Doctor or Therapist: Kelley Farmer, M.D. **Adult**

REGISTRATION INFORMATION

Please Print

Name: _____ Today's Date: _____

Address: _____ City: _____ ST: _____ Zip: _____

Birthdate: _____ Gender: F M SSN: _____

Relationship Status: Single Married Domestic Partner Divorced Widowed Separated Other: _____

CONTACT PREFERENCES

Primary Phone: _____
___OK to leave message with details
___ Leave call-back # only
___ Leave NO message

Secondary Phone: _____
___ OK to leave message with details
___ Leave call back # only
___Leave NO message

Your employer: _____ Job Title: _____

Spouse/Partner Name: _____ Birthdate: _____

Spouse/Partner Employer: _____ Work Phone: _____

Email: _____ (confidentiality cannot be guaranteed for email communication)

Signature: _____ Date: _____

PRIMARY CARE PHYSICIAN Name: _____

Phone:_____ Fax:_____

Address: _____ City: _____ ST: _____ Zip: _____

EMERGENCY INFORMATION In case of emergency, please notify: _____
Phone: _____ Relationship: _____

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Personal Representative/Description of Authority

NOTIFICATON OF CHANGES I understand I am responsible for notifying the office of any change of address, phone number and/or insurance.

_____ _____
Signature of Patient or Personal Representative Date

CONFIDENTIAL

NOTICE OF PRIVACY PRACTICES
(The following is a summary. The full text is located in our waiting room.)

We at Austin Psychotherapy Associates are committed to maintaining the confidentiality of your medical information. In most cases, your records will not be released without your written consent (which you can revoke). However, there are a few exceptions. We are permitted to disclose your medical information to other professionals involved in your treatment.

- We are permitted to use and disclose your medical information to your insurance company, if you choose to use them, or as required by worker's compensation law.
- We may disclose your medical information for public health concerns as mandated by federal or state government.
- We are required to report child abuse or neglect.
- We may release information if you are under the custody of law enforcement, or if ordered by the court.

You may request in writing that we restrict how your information is disclosed for treatment, payment or healthcare operations. Although we are not required to restrict this information, we will do so except in emergency situations.

It is our policy not to release information to family members or other individuals without your written consent. You have a right to access your health records with some limitations. (See restrictions in the full text.) You must submit your request in writing to the Privacy Officer.

Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or with the government. The contact information for the United States Department of Health and Human Services is:

U.S. Department of Health and Human Services
HIPAA Complaint
7500 Security Blvd., C5-24-04
Baltimore, MD 21244

Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Gayle Harkrider, Privacy Officer
4601 Spicewood Springs Rd
Building 4, Suite 200
Austin, TX 78759

This notice is effective November 14, 2006.

Privacy policies are mandated by Federal and State Law. If the privacy laws change, we will post the new notice in the office where it can be seen. Revised Federal and/or State Laws apply to all protected health information we maintain. When State and Federal Laws differ, our office will comply with the more restrictive law.

CONFIDENTIAL
Patient Copy
Revised 8/2014

KELLEY A. FARMER, M.D.
STATEMENT OF UNDERSTANDING

Consent for Care:
I give full consent for the completion of my evaluation and provision of treatment as necessary, by the above named physician, until otherwise notified. I understand that no promises have been made to me as to the result of treatment or procedures provided by this doctor. If I have any questions about the following information or about anything related to my treatment, I will discuss this with the doctor.

Confidentiality:
You have the right to confidentiality in your treatment. Information concerning your treatment will not be disclosed without your prior written permission except for the following legal exceptions:

1. Life or safety of you or someone else is seriously threatened.
2. There is good reason to believe that you are abusing or neglecting a child or vulnerable adult or if you give me information about someone else who is doing this, child/adult protective services and/or the appropriate law enforcement agency must be notified.
3. Court ordered treatment.
4. An insurance claim is filed and the claims payer requires information, i.e. diagnosis, types of treatment, dates, etc.
5. Parents or legal guardians of minors are legally privy to information disclosed during treatment. The doctor will discuss and clarify issues of privileged information regarding the child's treatment.

Emergencies/Telephone Counseling:
Medical and/or psychiatric emergencies should be directed to 911 if life or safety is threatened. The office phone number (512) 467-1376, is answered by staff during business hours and by a recording after hours. After hours, the answering service will direct your call to me or the doctor covering for me. The answering service phone number is (512) 404-9098, and is on our office recording.

