Leslie Psychology

735 Arlington Ave., Suite 212 St. Petersburg, FL 33701 Phone: (727)831 -1723

Client Information Form

Date: _____

Your name: _____ Nickname/alias: _____

Date of birth: _____ Age: _____ Sex: _____ SSN: _____

Address: Street: _____ Apt. _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ FAX: _____

Email address: _____

Calls will be discreet, but please indicate any restrictions: _____

Driver's License Number: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Do you have? Legal Guardian ☐ Yes ☐ No. Health Care Proxy ☐ Yes ☐ No Durable Power of Attorney for Health Care or Financial Matters ☐ Yes ☐ No If Yes: Name: _____ Phone: _____

Insurance Information

Primary Insurance Carrier: _____ AUTH# _____

Policy #: _____ Group#: _____ Phone: _____

Name of Policy Holder: _____ Policy Holder Date of Birth: _____

PolicyHolder SSN: _____

Secondary Insurance Carrier: _____

Policy #: _____ Group#: _____ Phone: _____

Name of Policy Holder: _____ Policy Holder Date of Birth: _____

PolicyHolder SSN: _____

How were your referred? Physician _____ Personal Recommendation _____ Other _____

Name: _____ Phone: _____

May I have your permission to thank this person for the referral? ☐ Yes ☐ No

Occupational Status: Employed _____ Unemployed _____ Retired _____ Disability _____

Your occupation: _____

Employer: _____ Address: _____

Education: Highest Degree or Grade Level _____ Date: _____

Did you serve in the military? ☐ Yes ☐ No Branch_____ Honorable Discharge ☐ Yes ☐ No

Presenting Problem: Please describe the main difficulty that has brought you to see me:

_____

_____

_____

Medical History: Your physician: _____ Phone: _____

Address: _____

May I communicate with your medical doctor so that we can coordinate your treatment? ☐ Yes ☐ No

Current Medical Conditions/ Allergies and Medications (Please list dose, date started)

_____

_____

_____

_____

Sara Leslie, Psy.D., Leslie Psychology
735 Arlington Ave., Suite 212, St Petersburg. FL 33701
Tel: (727)831-1723

Consent for Treatment

Name: _____

I hereby authorize Sara Leslie, Psy.D. to provide diagnostic and psychotherapeutic services as ordered by my physician or at my request. This authorization is given voluntarily, with knowledge of purpose and competency, and free from undue influence. Unless revoked in writing, this consent shall remain in force for one year after termination of services. I understand that this consent is revocable for any reason except retroactive to release of information already made in good faith.

Confidentiality:

I understand information exchanged during psychological consultation and treatment is confidential, apart from the following exceptions:

- A legitimate court order requires release of the information as specified in the subpoena.
- Statements of intent to harm oneself or another may result in the notification of the appropriate authorities and/or intended victims
- Information concerning suspected child abuse or neglect (Florida Statute 415.504) or suspected abuse, neglect or exploitation of aged persons or disabled adults (Florida Statute 415.103) must be reported as mandated.
- Information regarding treatment of a minor without parental consent may be shared with the parent(s), legal guardian(s) or legal authorities

Payment Options:

_____ Pay for each session at the time it is held.
_____Pay an appropriate copay fee at the time of each session, and have my insurance carrier (s) or other payer sources billed for mental health services. Pay any remaining balance after the insurance claims have been processed.

Assignment of Benefits

I, hereby, request that payment of authorized Medicare, Medigap, Medicaid, private commercial insurance or any other governmental insurance be made on my behalf to Sara Leslie, Psy.D. for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services, and to release all or part of my medical record by whatever means required for payment of my charges by my insurance carriers) or other designee(s). I also authorize release of information necessary for filing claims to the HIPAA compliant medical billing service designated by Dr. Leslie. I understand that my signature below acts as a signature on file. I understand my insurance company may be contacted prior to the delivery of service if precertification is needed to authorize payment for services.

Additional Notification:

I acknowledge that Dr. Leslie does not participate/attend in legal/court proceedings unless mandated by law.

Patient Signature

_____

Date _____

Legal Guardian or Authorized Representative Signature

_____

Witness Signature _____

SARA LESLIE, Psy.D.
LESLIE PSYCHOLOGY

FINANCIAL POLICIES AGREEMENT

Payment for services provided by Sara Leslie, Psy.D. is due at the time services are rendered unless payment by health insurance has been arranged prior to the visit. Session fee is $200.00 per session hour. If insurance coverage has been arranged, payment of any applicable copayment or deductible is due at the time services are rendered. You agree to be fully responsible for payment for all services not covered by your insurance. If there is a problem with your insurance coverage, you agree to pay your bill and work with your insurance company yourself. As a courtesy to you, we will attempt to verify your insurance coverage and determine your insurance benefits. However, if your insurance company has misinformed us or you feel we have misinformed or failed to adequately inform you regarding your benefits, you are still responsible for payment of all charges not covered by your insurance. We encourage you to verify your insurance benefits and coverage yourself and to make sure that you fully understand your coverage. By signing this agreement, you agree to be responsible for all charges for the client identified below, even if you believe that some other party should bear responsibility for these charges.

Some services may not be covered by health insurance. This may include charges for telephone consultation, written correspondence, or reports in connection with a client's evaluation or treatment, including consultation or correspondence with the client, family members, past or current treatment providers, educational professionals, attorneys, courts, agencies, or others. Limited telephone consultation is part of routine patient care and is undertaken without charge. However, when extensive telephone consultation or other than routine written correspondence or reports are requested or required, a charge for these services will be applied. Every effort will be made to notify you if such a charge is likely to occur. However, the exact amount charged cannot always be predicted.

