REGISTRATION INFORMATION

Please Print

CONFIDENTIAL

Child: _____ Birthdate: _____ Gender: M F

Your Name: _____ Relationship: _____ Today's Date: _____

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

Child's Grade: _____ School: _____ SSN: _____

Child lives with: ___ Both parents/1 home ___ Both parents/2 homes ___ 1 parent (specify): _____
___ Other relative: _____ ___ Other arrangement: _____

Do you have the legal right to seek mental health treatment for this child? ___ Yes___No
If NOT, do you have permission to seek such treatment? ___ Yes___No

CONTACT PREFERENCES

Phone (H): _____ (W): _____ (C): _____

___OK to leave message ___ OK to leave message ___ OK to leave message
___ with details ___ with details ___ with details
___ call back # only ___ call back # only ___ call back # only
___ NO message ___ NO message ___ NO message

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

Written Communication/Mail:
___ OK to mail to home address ___ OK to mail to work address: _____

Signature: _____ Date: _____

PRIMARY CARE PHYSICIAN Name: _____ Phone: _____

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

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

INSURANCE FILING Would you like us to file your insurance for you? Yes No

AUTHORIZATION AND RELEASE I hereby authorize the clinician to release all information necessary to secure payment of benefits from my insurance company. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I fully understand that I am financially responsible for all charger whether or not paid by my insurance company.

_____ _____
Signature of Insured/Guardian Date

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

Client Name: _____

Client Information (cont'd)

PAST AND PRESENT HISTORY

Put an (X) in the box which includes health/illness/condition history for you and your family.

	Good Health	Poor Health	Deceased	Depression	Suicide	Alcohol Abuse	Drug Abuse	Inattention	Psychosis	Severe Anxiety	Panic Attacks	Nervous Breakdown	Hospitalization for Mental Illness	Eating Disorder	Bipolar Disorder	Other
Patient																
Father																
Mother																
Brothers																
Sisters																
Mother's Mother																
Mother's Father																
Father's Mother																
Father's Father																

Client Name: _____

Registration Information (cont'd)

Medical Information:

Brief Medical History:

_____ Seizure Disorders	_____ HIV	_____ Migraines	_____ Developmental Delay
_____ Diabetes	_____ High BP	_____ M.S./M.D.	_____ Head Injury
_____ Heart Condition	_____ TB	_____ Polio	_____ Birth Trauma

_____ Other _____

_____

Current Medications and Dosage	Prescribing Doctor	Reason(s) for their use:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other persons living in the home:

Name	Relationship	How Long?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

It there is any other information you would like us to know at this time, please continue on the reverse side and check here _____. Thank you for completing the registration information.

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, at:

4601 Spicewood Springs Rd
Building 4, Suite 200
Austin, TX 78759

PATIENT COPY

This notice is effective November 14, 2006.

We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen.

SAM HACKWORTH, Ph.D.
STATEMENT OF UNDERSTANDING - CLIENT WHO IS A MINOR

Consent for Treatment of a Minor:
For any client below the age of 18, I certify that I have legal responsibility for this child _____ DOB: _____ and give full consent for the completion of an evaluation and the provision of treatment as necessary until otherwise notified. If applicable, I will provide legal documentation of guardianship and/or legal right to seek mental health intervention for this child. If legally required, or applicable, I have already informed my child's other parent of this assessment/treatment, or I will forthwith inform my child's other parent that we are seeking services by Dr. Hackworth.

Confidentiality:
You have the right to confidentiality in your assessment and/or therapy. Information concerning you will not be disclosed without your prior written permission except for the following legal exceptions:

1. If the life or safety of you or someone else is seriously threatened.
2. If 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 services.
4. An insurance benefit 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 therapist 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) 231-0164, 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 person covering for me. The answering service phone number is (512) 404-9098 and is on our office recording.

