Dr. Gail Poyner, Licensed Psychologist
Poyner Mental Health Services
14453 SE 29TH SUITE D CHOCTAW OK 73020
405.741.2844

BIOPSYCHOSOCIAL INTAKE

Important: Please fill out this form with detailed information. We review it prior to seeing you so that we can begin developing an understanding of your problems and how we can best meet your needs. "You" means the patient (yourself/your child).

PATIENT NAME:

PARENT NAME (IF CHILD):

DATE OF BIRTH:

PHONE NUMBER:

ADDRESS:

EMAIL ADDRESS:

EMERGENCY NAME AND PHONE #

1. Please describe, ***in detail***, the problems you're currently experiencing:

2. How long have you been experiencing these problems?

3. How have these problems been impacting your daily functioning?

Please put a check next to problems you are currently experiencing:

Anxiety	☐	No Need for Sleep	☐	Low Self-Esteem	☐
Depression	☐	Talking too Fast	☐	Increased Stress	☐
Sadness	☐	Panic Attacks	☐	Hearing Voices	☐
Social Withdrawal	☐	Poor Attention	☐	Seeing Things	☐
Appetite Changes	☐	Hyperactivity	☐	Abuse	☐
Sleep Problems	☐	Poor Concentration	☐	Financial	☐
Little Interest	☐	Poor Memory	☐	Medical Problems	☐
Feel Hopeless	☐	Impulsive	☐	Substance Abuse	☐
Feel Helpless	☐	Behavior Problems	☐	Trauma	☐
Irritability	☐	School Problems	☐	Legal	☐
Low Energy	☐	Relationship Issues	☐	OTHER	☐
Poor Memory	☐	Suspiciousness	☐		
Fearful	☐	Marital Problems	☐		
Isolation	☐	Divorce	☐		
Argumentative	☐	Loss/Grief	☐		
Critical	☐	Work Problems	☐		

Are you applying for Disability? Check One: ☐ YES ☐ NO

1. Are you having thoughts of suicide currently? ☐ YES ☐ NO If YES, please describe:

2. Have you ever attempted suicide? ☐ YES ☐ NO If YES, please describe (when, how):

3. Have you ever purposely cut, burned, or in some way tried to harm yourself?
   ☐ YES ☐ NO If YES, please describe:
   - How?
   - When and for how long:

4. Have you ever had <u>inpatient</u> mental health treatment? ☐ YES ☐ NO If YES:
   - When and for how long:
   - Describe the outcome:

5. Have you ever had counseling? ☐ YES ☐ NO If YES:
   - When and for how long:
   - Describe the outcome:

6. Have you ever taken medication for your mental health? ☐ YES ☐ NO If YES:
   - What medication and when:
   - Have any of the medications worked for you? ☐ YES ☐ NO If YES, which one(s):

7. Please list any medical problems you have:

8. Please list any medication(s) you are currently taking:

9. Have you ever experienced a head injury and/or concussions? ☐ YES ☐ NO If YES, please describe:

1. Have you ever experienced any traumatic events? ☐ YES ☐ NO If YES, only describe what you feel comfortable sharing.

2. Briefly describe your childhood and relationships with family members at the time:

3. Briefly describe your current family relationships:

4. Describe the quality of your relationships outside your family (friends, coworkers, etc.):

5. What do you do for fun?

1. Do you/did you have any head injuries, developmental or learning problems? ☐ YES ☐ NO If YES, please describe:

2. Describe your educational history (last grade completed, history of grades, history of any problems, etc.):

3. Describe any behavioral problems you're currently having:

4. Please describe your occupational history (where you work, past and current relationships with superiors and coworkers, ever been fired, job satisfaction, etc.):

5. Have you ever abused illegal and/or prescription drugs? ☐ YES ☐ NO If YES, please describe:

6. Have you ever had legal problems that led to an arrest, jail, or prison? ☐ YES ☐ NO If YES, please describe:

7. How many hours per day do you watch television? How many hours per day do you play videogames?

PLEASE PROVIDE US WITH ANY OTHER INFORMATION YOU BELIEVE WE NEED:

POYNER
mental health services
14453 SE 29th Street Suite D
Choctaw, OK 73020
(405) 741-2844

INFORMED CONSENT FOR TREATMENT AND/OR OTHER SERVICES CONTRACT

Welcome to the practice. This document contains important information about the professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them. By signing this document, you certify that you have read it in its entirety (six pages), understand it, agree with and will abide by each provision.

