# PATIENT REGISTRATION PLEASE PRINT

Patient's Full Name_____

Date of Birth_____SS#_____-_____-_____

Home Address_____ City _____State____ Zip_____

**PLEASE CHECK PREFERRED METHOD OF CONTACT**

Home Phone_____-_____-_____ ☐ Cell Phone _____-_____-_____ ☐

Email_____OPT IN TO RECEIVE EMAILS ☐

Patient Employer_____ Phone_____-_____-_____

If Student- Primary School_____

Family Physician _____Referred By_____

Emergency Contact_____Phone_____-_____-_____

**COMPLETE IF NOT MEDICAID**

Full Name of Insured _____Relationship_____ Occupation_____

Home Address_____ City _____State____ Zip_____

Employer and Address_____Phone_____-_____-_____

Insured's SS#_____-_____-_____

Insured's Primary Ins. Co. _____ I.D. No_____ Group No_____

**OFFICE BILLING AND INSURANCE POLICY**

1. I authorize use of this form on all of my insurance submissions.
2. I authorize the release of information to my insurance company(s).
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used in place of an original.

Printed Name _____ID #_____

Signature_____Date_____

It is your responsibility to pay any deductible amount, co-pay, co-insurance amount or any other balance not paid by your ins. the day and time service is provided. There will be a $25.00 service charge on all returned checks. In event that your account goes to collections, there will be a 20% collection fee added to your balance.
There is a 24-hour cancellation policy which requires that you cancel your appointment 24 hours in advance between the hours of 8am to 4pm Monday through Friday to avoid being charged. This charge is not applicable to Medicaid patients.

Signature_____Date_____

# TREATMENT CONTRACT

**PATIENT NAME**

The therapist and I have discussed my/my child's case and I was informed of the risks, approximate length of treatment, alternative methods of treatment, and the possible consequences of the decided on treatment which includes the following methods and interventions:

_X_ Stabilization
_X_ Decrease and relieve symptomatology
_X_ Improve coping, problem solving, and use of resources
_X_ Skill development
_X_ Grief resolution
_X_ Stress management
_X_ Behavior modification and cognitive restructuring
___ Other _____

1. While I expect benefits from this treatment I fully understand and accept that because of factors beyond our control, such benefits and desired outcomes cannot be guaranteed.
2. I understand that the therapist is not providing emergency service and I have been informed of whom/where to call in an emergency or during the evening or weekend hours.
3. I understand that regular attendance will produce the maximum possible benefits but that I or we am/are free to discontinue treatment at any time in accordance with the policies of SQUARE1.
4. I understand that I am financially responsible for any portion of the fees not covered or reimbursed by my health insurance.
5. I have been informed and understand the limits of confidentiality, that by law, the therapist must report to appropriate authorities any suspected child abuse or serious threats of harm to myself or another person.
6. I am not aware of any reason why I/we/he/she should not proceed with therapy and I/we/he/she agrees to participate fully and voluntarily.
7. I have had the opportunity to discuss all of the aspects of treatment fully, have had my questions answered, and understand the treatment planned. Therefore, I agree to comply with treatment and authorize the below named clinician(s) or whomever is designated to administer the treatment(s) to me or my child.

8. As parent or legal guardian of _____
I authorize his/her evaluation and treatment. As parent or legal guardian, I have the right to request information concerning the above minor's evaluation and treatment.

**10. I understand that the Square1 therapist will telephone me prior to departing for an appointment. If I do not answer the call, the therapist will report this as a "no-show" and will not keep the appointment. In the event of 2 "no-shows" in a 13 week period, all subsequent appointments will be suspended until review by Square1. I understand that I am to call my therapist or Square1 at 317-385-5350 if I need to reschedule any appointment.**

9. I have received a copy of the Notice of Privacy Practices for SQUARE1.

Printed Name of Patient_____

Signature of Patient/Parent/Guardian _____

Date_____

Printed Name of Therapist _____

Therapist Signature_____

Date_____

# CONSENT TO TELEHEALTH

**PATIENT NAME**

I understand that, as a part of SQUARE1 provided mental health therapy, the therapist may use "telehealth" services.

The use of "telehealth" for therapy services provided by SQUARE1 can include:

1. telephone conversations by audio only.
2. telephone conversations with video.
3. video conferencing through telephone or computer.

[X] I consent to the use of "telehealth" services by SQUARE1.