Scheduling of Appointments:
Please conscientiously keep all scheduled appointments. **If it is necessary to cancel an appointment, please give at least 24 hours notice. Monday appointments must be canceled before noon on the preceding Friday. You will be charged the Full Fee for missed appointments or appointments canceled without 24 hours advance notice (NOT just a co-pay amount). Insurance companies do not pay at all for missed appointments; this is strictly a patient's responsibility**. Exceptions to this policy may be made for unforeseen emergencies but must be discussed on a per case basis with the therapist.

Fee Policy:
All charges are ultimately your responsibility for all dates of service. All co-payments, unmet deductible expenses, and services or charges not covered by insurance are due at the time of service. Payment may be in the form of cash, check or credit card. Any returned checks are subject to a $25 charge. Account balances past due 90+ days incur a $25 late fee. Should your account be referred for collection, you agree to pay 8% interest plus all necessary collection fees and applicable attorney fees and/or court costs.

Fees for Services:
- Initial Diagnostic Interview = $195
- Individual Session (50 min.) = $145
- Individual Session (75 min.) = $220
- Family Session (50 min.) = $145
- Family Session (75 min.) = $220
- Correspondence (except legal work) = $145/hour
- Photocopying of records = $25 prepaid
- Missed Appointment or Late Cancellation = **Full Fee**
- Psychological Evaluation/Testing = $145/hour
- Consult at home/school/etc. = $145/hour, door to door
- Phone Consult (except legal work) = $145/hour
- Any legal work (billed in 15 min. increments) = $300/hour, door to door (e.g., court testimony, depositions, reports, phone calls)
- **Retainer required before any legal work (min. $1500, or Estimate)**
- **½ nonrefundable if court canceled/settlement with < 3 bus. days notice**
- **Minimum 7 days notice before any legal work is needed**

****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 Name Printed Guardian name printed

_____ _____
Guardian Signature Date

Revised: 1/2017

PATIENT COPY

SAM HACKWORTH, Ph.D.
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3. Court ordered services.
4. An insurance benefit is filed and the claims payer requires information, i.e. diagnosis, types of treatment, dates, etc.
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I UNDERSTAND AND AGREE TO THE ABOVE TERMS. PATIENT COPY

_____ _____
Client Name Printed Guardian name printed

_____ _____
Guardian Signature Date

Revised: 1/2017

Sam Hackworth, Ph.D. Office use: Provisional Dx: _____

Form must be complete
Patient Information

Patient Name _____ Marital Status _____

Current Address _____ Gender _____ Date of Birth ___/___/____

City, State, Zip. _____ Soc. Security Number _____-_____-_____

Telephone: (Home) _____ Telephone: (Work) _____

Employer's Name _____ Occupation _____

Employer's Address _____ E-Mail address _____

Family Physician _____ Referred by _____

In case of emergency, notify _____

_____ _____

(Area Code & Telephone #) (Relationship)

Insurance Information

If you are going to use insurance, we will need to get a copy of your insurance card.

▶ **YES or NO** ____ I authorize the release of any clinical or other information necessary to process my insurance claim.

▶ **YES or NO** ____ I authorize payment of insurance benefits to the above listed provider.

▶ **YES or NO** ____ Do you have other insurance outside of the listed insurance below? List on other sheet of paper.

Policy Holder's Name _____ Policy Holder's Soc. Sec. # _____-_____-_____

Policy Holder's ID # _____ Policy Holder's Group # _____

Effective date of coverage _____ Employer _____

Policy Holder's Date of Birth _____ Employer Phone # _____

Policy Holder's Current Address If different than above _____

(City, State, Zip Code, and Phone #)

Insurance Company claim phone number _____

Policy Holder's Gender _____ Policy Holder's Marital Status _____ Relationship to patient _____

_____ _____

Insured's Signature Date

Insurance Co. Billing Address: _____

MUST HAVE: _____

could be a third party _____

ALL QUESTIONS MUST BE FILLED IN COMPLETELY

Sam Hackworth, Ph.D.
-- Licensed Psychologist --

Austin Psychotherapy Associates
4601 Spicewood Springs Rd., Suite 4-200
Austin, TX 78759

Phone 512-231-0164
Fax 512-276-8958
www.austinpsych.com

Receipt and Understanding of Office Policies: Missed Appointments, Late Cancellations, and Other Fees

I have received, completely read, and signed Dr. Hackworth's "Statement of Understanding" form provide to me today, and I have either already asked any questions about that form or I will ask my questions before leaving the office today. I have also received a copy to keep for my records. My signature on the form indicates that I understand and agree to the terms outlined there.