IMPORTANT

- For their safety, children under the age of 13 cannot be left alone in the waiting room. Parents/Guardians are ultimately responsible for the safety of their children, including those 13 or older when left in the waiting room unsupervised.
- For everyone's safety, firearms, knives or other weapons are not allowed on the premises.
- To keep our office clean: no food or drink (other than water or food for babies) are allowed inside the building.
- Regarding substances: smoking and vaping are not allowed within 30 feet of our office, and no illicit drugs or alcohol are allowed on the premises.

THERAPY SERVICES

Psychotherapy varies depending on the personalities of the clinician and patient and the particular problems you hope to address. There are many different methods we may use in therapy. Psychotherapy calls for an active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about during our sessions and at home. Psychotherapy can have benefits and risks. Because therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings. On the other hand, although there are no guarantees as to what you will experience, psychotherapy has also been shown to have benefits for people who go through it. If you have concerns about working with us, it is important that we discuss them. However, to best meet your needs, we are always willing to facilitate a referral to another mental health professional. The same is true if we believe we are not the best office to meet your needs. Therapy typically consists of a once-weekly 50-minute session, but could occur more or less often depending on circumstances. Note: We cannot guarantee that you will be given appointments on a same day or same time basis.

TESTING, ASSESSMENTS AND EVALUATIONS

Occasionally during counseling/medication management sessions we will administer brief testing. Most often, evaluations are a 2-3 hour initial session with an assessor followed by a results session after the timely return of all the required assessments. Please see the Testing Agreement for more information. Important: Your insurance statements may show services on a date when you or your child were not in the office. This is because we are allowed to charge for test scoring, interpretation and report writing. You will be responsible for co-pays as directed by your insurance.

MEDICATION MANAGEMENT

Medication management is a separate service from therapy and testing offered at our office. The physician assistant who provides this service is capable of managing all psychiatric medications and offers goal-focused counseling during sessions. This is intended to aid in reducing or eliminating unwanted symptoms, to help you or your child achieve greater psychological comfort, to improve behavioral functioning and/or self control and achieve better adjustment to life circumstances. Not all cases are best managed by our provider so we will refer potential clients to more extensive psychiatric services as needed.

MEETINGS, PROFESSIONAL FEES, BILLING AND PAYMENTS

The hourly fee for therapy is $100. The hourly fee for testing is $175. The hourly fee for medication management is $200. You will be expected to pay for each service at the time it is given unless we agree otherwise, or unless you have insurance covering the services provided. Payments include but are not limited to self-pay, **co-pays**, **deductibles**, no shows and/or late cancellation fees. We reserve the right to charge a $65 no-show fee or late cancellation fee to the card on file, unless certain circumstances apply, as well as a $50 fee for returned checks. If your account has not been paid for more than 30 days and arrangements for payment have not been agreed upon, we will attempt to charge the card on file, then use legal means and/or collections. If these actions are necessary, their costs will be included in the claims. In most situations, the only information we will release regarding a patient's treatment is his/her name, the dates, times, and nature of services provided and the amount due.

If you have a health insurance policy, it will usually provide coverage for mental health treatment. However, you (not your insurance company) are responsible for the full payment of fees. ***You understand and agree that it is your responsibility to obtain any preauthorization of services required by your insurance—even if we have contacted your insurance and receive authorization or have attempted to receive authorization. If you do not obtain preauthorization and it is required by your insurance, you acknowledge that you are responsible for payment.*** Although we will do our best to determine if your insurance covers our services, we cannot guarantee coverage or continued coverage. Please read your insurance coverage information and call your plan administrator if you have any concerns about payment. You should also be aware that most insurance companies require that we provide them with your clinical diagnosis, but sometimes we are required to provide additional clinical information, such as treatment plans, progress notes, summaries or copies of the entire record (in rare cases). We cannot guarantee that your insurance company will keep your records confidential. Please call your plan administrator if you have any concerns. ***By using your insurance, you authorize us to release such information to your insurance company.***

If you become involved in legal proceedings that require our participation, you will be expected to pay for any professional time the provider spends on your legal matter, even if the request comes from another party. In the case of parenting and/or child issues, if we are required to testify, we will **NOT** give an opinion about either parent's custody, visitation, suitability, or fitness. If the court appoints a custody evaluator or *guardian ad litem* (GAL), we will only provide information if appropriate releases are signed or a court order is provided. Phone calls with a GAL will be charged at a rate of $50 per 30 minutes. If a provider is required to appear as a witness or perform work related to any legal matter, the party responsible for their participation agrees to reimburse them at the rate of $500 per hour for time spent traveling, speaking with attorneys, reviewing and preparing documents, testifying, being in attendance and/or any other case-related costs. **Important**: Your insurance will *not* cover legal services or fees.

