Livingston Psychological Services, PLLC
Client Information

This information is essential for determining patient fee responsibilities along With determining the expected coverage of the patient's respective Health Insurance Plan. Please submit this information at the time of scheduling an appointment.

Patient's Name: ______________________________

Patient's Cell Phone/Contact#: ______________________________

Patient's Emergency Contact#: ______________________________

Patient's Address: ______________________________

____

Patient's Date of Birth: ______________________________

Patient's Social Security: ______________________________

Patient's Email Address: ______________________________

Name of Health Insurance Plan: ______________________________

Health Insurance Plan Contract ID#: ______________________________

Health Insurance Group Plan#: ______________________________

Policy Holder Name: ______________________________

Policy Holder Date of Birth: ______________________________

Policy Holder Address If Different than above: ______________________________

____

Health Insurance Plan Yearly Deductible: ______________________________

What is remaining on Deductible For The Year: ______________________________

Expected Copay Per Visit$ ______________________________

Insurance Plan Policy Expiration: ______________________________

How Did You Hear About our Services? ______________________________

Service Fees

1. A Copy of Insurance Card & Driver's License will be made at the time of your first session.
2. It is the patient's primary responsibility to understand their own Health Insurance benefits. These benefits will also be confirmed by Livingston Psychological Services, PLLC if you need assistance.
3. Payment with Regards to deductible and Co-pay fees are expected at the time services are rendered.
4. Patients who are delinquent in payment of co-pays or their deductible for three consecutive weeks will be placed on "vacation" status until their account is brought up todate.

Note: Patients are expected to provide a credit card number for payment
Of Deductible, co-pays and or for sessions not covered by insurance. A $75.00 missed apt
And a $150.00 for a missed Intake fee. Patients will be charged for the
(missed session fee) with no prior notification:
Visa / Master Card / Discover / American Express

Debit Card Number: ____

Expiration Date & CV Code: ____

5. Missed Appointments: The cancellation of an apt must be made 24 hours before the scheduled appointment. Missed appointments where the patient failed to cancel the day prior or earlier, will incur a "missed appointment fee of $75.00 whether reminder was sent or not sent.
6. Re-scheduling an appointment the day prior to the original appointment date will not incur any fees.
7. It is important each new patient reads, understands, completes and signs this "Service Fees Schedule".

______________________________ ______________________________

Signature: **Date:**

To Law Enforcement: for example, to assist in an involuntary hospitalization process.
For Research Purposes: subject to a special review process, and the confidentiality requirements of a state and federal law.
To Prevent a Serious Threat to Health or Safety of an individual. We may notify the person, to tell someone who could prevent harm, or tell law enforcement officials.
To Protect Certain Elected Officials including the President, by notifying law enforcement officers of potential harm.

YOU HAVE THE FOLLOWING RIGHTS:

1. To receive a Copy of this Notice when you obtain care.
2. To Request Restrictions. You have the right to request a restriction or limitation on the mental health information we disclose about your treatment, payment or health care operations. You must put your request in writing. We are not required to agree with your request. If we do agree with your request, we will comply with your request except to the extent that disclosure has already occurred or if you are in need of emergency treatment and the information is needed to provide the emergency treatment.
3. To Inspect and Request a Copy of your records except in limited circumstances. A fee will be charged to copy your records. You must put your request for a copy of your records in writing. If you are denied access to your records for certain reasons, we will tell you why and what your rights are to challenge that denial.
4. To Request an Amendment and/or Addendum to your records: If you believe that information is incorrect or incomplete, you may ask us to amend the information or add an addendum (addition to the records) of no longer than 250 words for each inaccuracy. We may deny your request for an amendment if the information was not created by us, is not a part of the information which you would be permitted to inspect and copy or if the information is already accurate and complete. Even if we accept your request, we do not delete any information already in your records.
5. To Receive an Accounting of Certain Disclosure we have made of your mental health information. You must put your request for an accounting in writing.
6. To Request That We Contact you by Alternative Means (e.g, fax versus mail) or at an alternative location. You request must be in writing, and we must honor all reasonable requests.

Livingston Psychological Services, PLLC
Health Information Portability and Accountability Act (HIPPA)
Notice of Privacy Practices

This Notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

WE MAY USE AND DISCLOSE YOU MENTAL HEALTH INFORMATION

For **Treatment:** for example, we may give information about your psychological condition to other health care providers to facilitate your treatment, referrals or consultations.

For **Payment**: for example, we may contact your insurer to verify your eligible benefits, to obtain prior authorization, and to receive payment from your insurance carrier.

To **Individual Involvement in Your Care:** such as your parents (if you are a minor) your conservator, or members of Livingston Psychological Services treatment team.

For **Appointments and Services** to remind you of an appointment or tell you about treatment alternatives or health related benefits and service.

With Your Written Authorization, we may use or disclose mental health information for purposes not described in this notice only with your written authorization.

We May use your Mental Health Information for Other Purposes without your written Authorization:

As **Required by Law** when required or authorized by other laws, such as the reporting of child abuse, elder abuse or dependent adult abuse.

For **Health Oversight** Activities to government, licensing auditing and accrediting agencies as authorized or required by law including audits, civil, administrative or criminal investigations; licensure or disciplinary actions; and monitoring of compliance with law.

In **Judicial Proceedings** in response to court/administrative orders, subpoenas, discovery request or other legal processes.

To **Public Health Authorities** to prevent or control communicable disease, injury, or disability, or ensure the safety of drugs and medical devices.

Changes to this Notice: We reserve the right to change this Notice. We reserve the right to make the revised or Changed Notice effective for information we already have about you as well as any information we receive in the future.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Secretary of Department of Health and Human Services

You will not be penalized for filing a complaint!

Receipt and Acknowledge of Notice

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Livingston Psychological Services, PLLC Notice of Privacy Practices.

Signature of Client and Date:

____

Or

Signature of Parent, Guardian or Personal Representative and Date:

____

Authorization to Disclose Protected Health Information

As the person who is the subject of protected health information, I request and authorize:

Hampton Walker, Jr., PhD and Providers Of Livingston Psychological Services
204 W. Grand River, Suite 260
Howell MI 48843

Additional Party to release records to: ______________________________

Additional Party Address: ______________________________

Additional Party City/State/Zip: ______________________________

Additional Party Phone Number: ______________________________

I specifically authorize and request the disclosure of the following health information and records:

*Diagnosis and History
*Results of Clinical Tests
*Symptoms
*Prognosis
*Progress to date:
*Billing statements and payment records
*All other documentation in the record regarding my care, including Referrals and correspondence:

I understand that this authorization may be revoked at any time by giving written notice to the provider and company named above, except to the extent that the action has been taken in reliance on this authorization. Unless revoked earlier, this authorization will expire in 180 days from the date of signature. I understand that my signature on this authorization has no relationship to my ability to receive treatment, payment, enrollment, or eligibility for benefits.

____

Date:

____

Printed Name:

____

Signature: