Helena Psychotherapy

Welcome to Helena Psychotherapy, PLLC. Please complete the enclosed questionnaire before your meeting with me and bring the completed form to your appointment.

Please bring your driver's license, insurance card, and copay (if applicable) to your appointment.

Please arrive at least 10 minutes prior to all of your appointments.

Your appointment is scheduled for _____at_____a.m. or p.m.

If you have questions about this form, please contact the clinic at 406-475-4075.

Sincerely,

Patrick Van Wyk, Ph.D.
Licensed Clinical Psychologist

825 Helena Avenue, Helena, MT 59601.
Phone: 406-475-4075

Helena Psychotherapy, PLLC
Patrick Van Wyk, PhD
Licensed Clinical Psychologist

NEW PATIENT INFORMATION

Patient Information		Financially Responsible Person (if different)	
Name		Name	
Address		Address	
City, State, Zip		City, State, Zip	
Home Phone		Home Phone	
Work Phone		Work Phone	
Cell Phone		Cell Phone	
SSN		SSN	
Birth Date		Relationship to Client	
Age		Employer	
Ethnicity		**Emergency Contact**	
Primary Care Provider		Name	
Referral Source		Relationship to patient	
Date Form Completed:		Phone	

Primary Insurance Information		Secondary Insurance Information (if applicable)	
Insurance Company Name		Insurance Company Name	
Address to mail claims		Address to mail claims	
City, State, Zip		City, State, Zip	
Phone		Phone	
Policy Holder's Name (if different)		Policy Holder's Name (if different)	
Policy Holder's SSN		Policy Holder's SSN	
Policy Holder's Birth Date		Policy Holder's Birth Date	
Policy #		Policy #	

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CONTRACT

This contract establishes our agreement to the various policies outlined in the New Patient Packet. Your initials and signature indicate that you have read the information provided and agree to abide by the Practice Policies, the Financial Policy, and the HIPAA Privacy Notice.

1. I have read the Practice Policies and agree to abide by their terms: **Initials:** _____
2. I have read the Financial Policy and agree to abide by its terms. **Initials:** _____
3. I have been provided a copy of the HIPAA Privacy Notice. **Initials:** _____
4. Assignment and Release: I acknowledge that Patrick Van Wyk, PhD may release to third party payers requested medical and/or other information necessary to process my claim(s). I recognize that this information may include medical, psychological and psychiatric information and diagnosis. I hereby assign to Patrick Van Wyk all benefits which are or shall become payable from any third party payer who is responsible for payment of my charges. I authorize and direct all third party payers to pay all benefits directly to Patrick Van Wyk. **Initials:** _____

Patient and/or persons legally and financially responsible for patient's medical bills agree to pay patient's account regardless of the existence of insurance or other third party liability. Full payment will be made promptly unless other credit arrangements are made. Patrick Van Wyk is free to declare the entire balance to be due and payable if any scheduled payments are missed.

If at any time a balance due is more than 30 days old and appropriate payment arrangements have not been made, or the agreed upon payment plan is defaulted on, a suit may be brought in court, and the prevailing party may, in the discretion of the court, be entitled to recover all costs, including reasonable attorney fees, costs of court, service of process fees, and levying fees. Further any unpaid balance or damages owed may be placed with a third party collection agency either before or after a suit is brought, or in the absence of a suit. In the event any amount is placed for collection with any third party collection agency, the fee charged by the agency may be added to the total amount due and shall be in addition to any other costs (such as court costs and attorney fees-including attorneys' fees incurred by either party or the agency), incurred directly or indirectly to collect amounts owed.

I agree to pay all costs of collection, including fees described above, if the account is not paid on time.
Initials: _____

I authorize treatment of the person named below and agree to pay all fees and charges for any services.
Initials: _____

_____	_____	_____
Client Name (printed)	Client Signature	Date
_____	_____	_____
Parent/Guardian Name (printed)	Parent/Guardian Signature	Date

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PRACTICE POLICIES

This document contains important information to help you understand psychological treatment/services. After you have reviewed this document, please discuss any questions or concerns with me. Once you sign this document, it serves as a contract between us.