COMMUNICATION

Regular business hours are M-Th from 8:00 a.m. – 5:00 p.m. We are closed on Friday unless you have a special arrangement. If you are unable to reach us and there is an emergency (i.e. thoughts of suicide/homicide/self-harm) you must call 911 or go to the nearest emergency room. The providers are often not immediately available by telephone. The phone is answered by office staff who work during regular business hours or voice mail. Our office will make every effort to return your call within 24 hours with the exception of weekends and holidays. We highly recommend scheduling an appointment for anything you would like to discuss with a provider as their schedules do not allow for returning phone calls directly. We have a separate voicemail specifically for medication refill requests as our administrative staff does not have the training to help with these requests. We request you leave **one message per request** for the provider to handle. Multiple messages will increase the time it takes for your request to be handled. We do have an email that the administrative staff manages during regular business hours as a secondary communication option. This email address is poynermentalhealthservices@protonmail.com and is HIPAA compliant. We will use this email to send paperwork and discuss scheduling and billing topics as needed. We do not communicate via social media with patients, nor do we respond to this type of communication from anyone in treatment with one of our providers. When you provide this office with a telephone number and/or email, you are giving the staff permission to contact you and/or leave a voicemail, unless you state otherwise in writing. In addition, you give us permission to fax or electronically transmit billing and/or collections information. Finally, you give the staff permission to fax information you have approved with a signed release of confidentiality (such as records) or is mandated by an outside entity (i.e. legal or protective services). We reserve the right to charge ten cents per page of copied material.

ACCESS AND STORAGE OF RECORDS AND ELECTRONIC HEALTH INFORMATION

Your records are stored in the following manners: Paper file that is stored in a locked office in a locked file cabinet and/or in an electronic file that is protected by encryption.

DRIVING IMPAIRMENT

We respectfully request that you be free of alcohol or other intoxicants prior to to the office. If, during the session, the provider comes to suspect that your senses are impaired in any way, we will address that concern to determine if we can continue the appointment. If, in fact, you are "intoxicated" for whatever reason, the session will end and the provider or office staff will attempt to make arrangements for safe transportation from the office (i.e. calling a relative, friend, emergency contact, or calling a taxi cab). If, for some reason, you refuse to cooperate, then we have the option to contact the police in order to ensure your safety and the safety of others. In the event that an appointment is ended due to suspected intoxication, the full fee for the session will be due, regardless of the actual duration of the session. If we have realistic concerns related to your ability to drive safely because of, but not limited to, mental illness, dementia or a medical problems, we reserve the right to contact the Department of Public Safety in that regard.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a clinician is protected by law. Releasing information requires your written permission except in certain circumstances. If a judge orders a provider's testimony or records, we must comply. We are legally required to take protective actions if we believe that a child, vulnerable adult or elderly person is being abused or has

been abused, or if we believe a person has the intention or plan to hurt themselves or another person. These actions may include notifying a state agency and/or a potential victim and/or contacting the police and/or seeking inpatient care. However, we will attempt to fully discuss it with you before taking any action.

You should be aware that the practice employs multiple health professionals including administrative staff. In most cases, we need to share protected information with these individuals for both clinical (consultation with clinicians only) and administrative staff for such services as scheduling, billing and quality assurance. During a consultation, we make every effort to avoid revealing the identity of the patient, and any clinician consulted is also legally bound to keep the information confidential. Ordinarily, we will not tell you about these consultations unless we believe that it is important to our work together. All clinicians and staff members will be given training about protecting your privacy and will agree not to release any information outside of the practice without the permission of a professional staff member.

Although this written summary of exceptions to confidentiality is intended to inform you about potential issues that could arise, it is important that we discuss any questions or concerns you have. We will be happy to discuss these issues with you and provide clarification upon your request. However, if you need specific clarification or advice we are unable to provide, formal legal advice may be needed, as the laws governing confidentiality are quite complex.