Scheduling of appointments:
It is your responsibility to schedule and keep all appointments. We are unable to guarantee that you will get a reminder call. If it is necessary to cancel an appointment, you must give at least 24 hours notice. Monday appointments must be canceled before noon on the preceding Friday**. You will be charged my full fee of $95 for missed appointments or appointments canceled without 24 hours advance notice.** I am unable to make exceptions to this policy.

Fee policy:
Payment is due at the time of service. Any returned checks are subject to a $20 charge. Should your account be referred for collection, you agree to pay 6% interest plus a $25 collection fee and reasonable attorney fees and/or court costs.

Fees for services:

Diagnostic evaluation (50 min.) $300	**Missed appointment = full fee**
Medication management (up to 15 min.) $95	Written reports and forms $10 - $50 depending on time involved
	Fees for other services provided upon request

I work with a group of independent mental health professionals, under the name of Austin Psychotherapy Associates. This group is an association of independently practicing professionals who share certain expenses and administrative functions. While the members share a name and office space, I want you to know that I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained and no member of the group can have access to them without your specific, written permission.

I UNDERSTAND AND AGREE TO THE ABOVE TERMS.

_____ _____
Client Signature Date

_____
Print Name

CONFIDENTIAL

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_____ _____
Client Signature Date

_____
Print Name

CONFIDENTIAL
PATIENT COPY
Revised 8/2014

IMPORTANT NOTICE REGARDING PRESCRIPTIONS

Kelley Farmer, M.D.

- At the end of each appointment, you will be asked to make a follow-up appointment. There will be a $10.00 fee for prescriptions called in as a result of a missed appointment or failure to make a follow-up appointment within the period required. If that occurs, no more than a month's supply will be called in and you will need to make a follow-up appointment.

- There will be **no** refills called in after hours, on weekends or holidays.

- There will be a $5.00 charge per prescription for all prescriptions written outside an office visit. This includes prescriptions called in because a written prescription was lost, misplaced, or not turned into the pharmacy.

- Patients residing out of town requesting that prescriptions be mailed will need to provide a supply of self-addressed, stamped envelopes. There will be an additional $5.00 charge for mailing prescriptions if stamped envelopes are not supplied.

- CONTROLLED SUBSTANCES (ADD/ADHD) PRESCRIPTIONS: Controlled substance prescriptions are regulated by the Drug Enforcement Agency and the DPS (from whom I must purchase special forms) and thus cannot be called in to the pharmacy. There is 21-day expiration on controlled substance prescriptions. Expired prescriptions of this type must be returned before a replacement will be issued. There will be a $20.00 fee for rewriting a controlled substance prescription.

- If controlled substance prescriptions or medications are expired, lost in the mail, stolen, misplaced, etc., be advised that I cannot re-issue a prescription until the expired prescription is returned or 30 days have lapsed since the prescription was originally written. I cannot write prescriptions early. I cannot pre-sign or post-date prescriptions.

- If your prescription requires a prior authorization from your insurance company, there will be a $5.00 charge. If the insurance company requires a telephone call from Dr. Farmer or a letter of necessity, there will be an additional $10.00 charge.

I have read and understand this policy regarding prescriptions.

_____

Client Name Printed

_____ _____

Client Signature Date

CONFIDENTIAL

Revised 8/2014

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Kelley Farmer, M.D.

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I have read and understand this policy regarding prescriptions.

_____

Client Name Printed

_____ _____

Client Signature Date

CONFIDENTIAL

Patient Copy

Revised 8/2014

Prescriptions From Other Providers

Date of Notification	Medication	Frequency of Use	Reason for Use	Authorization to Speak with Dr.

Frequently Used Over the Counter Drugs, Supplements, and Herbal Remedies

Date of Notification	Medication	Frequency of Use	Reason for Use	Authorization to Speak with Dr.

_____
Client Name Printed

_____ _____
Client Signature Date

CONFIDENTIAL

4601 Spicewood Springs Road
Building 4, Suite 200
Austin, Texas 78759
Office: (512)467-1376
Fax: (512)467-8658

Credit Card Authorization Form

Date: _____

RE: Patient _____

I am providing the following credit card information to Dr. Kelley Farmer to keep on file in the event that I do not keep an appointment, or I cancel an appointment without 24 business hours' notice (with full details of relevant office policies provided to me already on separate forms).

I authorize Dr. Farmer to charge my credit card account the full specified amount for the missed appointment.

Select one: VISA MASTERCARD

Card number: _____

Expiration date: _____ CVV CODE: _____

Name on card: _____

Credit card billing address information:

City_____ State_____ Zip code: _____

Cardholder's phone number: (_____)_____
Area Code

Signature: _____

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