When an appointment is missed or canceled without at least 24 hours prior notification, the full fee applicable to the canceled appointment may be charged. If the appointment falls on the first business day of the week, notification of cancellation must be received by noon of the last business day of the preceding week. Fees charged for missed appointments or late cancellations must be paid prior to the next appointment. A service charge of 1.5% of the outstanding balance or a minimum of $5.00 will be added each 30 day billing cycle to all outstanding self-pay balances over 60 days past due. A charge of $25.00 will be applied for all checks returned unpaid. If an overdue account is sent to a collection agency, collection fees and expenses will be added to the amount due. A copy of the currently applicable fee schedule for Sara Leslie, Psy.D. is available upon request.

ACKNOWLEDGEMENT AND AGREEMENT

I have read the above and affirm that everything in this form that was not clear to me has been explained to my satisfaction. I understand that it is my responsibility to know my insurance benefits. I hereby agree to abide by the policies specified above and to be responsible for all fees and charges for services provided by Sara Leslie, Psy.D. to or on behalf of the client named below. This agreement will continue as long as Sara Leslie, Psy.D. provides services or until a written request that this agreement be terminated is received by Sara Leslie, Psy.D.

Assignment of Health Insurance Benefits: The signature below authorizes payment directly to Sara Leslie, Psy.D. of benefits payable under the health insurance policy covering the client named below. A photocopy of this form is to be considered as valid as the original. For Medicare Clients Only: The undersigned hereby requests that payment of authorized benefits be made to Sara Leslie, Psy.D. on behalf of the client named below. The undersigned authorizes any holder of medical information about the client to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services. A photocopy of this form is to be considered as valid as the original.

_____	_____	_____
Signature of Client	Name of Client, Printed	Date
_____	_____	_____
Signature of Responsible Party	Name of Responsible Party, Printed	Date

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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

Effective date:

If you consent, **SARA LESLIE, PSY.D.** is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, test results, diagnosis, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for treatment purposes are:

I. The provider obtains treatment information about you and records it in a health record

II. During the course of your treatment, the provider determines that he/she will need to consult with another specialist in the area. He/She will share the information with such specialists and obtain his/her input.

An example of use of your health information for payment purposes:

I. SARA LESLIE, PSYD submits a request for payment to your health insurance company. The health insurance company requests information from them regarding services rendered. We will provide that information to them about you and the care you receive.

II. SARA LESLIE, PSYD verifies insurance coverage prior to your first appointment.

An example of use of your health information for health care operations:

I. The state licensing authority wants to review records to assure that we have acted consistent with state law regarding your care. In doing so, it wants to take a sampling which includes review of your chart. At the licensing authority's request, we will provide it with a copy of your chart.

Your health information rights:

The health record and billing records we maintain are the physical property of the provider. The information in it, however, belongs to you. You have a right to:

II. Request a restriction on certain uses and disclosures of your protected health information by delivering the request in writing to our office. We are not required to grant the request, but we will comply with any request granted.

III. Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information by making a request at our office.

IV. Request that you be allowed to inspect and receive a copy of your health record and billing record. You may exercise this right by delivering the request in writing to our office using the form we provide to you upon request.

V. Appeal a denial of access to your protected health information except in certain circumstances.

VI. Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office using the form we provide to you upon request

VII. File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information

VIII. Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. The accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request.

IX. Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we provide to you upon request.

X. Revoke any authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health information for treatment, payment, and health care operations purposes.

If you want to exercise any of the above rights, please contact:
SARA LESLIE, PSYD @ LESLIE PSYCHOLOGY 735 ARLINGTON AVE., SUITE 212 ST PETERSBURG, FL 33701, (727)831-1723

in person, or in writing, during normal business hours. The therapist will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

SARA LESLIE, PSY.D is required to:

1. Maintain the privacy of your health information as required by law
2. Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you
3. Abide by the terms of this Notice
4. Notify you if we cannot accommodate a requested restriction or request
5. Accommodate your reasonable requests regarding methods to communicate health information to you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice to reflect these changes. You are entitled to receive a revised copy of the Notice by calling or requesting a copy of our Notice or by visiting the office to obtain a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the following person:
SARA LESLIE, PSY.D 735 ARLINGTON AVE. SUITE 212 ST. PETE, FL 33701, (727)831-1723

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to the following person:
SARA LESLIE, PSY.D 735 ARLINGTON AVE. SUITE 212 ST. PETE, FL 33701, (727)831-1723
You may also file a complaint by mailing or e-mailing it to the Secretary of Health and Human Services.

We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from our office.

We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Uses and Disclosures

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other persons responsible for your care, about your location, about your general condition, or your death.

Communication with Family
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Marketing
We may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits or services that may be of interest to you.

Workers Compensation
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health
As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse and Neglect
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Law enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

To avert a serious threat or health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions
We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Other uses
Other uses and disclosures in addition to those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke that authorization as previously stated.

SARA LESLIE, PsyD
LESLIE PSYCHOLOGY

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT:

I have received the *Notice of Privacy Practices* and I have been provided an opportunity to review it.

Name: _____ Birth Date: _____
(*please print name*)

Signature: _____ Date: _____
(*please sign in ink*)