PARENT AUTHORIZATION FOR MINOR'S MENTAL HEALTH TREATMENT

In order to authorize mental health treatment for your child, you must have either sole or joint legal custody of your child. If you are separated or divorced from the other parent of your child, please notify the office immediately. You must provide the office with a copy of the most recent custody decree that establishes custody rights of you and the other parent or otherwise demonstrates that you have the right to authorize treatment for your child. You must furnish signed copies of this Informed Consent by both custodial parents for our office to be able to schedule your child as a new client. If you are separated or divorced from the child's other parent, please be aware that we may find it necessary to contact the other parent and advise them of appointments with your child.

One risk of child therapy involves disagreement among parents and/or disagreement between parents and the provider regarding the child's treatment. If such disagreements occur, the provider will listen carefully so that they can understand your perspectives and fully explain their perspective. Ultimately, parents decide whether treatment will continue. If either parent decides that treatment should end, we will honor that decision unless there are extraordinary circumstances. However, in most cases, we will ask that you allow me the option of having a few closing appointments with your child to appropriately end the treatment relationship.

In the course of treatment of your child, the provider may meet with the child's parents/guardians separately or together. Note: the patient is your child – not the parents/guardians/siblings/other family members of the child. If the provider meets with you or other family members in the course of your child's treatment, they may document the meeting in your child's treatment records. Please be aware that progress notes will be available to any person or entity that has legal access to your child's treatment record. In some situations, we are required by law or by the guidelines of governing boards to disclose information, whether or not the provider has you or your child's permission. We have listed some of these situations below.

Confidentiality ***cannot be maintained*** when:

- A child tells the provider they plan to cause serious harm or death to themselves, and they believe the child has the intent and ability to carry out this threat in the very near future. The provider must take steps to inform a parent or guardian or others of what the child has told them and how serious they believe this threat to be and to try to prevent the occurrence of such harm.
- A child tells the provider they plan to cause serious harm or death to someone else, and they believe the child has the intent and ability to carry out this threat in the very near future. In this situation, the provider must inform a parent or guardian or others, and they may be required to inform the police and/or the person who is the target of the threatened harm.
- A child is doing things that could cause serious harm to them or someone else, even if they do not intend to harm themselves or another person. In these situations, the provider will need to use their professional judgment to decide whether a parent or guardian should be informed.
- A child tells the provider, or they otherwise learn that, it appears that a child is being neglected or abused--physically, sexually or emotionally--or that it appears that they have been neglected or abused in the past. In this situation, the provider is required by law to report the alleged abuse to the appropriate state child-protective agency.
- The provider is ordered by a court to disclose information.

DISCLOSURE OF MINOR'S TREATMENT INFORMATION TO PARENTS

Treatment is most effective when a trusting relationship exists between the clinician and the patient. Privacy is especially important in earning and keeping that trust. As a result, it is important for children to feel free to discuss personal matters without fear that their thoughts and feelings will be immediately communicated to their parents. It is office policy to provide you with general information about your child's treatment, but not to share specific information your child has disclosed to the provider without your child's agreement, unless what is shared puts the child in danger. You can always ask the provider questions about the types of information they would disclose. Even when we have agreed to keep your child's treatment information confidential from you, the provider may believe that it is important for you to know about a particular situation that is going on in your child's life. As such, when meeting with you, the provider may sometimes describe your child's problems in general terms, without using specifics, in order to help you know how to be more helpful to your child.

PARENT/GUARDIAN AGREEMENT NOT TO USE MINOR'S THERAPY INFORMATION/RECORDS IN CUSTODY LITIGATION

When a family is in conflict, particularly conflict due to parental separation or divorce, it is very difficult for everyone, particularly for children. Although the provider's responsibility to your child may require helping to address conflicts between the child's parents, the provider's role will be strictly limited to providing treatment to your child. You agree that in any child custody/visitation proceedings, neither of you will seek to subpoena records or ask the provider to testify in court, whether in person or by affidavit, or to provide letters or documentation expressing their opinion about any matter related to you or your child. However, your agreement may not prevent a judge from ordering the provider's testimony. If the provider is required to testify, they are ethically bound not to give their opinion about either parent's custody, visitation suitability, or fitness. If the court appoints a GAL or Child Protective Services is involved, the provider may be compelled to release information.

