Patient Information

John H. Trask, Ph.D. PLLC

IDENTIFYING INFORMATION

Please Print Clearly **PLEASE FILL IN COMPLETELY**

Date_____ Client's Social Security #_____

Client's First Name_____MI_____ Last Name_____

Address_____ City_____ State_____ Zip_____

Telephone (Home)_____ (Cell)_____ (Work)_____

Birth date____/____/____ Age_____ Gender __F __M Race_____

Name of Spouse/Guardian_____ Phone_____

Address_____ City_____ State_____ Zip_____

Person Responsible for Payment_____ Soc. Sec. #_____

Signature of Person Responsible for Payment **X**_____ (Must be signed for services to begin)

Emergency Information

In case of emergency, contact:

Name (1) _____ Relationship_____ Phone_____Work_____

Address_____ City_____ State_____ Zip_____

Name (2) _____ Relationship_____ Phone_____Work_____

Address_____ City_____ State_____ Zip_____

Physician_____ Phone_____

Address_____ City_____ State_____ Zip_____

Psychiatrist_____ Phone_____

Address_____City_____ State_____ Zip_____

Other Physicians_____ Phone_____

Current Medications_____

Allergies_____

Employment Information (If client is a child, use parent's employment)

Client/Guardian: Place_____ Phone_____Hrs_____

Spouse: Place_____ Phone_____Hrs_____

Insurance Information

Primary Insurance_____

Phone_____

Contract/ID#_____

Group/Acct#_____

Subscriber_____

Subscriber Date of Birth _____

Client's relationship to Subscriber

__Self __Spouse __Child __Other_____

Secondary Insurance_____

Phone_____

Contract/ID#_____

Group/Acct#_____

Subscriber_____

Subscriber Date of Birth_____

Client's relationship to Subscriber

__Self __Spouse __Child __Other_____

Referral Source

How did you hear of me?_____

Privacy of Information Policies

John H. Trask, Ph.D. PLLC

This form describes the confidentiality of your medical records, how the information is used, your rights, and how you may obtain this information. Effective 4-14-03

My Legal Duties
State and Federal laws require that I keep your medical records private. Such laws require that I provide you with this notice informing you of my privacy of information policies, your rights, and my duties. I am required to abide these policies until replaced or revised. I have the right to revise my privacy policies for all medical records, including records kept before policy changes were made. Any changes in this notice will be made available upon request before changes take place.

The contents of material disclosed to me in an evaluation, intake, or counseling session are covered by the law as private information. I respect the privacy of the information you provide me and I will abide by ethical and legal requirements of confidentiality and privacy of records.

Use of Information
Information about you may be used by this office for diagnosis, treatment planning, treatment, and continuity of care. I may disclose it to health care providers who provide you with treatment, such as doctors, nurses, mental health professionals, and mental health students and mental health professionals or business associates affiliated with this practice such as billing, quality enhancement, training, audits, and accreditation.

Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian or personal representative. It is the policy of this office not to release any information about a client without a signed release of information except in certain emergency situations or exceptions in which client information can be disclosed to others without written consent. Some of these situations are noted below, and there may be other provisions provided by legal requirements.

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person or persons, a health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, a health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Public Safety
Health records may be released for the public interest and safety for public health activities, judicial and administrative proceedings, law enforcement purposes, serious threats to public safety, essential government functions, military, and when complying with worker's compensation laws.

Abuse
If a client states or suggests that he or she is abusing a child or vulnerable adult, or has recently abused a child or vulnerable adult, or a child (or vulnerable adult) is in danger of abuse, a health care professional is required to report this information to the appropriate social service and/or legal authorities. If a client is the victim of abuse, neglect, violence, or a crime victim, and their safety appears to be at risk, I may share this information with law enforcement officials to help prevent future occurrences and capture the perpetrator.

Prenatal Exposure to Controlled Substances
Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

In the Event of a Client's Death
In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records.

Professional Misconduct
Professional misconduct by a health care professional must be reported by other health care professionals. In cases in which a professional or legal disciplinary meeting is being held regarding the health care professional's actions, related records may be released in order to substantiate disciplinary concerns.

Judicial or Administrative Proceedings
Health care professionals are required to release records of clients when a court order has been placed.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

Other Provisions
When payment for services are the responsibility of the client, or a person who has agreed to providing payment, and payment has not been made in a timely manner, collection agencies may be utilized in collecting unpaid debts. The specific content of the services (e.g., diagnosis, treatment plan, progress notes, testing) is not disclosed. If a debt remains unpaid it may be reported to credit agencies, and the client's credit report may state the amount owed, the time-frame, and the name of the practice or collection source.

Insurance companies, managed care, and other third-party payers are given information that they request regarding services to the client. Information which may be requested includes type of services, dates/times of services, diagnosis, treatment plan, description of impairment, progress of therapy, and summaries.