Testing/Assessment:

If your meeting involves testing, I will conduct a clinical interview along with other psychological tests. The purpose of psychological assessment is for me to learn about your knowledge, attitudes, capabilities, and/or motivation. Psychological testing provides a picture of your general psychological state and can help me identify whether there are significant psychological factors that might impact your ability to make permanent lifestyle changes, recover from medical and surgical treatments and cope with the emotional adjustments following medical and surgical treatments. The testing also provides me with information about your strengths, weaknesses, coping styles, self-care and ways of relating. This information can be used to tailor treatment plans and recommendations to your specific needs and to optimize the care you receive.

Throughout the assessment process, you have the right to inquire about the nature and purpose of the tests administered and to have your questions about the tests answered. You also have the right to a summary of the test results and recommendations. It is important that you know that the evaluation process and the discussion of life experiences may bring up uncomfortable feelings. Psychological responses to the evaluation process may include, but are not limited to: anxiety, depression, frustration, anger, distress or disappointment. Please discuss these with me if they occur.

If you are seeing me for pre-surgical assessment, more sessions may be needed in order to determine whether you are an appropriate candidate for surgery and/or to address certain issues prior to being approved for surgery. You will be responsible for the additional expenses if I feel that another session is necessary. If additional sessions are necessary and you have insurance, please be sure to get authorization for further sessions from your insurance company.

Treatment:

Psychotherapy and health and behavior intervention has been shown to be effective in treating a variety of problems that interfere with good psychological and physical health. In addressing a number of problems, it has also been shown to lead to better relationships and good outcomes for specific problems. These effects do not necessarily occur in all cases. You and I will identify and discuss your goals for treatment and the potential for psychotherapy or health and behavior intervention to adequately achieve these goals. We will work together to establish a treatment plan. Although treatment has many benefits, there may be times that you experience uncomfortable feelings. Please discuss these with me as they occur.

Confidentiality:

The information obtained in psychological services and evaluations is confidential and I can only release information about our work with your written permission. There are exceptions for situations in which I am required to release information without your permission. Examples are:

1) If there is evidence of physical, emotional, and/or sexual abuse of a child or a vulnerable adult.
2) If I judge that you are in danger of harming yourself or others.
3) If a court orders the release of the information.

I may occasionally consult with other professionals about a case. During a consultation, I do not disclose the identity of my client, unless you have given me a release to do so. The consultant is also legally bound to keep the information confidential. If you don't object, I won't tell you about these consultations unless I feel it is important in our work together.

If treatment involves more than one client (as in family or marital therapy), all involved parties have access to the records pertaining to that treatment. In addition, in the case of a minor or an adult deemed incompetent, usually the parent or legal guardian has the right to all treatment records.

Meetings:
Testing sessions are generally 2-3 hours in length and treatment sessions are generally 53 minutes long and are scheduled at a mutually agreed upon time and frequency. I will notify you if it is expected that your session will run longer than this.

Please note that you should not bring children with you to your appointments unless (a) it is planned that they will participate in the session or (b) you bring another adult to supervise them during the session. You may not leave children unattended in the waiting area.

Contacting Me:
My office hours are Monday through Thursday, approximately 9:00am-5:00pm. If I am not immediately available by telephone, please leave a message and I will return your call as promptly as possible. I do not check my messages when I am out of the office. If you are having a mental health crisis or emergency and I am not available, contact your physician or the nearest emergency room and ask for the Mental Health Professional on call.

Cancellations:
If you are unable to keep an appointment, please cancel at least 24 hours in advance. If unexpected events occur, please cancel as early as possible. It is your responsibility to reschedule your appointment. If you have a pattern of missed appointments without advance cancellation we will discuss this matter and attempt to resolve it. If resolution does not occur and the pattern of missed appointments continues, your treatment may be terminated. Please be aware that the second time you do not show up on time for an appointment or cancel within less than 24 hours notice, a missed appointment fee will be charged. This fee must be paid before our next appointment. If your treatment provider needs to cancel or move an appointment time, he or she will attempt to notify you at least 24 hours in advance if possible.