NOTICE OF POLICY AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION (PHI)
Health Insurance Portability and Accountability Act (HIPAA)

This notice describes how mental health and medical information about you may be used and disclosed and how you can obtain access to this information. **Please review this policy carefully.**

I. Uses and Disclosures for Treatment, Payment and Health Care Operations

We may use or disclose your Protected Health Information (PHI) for treatment, payment and healthcare operations and purposes with your consent. To help clarify these terms, here are some definitions:

a. "PHI" refers to information in your health record that could identify you.
b. Treatment, Payment and Health Care Operations:
    - "Treatment" is when the provider provides, coordinates or manages your health care and other services related to your health. An example of treatment would be when the provider consults with another health care provider, such as your family physician, primary care physician or another clinician.
    - "Payment" is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your healthcare or to determine eligibility or coverage.
    - "Health Care Operations" are activities that relate to the performance and operation of my practice. Examples of Health Care Operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, case management and care coordination.
c. "Use" applies on to activities within the office/practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
d. "Disclosure" applies to activities outside the office/practice such as releasing, transferring or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse or Neglect: If the provider has reason to believe that a child under the age of 18 years is the victim of abuse or neglect, the law requires that the provider makes a report to the appropriate government agency, usually to the Department of Human Services. Once such a report is filed, the provider may be required to provide additional information.
- Adult or Domestic Abuse: If I have reason to believe that a vulnerable adult is suffering from abuse, neglect or exploitation, the provider is required by law to make a report to either the Oklahoma Department of Human Services, the District Attorney's office or the Municipal Police Department as soon as the provider becomes aware of the situation. A vulnerable adult means an individual who is an incapacitated person who, because of physical or mental disability, incapability or other disability, is substantially impaired in the ability to provide adequately for the care or custody of him/herself, or is unable to

manage his/her property and financial affairs effectively, or to meet essential requirements for mental or physical health or safety, or to protect him/herself from abuse, neglect or exploitation without assistance from others.

- Health Oversight: If you file a disciplinary complaint against your provider with the Oklahoma State Board of Examiners of Psychologists, Oklahoma State Board of Mental Health, or the Oklahoma Medical Board, they would have the right to view your relevant confidential information as part of the proceedings.
- Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnoses and treatment and records thereof, such information is privileged under State law and we will not release the information without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health and Safety: If you communicate to the provider an explicit threat to kill or inflict serious bodily injury upon a reasonably identifiable person, and you have the apparent intent and ability to carry out that threat, the provider has the legal duty to take reasonable precautions. These precautions may include disclosing relevant information from your mental health records, which is essential to protect the rights and safety of others. The provider also has such a duty if you have a history of physical violence of which they are aware, and they have reason to believe there is a clear and imminent danger that you will attempt to kill or inflict serious bodily injury upon a reasonably identifiable person.
- Worker's Compensation: If you file a Worker's Compensation claim, you will be giving permission for the Administrator of the Worker's Compensation Court, the Oklahoma Insurance Commissioner, Attorney General or District Attorney (or a designee for any of these) to examine your records relating to the claim.
- Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as text messages, emails or letters).
- Agency Review: As an agency contracted with the State of Oklahoma, PHI can be released to the Oklahoma Health Care Authority or Oklahoma Department of Mental Health and Substance Abuse Services for oversight activities as authorized by law, including conducting or arranging for a medical review, auditing functions, including fraud, abuse detection and compliance programs. In addition, our compliance officer conducts periodic quality control audits or institutional reviews which will require access to your records.

III. Patient's Rights and Clinician's Duties

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer (Kim Woodhouse, LPC) at 14453 SE 29th St. Suite D, Choctaw, OK 73020:

- Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of Protected Health Information about you. However, we are not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:
  You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a counselor at our office. Upon your request, the office will send your bills to another address.)

- Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, the office will discuss with you the details of the request and denial process.
- Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. The office may deny your request, but on your request, we will discuss with you the amendment process.
- Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, the office will discuss with you the details of the accounting process.
- Right to a Paper Copy: You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.
- Clinician's Duties: We are required by law to maintain the privacy of PHI and to provide you with a notice of legal duties and privacy practices. The office reserves the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, the office is required to abide by the terms currently in effect. If we revise our policies and procedures, the office will notify you in writing by mail, or at your next appointment.

IV. Questions and Complaints

If you desire further information about our privacy practices, or if you have questions, please contact this office. If you are concerned that your privacy rights have been violated or you disagree with a decision I made about access to your records, you may contact the Privacy Officer (Kim Woodhouse, LPC) of Poyner Mental Health Services at 14453 SE 29th St. Ste. D Choctaw, OK 73020.