Information about clients may be disclosed in consultations with other professionals in order to provide the best possible treatment. In such cases the name of the client, or any identifying information, is not disclosed. Clinical information about the client is discussed.

In the event in which the mental health professional must telephone the client for purposes such as appointment cancellations or reminders, or to give/receive other information, efforts are made to preserve confidentiality. Please notify me in writing where I may reach you by phone and how you would like me to identify myself. For example, you might request that when I phone you at home or work, I do not say my name or the nature of the call, but rather my first name only. If this information is not provided to me (below), I will adhere to the following procedure when making phone calls: First I will ask to speak to the client (or guardian) without identifying myself. If the person answering the phone asks for more identifying information I will say that it is a personal call. I will not identify myself (to protect confidentiality). If I reach an answering machine or voice mail I will follow the same guidelines.

Your Rights
You have the right to request to review or receive your medical files. The procedure for obtaining a copy of your medical information is as follows. You may request a copy of your records in writing with an original (not photocopied) signature. If your request is denied, you will receive a written explanation of the denial. Records for non-emancipated minors must be requested by their custodial parents or legal guardians. The charge for this service is $1.00 per page, plus postage.

You have the right to cancel a release of information by providing me a written notice. If you desire to have your information sent to a location different than my address on file, you must provide this information in writing.

You have the right to restrict which information might be disclosed to others. However, if I do not agree with these restrictions, I am not bound to abide by them.

You have the right to request that information about you be communicated by other means or to another location. This request must be made to me in writing.

Your have the right to disagree with the medical records in my files. You may request that this information be changed. Although I might deny changing the record, you have the right to make a statement of disagreement, which will be placed in your file.

You have the right to know what information in your record has been provided to whom. Request this in writing.

If you desire a written copy of this notice you may obtain it by requesting it from the Practice Director at this location.

Complaints
If you have any complaints or questions regarding these procedures, please contact me. I will get back to you in a timely manner. You may also submit a complaint to the U.S. Dept. of Health and Human Services and/or the Michigan Department of Consumer and Industry Services. If you file a complaint I will not retaliate in any way.

Direct all correspondence to: John H. Trask Ph.D. PLLC 650 E. Big Beaver Rd Suite A Troy, MI 48083
I understand the limits of confidentiality, privacy policies, my rights, and their meanings and ramifications.

Client's name (please print): _____

Signature: _____ Date: _____/_____/_____

Signed by: __client __guardian __personal representative

Consent to Treatment and Recipient Rights

John H. Trask, PhD. PLLC

I, _____, the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent for the minor or person under my legal guardianship mentioned above, at the office of John H. Trask Ph.D., PLLC. Further, I consent to have treatment provided by this fully licensed psychologist. The rights, risks and benefits associated with the treatment have been explained to me. I understand that the therapy may be discontinued at any time by either party. You are encouraged to discuss this decision prior to acting on it alone. This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Recipient's Rights declaration and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from Dr. Trask.

Non-Voluntary Discharge from Treatment: A client may be terminated from the Center non-voluntarily, if: A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at my office, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with Dr. Trask or request to re-apply for services at a later date.

Client Notice of Confidentiality: The confidentiality of patient records maintained by Dr. Trask is protected by Federal and/or State law and regulations. Generally, Dr. Trask may not say to a person outside the Center that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: 1) the patient consents in writing, 2) the disclosure is allowed by a court order, or 3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation.

Violation of Federal and/or State law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or State law and regulations do not protect any information about a crime committed by a patient either at the office of Dr. Trask, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect, or adult abuse from being reported under Federal and/or State law to appropriate State or Local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is Dr. Trask's duty to warn any potential victim, when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to access the client's records. When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about client, not clinical information. My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. Client data of clinical outcomes may be used for program evaluation purposes, but individual results will not be disclosed to outside sources.

I consent to treatment and agree to abide by the above stated policies and agreements with John H. Trask Ph.D. PLLC.

_____ _____

Signature of Client/Legal Guardian Date

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

_____ _____

Witness Date

Release of Information Authorization to Third Party Payer

I (we) authorize John H. Trask, Ph. D. PLLC to disclose case records (diagnosis, case notes, psychological reports, testing results, or other requested material) to the above listed third-party payer or insurance company for the purpose of receiving payment directly to John H. Trask, Ph.D. PLLC.

I (we) understand that access to this information will be limited to determining insurance benefits, and will be accessible only to persons whose employment is to determine payments and/or insurance benefits. I (we) understand that I (we) may revoke this consent at any time by providing written notice, and after one year this consent expires. I (we) have been informed what information will be given, its purpose, and who will receive it. I (we) certify that I (we) have read and agree to the conditions and have received a copy of this form.

Person(s) responsible for account: _____ Date: _____/_____/_____

Person(s) receiving services: _____ Date: _____/_____/_____

Person(s) or guardian(s): _____ Date: _____/_____/_____