit against me, I am permitted to disclose relevant information regarding you, in order to defend myself.
- If you file a worker's compensation claim, information directly related to that claim must be provided to the Workers' Compensation Commission, upon written request.
- As a mandated reporter, I am legally obligated to take actions that I believe are necessary to protect others from harm, and I may have to reveal some information about your treatment. For example, if I have reason to know or suspect that a child has been abused or neglected by an adult, or has been a victim of sexual abuse by another child, the law requires that I file a report with the Department of Children, Youth, and Families. Once such a report is filed, I may be required to provide additional information.

RETURN OF BORROWED ITEMS:

My personal books and electronic media are made available to encourage learning. Kindly return them when instructed. If they are lost or misplaced, you should replace them (in-kind or monetarily).

ACKNOWLEDGEMENT:

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

Patient signature:_____

Date:_____