You may also send a written question or complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

V. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on January 1, 2024. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. The office will provide you with a revised notice in writing by mail or at your next appointment.

You have the right to services:

- That respect your privacy and dignity; that they are provided in a prompt, courteous and respectful manner;
- That respect your cultural and ethnic identity, religion, disability, gender, age, marital status and sexual orientation;
- That are provided in a physical environment that is safe, sanitary, allows for effective treatment and which safeguards the privacy and confidentiality of interactions with your provider;
- From providers who are qualified, competent, focused on your care, and reasonably accessible to you;
- That emphasize your participation in developing a treatment plan specific to your needs and include your agreement to work toward defined goals;
- That in relation to admission, discharge or treatment, are free of discrimination on the basis of age, sex, race, creed, color, national origin, ethnicity, religion, pregnancy, marital status, disability or sexual orientation.

Rights to Current Information Concerning:

- Your diagnosis, recommended appropriate or medically necessary treatment options that relate to your care, potential alternatives and accompanying risks, benefits and costs (in writing for Medicare patients). This information, regardless of cost or benefit coverage, will be explained in terms and in a language that you can reasonably understand;
- Written financial agreements in which you entered for treatment services rendered;
- Possible consequences or conditions under which you may be transferred to another treatment program or therapist and the accompanying risks, benefits and costs of such a transfer;
- Names and credentials of providers involved in your care;
- Your responsibilities to ensure better treatment outcomes;
- Your records and having information explained or interpreted as necessary, except when protected or restricted by law;
- How to access emergency services needed outside of normal business hours or when you are away from you usual place of residence or work;
- How your healthcare insurance plan evaluates new technology for inclusion as a covered benefit;
- How to select a new behavior healthcare delivery office or provider if your current provider is affected by termination or closure;
- Resources and procedures available through your healthcare insurance plan for communicating concerns or questions, for expressing dissatisfaction with services or care, and for requesting an appeal if not satisfied with any decisions regarding dissatisfaction with services or care;
- Services available to you and charges for those services including services not covered under health plan's benefits.

INFORMED CONSENT FOR TREATMENT AND/OR OTHER SERVICES CONTRACT

Patient Name: _____ Guardian: (if patient is a child): _____

The client or responsible party must sign this form before services can begin.

By signing below, I certify that I have read, had any questions answered, fully understand, agree with and will abide by the provisions contained in the entire INFORMED CONSENT FOR TREATMENT AND/OR OTHER SERVICES CONTRACT. If you would like a copy of this document, please let us know.

_____ _____

Patient or Guardian or Authorized Patient Representative Date

POYNER
mental health services
14453 SE 29th Street Suite D
Choctaw, OK 73020
(405) 741-2844

Appointment Reminders

We can now send you appointment confirmation messages and reminders by text message and email. If you wish to receive these messages we require your consent.

If you wish to receive these messages, please read the disclaimer below then complete and sign.

I consent to Poyner Mental Health Services contacting me by text message and email for the purposes of appointment reminders.

I acknowledge that appointment reminders by text and email are an additional service and that these <u>may not</u> take place on all occasions, and that the responsibility of attending appointments or canceling them still rests with me. I can cancel the reminders at any time.

I acknowledge that Poyner Mental Health Services can only have one phone on file for reminders and will **<u>not</u>** be responsible for contacting any other parent/guardians for appointment reminders.

Text messages and emails are generated using a secure platform. I understand that they are transmitted over a public network onto a personal device and as such may not be secure. However, the practice will not transmit any information which would enable an individual patient to be identified.

I agree to advise the practice if my mobile number or email changes or is no longer in my possession.

Patient Name_____ Date of birth_____

Name of parent/guardian (If applicable)_____

Mobile Number_____ Email_____

By signing I agree to all the terms and conditions above.

Signature _____ Date_____

Credit Card Consent Form

Poyner Mental Health Services requires all patients to securely store a form of payment by credit card for all patients. You may still choose to pay by cash, check, HSA, or credit card on the day of your appointment, and your card information will only be kept on file to be used in the case of account balances over 30 days past due or no show/late cancellation fees. Patients who cancel counseling or medication management appointments with less than 24 hours notice, arrive 15 minutes or more past their scheduled appointment, or do not show up for scheduled appointments will be charged a $65 fee. Patients who cancel testing appointments with less than 48 hours notice, arrive 15 minutes or more past their scheduled appointment, or do not show up for the scheduled appointment will be charged a $200 fee.