In addition to the general information on that form, I am specifically stating that I understand and agree that:

- There is a *significant charge for missed appointments or appointments canceled with less than 24 hours notice* (with Monday appointments having to be canceled by noon Friday – not later Friday or over the weekend, as staff will not hear that message until Monday). More specifically, if I am using insurance, I understand the charge will be the full and total amount allowed by my particular insurance, and not just the copay I would normally have paid for a kept appointment. For instance, if my insurance allows a total charge of $110 (with a copay of $15, and insurance paying the remaining $95) for a *kept appointment,* I know that a *missed appointment or appointment canceled late* would, in this example, result in a charge to me of the total $110. I understand that it is in no way possible or legal to ask insurance to cover a visit that did not occur. If I am not using insurance, I understand that the charge will be the full fee amount, as usual.
- "Forgetting" an appointment; mixing up date/times; last minute changes in personal, work, or school schedules; changes in routine during holidays and school vacations; and deciding on my own that it is not necessary to return for therapy are *still considered either a missed appointment or late cancellation, as applicable*.
- It is my responsibility to inform any other adults who may transport my child (or me) to an appointment of all office policies, and to have them read this form, because *in the event of a missed appointment or late cancellation by them I would remain the person responsible for payment of all charges as above*.
- Dr. Hackworth, like most if not all other psychologists, has this specific policy, and makes it very clear here, because when I make an appointment I – and no one else – am essentially renting his office for a full hour. I know that if I do not keep and appointment, or call late to cancel it, that I will have essentially shut down his practice for that hour; all doctors and therapists in this office are independent practitioners, and share expenses only, not income.
- If my insurance lapses or changes, I must immediately notify Dr. Hackworth's office of the new policy information, as any delay in authorization of new insurance benefits often results in insurance denial of payment. *If insurance lapses or denies payment, I know that I am then solely responsible for full payment of fees.*
- *Insurance does not usually pay at all for phone calls, letters, or written summaries (to teachers, physicians, etc.) and, therefore, I know that I would be required to myself pay for any of those services.* I know that, for mental health benefits, insurance pays only for a *specified number of minutes for my actual visit in the office* (usually 45-50 minutes) – and nothing beyond that – so that the only way Dr. Hackworth can provide those services is to charge for them. (Note: it is likely that no other service covered by your insurance limits benefits to specified minutes in an office, but this is, in fact, true.)

_____	_____	_____	_____
(Parent/Guardian, or Patient if 18+)	Date	(Parent/Guardian, or Patient if 18+)	Date

PATIENT COPY

Sam Hackworth, Ph.D.
-- Licensed Psychologist --

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PATIENT COPY

_____ _____ _____ _____

(Parent/Guardian, or Patient if 18+) Date (Parent/Guardian, or Patient if 18+) Date

Using Insurance Questionnaire

Use the following guideline when calling your insurance company to get pre-authorization for your first session. If you have difficulty getting the necessary information for your pre-authorization, please contact our office, (512) 467-1376, so that our staff may help you.
Call the Mental Health or Customer Service number on your insurance card and tell them that you "need to verify outpatient mental health benefits".