[ ] I do not consent to any "telehealth" services by SQUARE1.

I understand that my above election for or the denial of "telehealth" services can be changed by me at any time, with written notification.

Printed Name of Patient_____

Signature of Patient/Parent/Guardian _____

Date_____

# Notice of Privacy Practices

SQUARE1 values the privacy of its clients and the confidentiality of the personal and health information entrusted to us. In order to protect this privacy, we have policies and procedures to limit disclosures of personal information to those minimally necessary for the medical care of the client, those for which the client has given permission, and/or those required by law or public safety.

The following privacy policy is adopted to ensure that this medical practice complies fully with all federal and state privacy protection laws and regulations. Protection of patient privacy is of paramount importance to this organization. Violations of any of these provisions will result in severe disciplinary action including termination of employment and possible referral for criminal prosecution.

### A. Potential disclosures of an individual's information include

1. **Treatment.** Counseling information may need to be shared with SQUARE1 counselors, psychologists, staff psychiatrists and trainees in counseling, psychology and psychiatry in order to provide effective and efficient care.

2. **Billing.** If a client misses an appointment without a 24-hr. advance notice, a $25.00 fee is charged. The charge is forwarded to SQUARE1's Receivable Office and a statement is sent to the client. Billing information may contain personal information to include name, identification number, and date of service. The client bill appears as a "Medical Clinic Charge" without the medical diagnoses or procedures. Bills are mailed by the Accounts Receivable Office to the address provided by the client. No third party billing through insurance companies is provided.

3. **Oversight activities.** Oversight includes internal and external audits, chart reviews, investigations, licensures, and inspections required for compliance with government and accreditation programs and laws as well as SQUARE1's quality assurance/risk management programs. Only the minimal necessary information will be released and it will usually be of a general/composite nature. However, on occasion, reviews will involve sighting of individual information by the auditor, accreditation examiner, or qualified professional. All individuals performing these reviews, audits, and accreditation visits will be required to agree with and sign the non-disclosure confidentiality standards of the Counseling Center before being allowed access.

4. **Public health and safety.** Personal counseling and health information may be disclosed to the proper authorities to report intent to harm self or others, deaths, certain infectious diseases, occupational injuries and diseases, child or incapacitated adult abuse/neglect, problems with medications and other products as required by law to prevent/control disease, injury or disability to the client or to others.

5. **Legal requirements.** Counseling information may be disclosed as required by court or administrative order, subpoena, discovery request, or other lawful process.

6. **Contacts.** The client may be contacted by SQUARE1 to provide appointment reminders or other information of health-related benefits or services that may be of interest to the patient.

7. **Other uses.** Uses and disclosures of health and personal information other than described above will be made only with the client's (your) written authorization. Such authorization when given may be revoked in writing by the patient (you) at any time.

### B. The client also has certain rights. These include

**1. The right to inspect and obtain copies of counseling records.** Any such requests must be made in writing by the client utilizing SQUARE1's authorization for release information form or in the case of information to be released to another health care provider the form provided by that provider. A cost-based fee may be charged for copying counseling records. SQUARE1 may deny, in writing, the release or viewing of personal counseling information if the Administration of SQUARE1 determines that the release of the information may be harmful to the client or another

person. When such a request is denied the client may request in writing a review of the denial by the Administration of SQUARE1.

2. **The right to request amendments of counseling information.** Such requests must be made in writing to the Clinical Director of SQUARE1. Such requests will be reviewed and may be denied. If denied, a written denial and its reasons will be provided to the client and he/she has to the right to submit a rebuttal and request for review of such denial by the Administration of SQUARE1.

3. **The right to request limits on the amount or types of counseling information released.** Such requests must be made in writing to the Clinical Director of SQUARE1. SQUARE1 may not agree with this request when it is felt to be in the client's best interest to release the information and/or when such a release is mandated by the uses outlined in section A. above.

4. **The right to request that communications between the client and SQUARE1 be kept confidential.**

### C. Duties of SQUARE1

1. **Maintaining privacy.** SQUARE1 is required by law to maintain the privacy of protected counseling information and to provide and abide by this notice of its legal duties and privacy practices.