A fee ***WILL*** be automatically charged to the card on file if an appointment is not canceled with enough notice.

By signing below, I understand and agree to the terms of this agreement, agree to pay, and specifically authorize the charging of my credit card as stipulated. I further agree that in the event my credit card becomes invalid, I will provide a valid credit card upon request to be charged for the payment of any outstanding balances owed. Delinquent accounts may be sent to collections if a payment plan has not been set up within 30 days of account finalization.

Patient Name: _____

If you would like an unsecured emailed copy of your receipts, please identify the address you would like used below:

_____

Last Four Digits of Card Number ___ ___ ___ ___

Name on Credit Card: _____

Signature of Guarantor for Payment: _____ Date: _____

This credit card authorization will remain in effect and on file with Poyner Mental Health Services unless revoked in writing or until the therapeutic relationship is terminated, at which time, authorization to charge your credit card will be revoked, unless an outstanding balance remains on your account after termination.

Please send completed paperwork to this email: poynermentalhealthservices@protonmail.com

Testing/Assessment Agreement

Patient Name: _____Date of Birth: _____

General Information

Testing or assessments are conducted for the purposes of diagnostic clarification and treatment planning. It is often a useful tool in the course of understanding the nature of the problem and to figure out the best way to go about addressing it.

Psychological Evaluations are a service provided by a Licensed Psychologist (Doctoral level practitioner). Psychologists can diagnose and provide recommendations. **Only Dr. Gail Poyner can conduct a psychological evaluation at our office.**

Assessments conducted by a Licensed Professional Counselor (LPC; Master's level practitioner) provide insight about an individual's various areas of functioning (e.g., emotional, behavioral, and environmental) and help to form a profile that informs the treatment planning process. LPCs conduct evaluations specific to the referral request. If you have any questions about the education or qualifications of the clinician to perform the assessment, please ask at the intake appointment.

Each assessment tool is specifically chosen to answer the referral question(s). The selection of assessment tools attempts to maximize the validity of the results, while minimizing time and cost. Tests must be properly administered, scored, interpreted, and then a brief summary is written. It can take about 2 to 3 weeks from the time the last test data is received for a written report to be completed. Paperwork is often sent both physically and electronically to teachers, parents, or other informants in order to obtain the most accurate results. The assessor has a short window of time to complete the scoring process. All paperwork must be returned to us within 30 days or the results will not be considered valid. Once this window of time to return paperwork has passed, the assessor must begin the entire testing process again. It is your responsibility to make sure all assessment paperwork is returned in a timely fashion and communicate any obstacles you encounter.

The assessor conducting the assessment will be: Gail Poyner, PhD (Oklahoma license 950), Kim Woodhouse, LPC (Oklahoma license 6955), or Helen Allred, LPC (Oklahoma license 3708). The practice of Licensed Psychologists is regulated by the Oklahoma State Board of Examiners of Psychologists. The address by which this regulatory body can be reached is: 421 NW 13th Street, Suite 180 Oklahoma City, OK 73103. The phone number is (405) 522-1333 and their website is https://www.ok.gov/psychology/. The practice of Licensed Professional Counselor's is regulated by the State Board of Behavioral Health. The address by which this regulatory body can be reached is: 3815 N. Santa Fe, Suite 110, Oklahoma City, OK 73118. The phone number is (405) 522-3696 and their website is https://www.ok.gov/behavioralhealth/

People understandably enter the testing process with many different expectations. However, no diagnosis or outcome is ever guaranteed, and there is no guarantee that patients or other involved parties will be happy with the results (i.e., diagnosis and/or report of patient's functioning). At times, people who have requested testing have not agreed with the results. We will do our best to explain the outcomes of testing. Assessors are bound by ethical and legal standards which prohibit them from deleting or altering information that becomes part of the testing record. If it is relevant to the case, it will go in the report. While we strive to maintain the confidentiality

of our patients as required by law, we may be required to provide information to a court as mandated by a judge or as may otherwise be legally required.

Your Rights

You have the right to inquire about the nature and purpose of all tests and procedures, and you have the right to receive feedback about test results/interpretations/recommendations, unless there is an entity that can legally state otherwise. In these cases, no confidentiality exists and we have no control over who has access to the information. In certain cases (legal, child protective cases, military, Social Security disability and others), the results of an evaluation could have the potential to positively or negatively impact a person, but you *always* have the right to refuse to participate in an evaluation.