Professional Records:
Treatment providers must keep treatment records. You may request a copy of your records, or I can prepare a summary for you. Professional records contain jargon that is specific to psychology, they can be easily misinterpreted by readers outside the profession of psychology. Thus, if you wish to see your records, I recommend that we review them together so that I can answer your questions. A copying fee may apply.

Please let me know if you have any questions about the above information and I'd be happy to discuss them with you.

Helena Psychotherapy, PLLC
Patrick Van Wyk, PhD
Licensed Clinical Psychologist

FINANCIAL POLICY

Fees: Fees for services are outlined in the table below. You are responsible for payment of all fees for service.

Service	Fee	CPT Code
Diagnostic Interview (50 minutes to 1 hour)	$285	90791
Individual Psychotherapy (16-37 minutes)	$125	90832
Individual Psychotherapy (38-52 minutes)	$165	90834
Individual Psychotherapy (53 or more minutes)	$175	90837
Family Psychotherapy (80 minutes)	$225	90847
Group Psychotherapy (60-90 minutes)	$60	90853
Psychological Testing (per 60 minutes)	$160	96101, 96103
Medical Team Conference	$165	99366, 99368
Health and Behavior Assessment (per 15 minutes)	$65	96150, 96151
Health and Behavior Intervention (per 15 minutes)	$60	96152
Health and Behavior Group (per 15 minutes)	$15	96153
Health and Behavior Family (with patient) (per 15 minutes)	$60	96154
Health and Behavior Family (without patient) (per 15 minutes)	$50	96155

Insurance Coverage: If you have insurance or another payer which pays for all or part of these services, your insurance company or payer will be billed by my billing center. Pre-authorization for services are often required by insurance companies prior to obtaining care. You are responsible for obtaining preauthorization.

Please bring your insurance card with you to your first appointment as well as your co-pay. Co-pays will be collected at the time of service. Cash or check is accepted.

Uninsured/Motor Vehicle Accident/Legal Claims: If you are uninsured or this is related to a motor vehicle accident or legal suit, I require you to pay 100% of the charge at the time of your appointment.

If you pay in full at time of service (self-pay), then you will receive 5% off your bill.

Past Due Accounts: For unpaid balances, you will be billed monthly.

Returned Check Fee: In addition to the amounts your bank may charge you, I may charge $30 for any returned/dishonored check as well as any other statutory penalty allowed by law.

Missed Appointment Fee: The second time a client does not show up on time for an appointment, or cancels with less than 24 hours notice, a missed appointment fee of **$50** will be charged. This fee must be paid before our next appointment. Clients with two or more missed appointments may be asked to transfer their records to another provider.

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NOTICE OF PRIVACY PRACTICES

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

If you have any questions about this Notice, please contact the Privacy Officer, Patrick Van Wyk, PhD.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your provider, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your provider's practice.

Following are examples of the types of uses and disclosures of your protected health information that your provider's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other providers who may be treating you. For example, your protected health information may be provided to a provider to whom you have been referred to ensure that the provider has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time to time to another provider or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your provider, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your provider.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your provider's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities. We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you. We may use or disclose your demographic information and the dates that you received treatment from your provider, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object: We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your provider created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object

to the use or disclosure of the protected health information, then your provider may, using professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable), and your religious affiliation. All of this information, except religious affiliation, will be disclosed to people that ask for you by name. Your religious affiliation will be only given to a member of the clergy, such as a priest or rabbi.

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your provider and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your provider is not required to agree to a restriction that you may request. If your provider does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your provider. You may request a restriction in writing.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your provider amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Officer, Patrick Van Wyk, at the address and number below for further information about the complaint process.

This notice was published and becomes effective on October 14, 2012.