Name of patient/client: _____

Name and social security number of policy holder: _____

Name of Insurance Company: _____

Name of company handling your mental health benefits (sometimes different from the insurance company):
_____

Phone number called: _____

Person you talked to at time of call: _____

Date and time of call: _____

Ask for the following information:
Is (doctor/therapist name and degree) currently a network provider for my plan? _____

If not, what are my out-of-network benefits? _____

Is pre-certification necessary? _____

If yes, enter the number of sessions approved and the CPT codes _____,
the authorization number and date span covered _____

Do I have a deductible for mental health services?_____
If yes, how much is it and how much has been met so far? _____

In what month does your policy year begin? _____

What is my copayment for each visit, or what is the percentage of coverage?
_____

What are the restrictions or limitations to my coverage? a) pre-existing conditions: _____b) dollar amount per year? _____, per lifetime? _____c) number of visits per year?_____, number of visits per lifetime? _____ d) is couples or family therapy covered? _____ e) is psychological or psychoeducational testing covered? _____If so, what are the benefits? _____

What is the billing address for claims? _____

Sam Hackworth, Ph.D.

NOTICE: CHANGE OF CREDIT CARD PROCEDURES
(1/19/2016)

Effective immediately, I can no longer accept the following, or similar, types of credit cards:
-Signature Visa
-Signature Preferred and/or Corporate Visa
-WorldCard MasterCard
-WorldCard World MasterCard
-Rewards Visa
-Rewards MasterCard
-Business MasterCard
-Business Visa

And: Any other type of Rewards, Points, or CashBack card

Why can I no longer accept those? The typical, basic credit card, whether Visa or MasterCard, ends up charging me approximately $5 to process a charge, after all of their percentages, numerous fees, taxes, etcetera, are added together. However, after reviewing the details of the past year, I see that most of the above types of cards charge me an additional $5 - $8 per transaction. But, some are charging me an additional $8 - $12 per transaction (one even recently charged an added $14 for the transaction), *above and beyond* the typical, or average, $5 per transaction. For some of you, this means your entire copay went to credit card companies.

As best I can tell, there are at least 2 basic reasons for these stunning fees. First - and I don't think most people realize this - whether it's me, Target, or Southwest Airlines, for example, we as 'merchants' are charged an amount to pay for the rewards or points or cash-back your credit card company "gives" you. The fact is, though, they charge me much, much more for those rewards or points than they actually give you, meaning the above fees are going straight to credit card company profits. Second, if you have a business or corporate card the regulations on those were loosened a few years ago and I'm guessing some of those fees were snuck into the final regulations. Either way, I can no longer absorb the costs that I have outlined above. Large businesses and companies may be able to, but I cannot.

Your options:

_____ I will now use cash or check for all future charges.

_____ I will now use another type of credit card here and will provide that card information.

_____ I will continue to use one of the above types of cards and agree to pay an additional 5% per transaction.

Name:_____Signature & Date:_____

Sam Hackworth, Ph.D.

Credit Card Information

Please provide the required information about the credit card you will use to pay any fees for missed appointments or to make payments on your account.

Type of Credit Card: ❑Visa ❑Master Card

[Note: Dr. Hackworth is not able to process Health Savings Account (HSA) or FLEX cards.]

Credit Card Number: _____

3 Digit Security Code on Back of Card: _____ Expiration Date: _____

Name as printed on card: _____

Billing address for credit card: _____

_____

_____

By my signature below, I grant Sam Hackworth, Ph.D my permission to charge the account described above for missed appointments or late cancellation fees.

_____ _____

Signature Date

_____

Printed Name

(Optional – Line through if you do not wish to grant this permission)
By my signature below, I grant Sam Hackworth, Ph.D. my permission to charge the account described above for insurance copays of scheduled sessions.

_____ _____

Signature Date

_____

Printed Name

(Optional – Line through if you do not wish to grant this permission)
By my signature below, I grant Sam Hackworth, Ph.D. my permission to charge the account described above for any outstanding balance on a monthly basis.

_____ _____

Signature Date

_____

Printed Name

PAYMENTS DUE: Your payment or co-payment is expected at each session. Also, please realize that any amounts left unpaid by your insurance (such as annual deductibles) will be your responsibility to pay.
CANCELED APPOINTMENTS: Please remember that without a full 24-hours notice (by noon on Friday for a Monday appt), your credit card will be billed for full payment of your missed session. A missed session cannot be billed to insurance.