### D. Effective date and changes

1. This notice is effective from June, 2019 and is made available to all clients during the initial interview. Copies of the notice may be obtained by requesting them from SQUARE1. SQUARE1 reserves the right to make changes to this notice and/or its policies without notification other than posting or making available copies of revised notices in locations as described above. Such changes, if and when made, will become effective for all of the client information that SQUARE1 maintains.

### E. Information and complaints

1. Clients may file complaints regarding the security and/or privacy of their personal counseling information with:

Dr. Michele Thorne, Ph.D., HSPP
Clinical Director
374 Shadow Creek Pass
Greenfield, Indiana 46140

Additionally, clients may file formal complaints about possible violations of the privacy rules with the United States Department of Health and Human Services at:

Office of Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
OR
OCR Hotline – 1-800-368-1019

# LIMITS ON PATIENT CONFIDENTIALITY

**PATIENT NAME** _____

We are REQUIRED to disclose confidential information if any of the following conditions exist:

1. You are a danger to yourself or others.
2. You seek treatment to avoid detection or apprehension or enable anyone to commit a crime.
3. Your therapist was appointed by the courts to evaluate you.
4. Your contact with your therapist is for the purpose of determining sanity in a criminal proceeding.
5. Your contact is for the purpose of establishing your competence.
6. The contact is one in which your psychotherapist must file a report to a public employer or as to information required to be recorded in a public office, if such report or record is open to public inspection.
7. You are under the age of 16 years and are the victim of a crime.
8. You are a minor and your psychotherapist reasonably suspects you are the victim of child abuse.
9. You are a person over the age of 65 and your psychotherapist believes you are the victim of physical abuse. Your therapist may disclose information if you are the victim of emotional abuse.
10. You die and the communication is important to decide an issue concerning a deed or conveyance, will or other writing executed by you affecting as interest in property.
11. You file suit against your therapist for breach of duty or your therapist files suit against you.
12. You have filed suit against anyone and have claimed mental/emotional damages as part of the suit.
13. You waive your rights to privilege or give consent to limited disclosure by your therapist.
14. Your insurance company paying for services has the right to review all records.

**If you have any questions about these limitations, please discuss them with your therapist.**

Signature:_____Date: _____

I am consenting to my (or my dependent) receiving outpatient treatment.

# RELEASE OF INFORMATION **SCHOOL**

**PATIENT NAME**

I authorize SQUARE1 to contact:

School Name_____

Address _____

Information To Be Released By Or Exchanged:

___History and Physical Exam
___Discharge Summary
___Psychiatric Evaluation
___Psychological Test Results
___Chemical Recovery History
___Dates of Hospitalization
___Court/Agency Documents
___Mental Status
___Treatment Plans
___ Progress Notes
___Therapist Orders
___Diagnoses
___Crisis Intervention Reports
___Medical Records
___Family Systems Eval
___Nursing Notes
___Consultation Reports
___Educational Records
___Educational-Tests and Reports
___Attendance Record
_ Psychosocial Report
___Lab results

Other (specify)_____

Signature:_____ Date: _____


# RELEASE OF INFORMATION-PRIMARY PHYSICIAN

**PATIENT NAME** _____

I authorize SQUARE1 to contact:

Name of Doctor_____

Address _____

Information To Be Released By Or Exchanged:

___History and Physical Exam
___Discharge Summary
___Psychiatric Evaluation
___Psychological Test Results
___Chemical Recovery History
___Dates of Hospitalization
___Court/Agency Documents
___Mental Status
___Treatment Plans
___ Progress Notes
___Therapist Orders
___Diagnoses
___Crisis Intervention Reports
___Medical Records
___Family Systems Eval
___Nursing Notes
___Consultation Reports
___Educational Records
___Educational-Tests and Reports
___Attendance Record
___Psychosocial Report
___Lab results

Other (specify)_____

Signature:_____ Date: _____


# RELEASE OF INFORMATION

**PATIENT NAME**

I authorize SQUARE1 to contact:

Name_____

Address _____

Information To Be Released By Or Exchanged:

___History and Physical Exam
___Discharge Summary
___Psychiatric Evaluation
___Psychological Test Results
___Chemical Recovery History
___Dates of Hospitalization
___Court/Agency Documents
___Mental Status
___Treatment Plans
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___Medical Records
___Family Systems Eval
___Nursing Notes
___Consultation Reports
___Educational Records
___Educational-Tests and Reports
___Attendance Record
___Psychosocial Report
___Lab results

Other (specify)_____

Signature:_____ Date: _____