Insurance and Financial Obligations

Currently, Poyner Mental Health Services accepts payment directly from some insurance companies. We will make every effort to verify benefits and coverage before services begin and strive to follow the insurance company's requirements and procedures to obtain payment. However, payment from insurance is never guaranteed, even if testing has been preauthorized. The insurance company may not consider certain kinds of testing "medically necessary" or it may not cover testing for certain diagnoses. Even if pre-authorization has been received, insurance may ultimately refuse to pay for any testing services at all or may only pay for a portion of the total amount billed. The patient is always responsible to pay coinsurance, co-pays, deductibles and other amounts not covered by insurance.

If the patient expects to seek insurance payment, *the patient (or the person who has assumed financial responsibility for the patient) is solely responsible* to verify the terms under which psychological or neuropsychological testing services are covered and should communicate those requirements to Poyner Mental Health Services prior to the first appointment. The business website has a guide entitled "Insurance Verification Sheet for Testing/Assessments" which outlines the steps to be followed when calling the insurance company to verify coverage. This completed guide should be returned to Poyner Mental Health Services before scheduling the initial appointment.

Payment and Cancellation Information

We accept cash, checks, most major credit cards, and HSA or FSA funds. We will hold credit card information on file before the first appointment and charge for any outstanding balances, unless an alternate payment arrangement is made.

For out-of-network services and private pay agreements, we will bill the patient the full hourly rate of $175/hour. In these cases, half of the total charge must be paid by the first appointment and the other half must be paid by the feedback session. Regardless of the results, payment in full is required by the feedback session. Test reports will not be released until the account is paid in full.

If we have a contract with your insurance company, we will not bill for in-network covered services above the rate we have agreed to with your insurance company. The rate varies among different insurance plans. We generally bill insurance at the time of service and the patient (or the person assuming financial responsibility for the patient) is responsible to pay the balance for any services that insurance does not cover, at the contracted rate. Some insurance companies do not make incremental payments for each day that testing is administered. Instead, they pay in a lump sum once the testing and related report have been completed. Please be aware that the insurance claim may therefore only show one date of service which may be the day the report is written and not a day when the patient was seen. The patient must also inform Poyner Mental Health Services if insurance changes or is expected to change during the patient's assessment period. Changes in insurance before testing is complete and a report is written may complicate

reimbursement between multiple insurance companies and may cause the patient to be responsible for a greater portion of the bill.

Testing is time consuming and requires us to dedicate large blocks of time for assessment appointments. Consequently, Poyner Mental Health Services charges a Late Cancellation and No-Show fee equal to $200 for time scheduled for testing. Patients will not be charged for any appointments that are cancelled at least 48 hours (2 full days) in advance or if their appointment time can be filled by another patient. **Patients who fail to arrive as scheduled and have not provided 48 hours' notice will be charged this fee - $200.00.** Additionally, we require a $200.00 retainer before we will schedule another appointment if a patient has cancelled/no-showed previously, which will be returned if the testing is completed and no balance is remaining.

It is important to note that insurance companies DO NOT provide reimbursement for cancelled or "no-show" appointments so these charges will never be eligible for insurance reimbursement. It will be the patient's responsibility to pay. To be fair to other patients who could use the scheduled time, Poyner Mental Health Services reserves the right to refer patients out if appointments are missed/cancelled.

A $50 insufficient funds fee will be charged for any returned checks. The patient will also be responsible for any and all costs associated with collecting outstanding balances for services rendered including referrals to collection agencies, reasonable attorney fees and interest charges.

The patient (or the individual or entity assuming financial responsibility for the patient) should initial and sign below to acknowledge the following:

_____ I **assume total financial responsibility for any testing that is not paid for by insurance for whatever reason.**
_____Testing services may not be considered "medically necessary," the diagnosis may not be covered, or the claim may only be partially reimbursed through insurance, which would leave me financially responsible for all uncovered charges.
_____ Testing may require a pre-authorization or referral, and it is my responsibility to find out if this is necessary before services are rendered.
_____ Poyner Mental Health Services is authorized to provide the patient's insurance company with information the company needs to issue payment.

Choose one:

____*I HAVE called the insurance carrier and asked all necessary questions with respect to verifying coverage and pre-authorization and have communicated those findings to Poyner Mental Health Services so they may file an insurance claim for services.*

____*I HAVE NOT called to verify coverage for psychological testing with the insurance carrier. I choose to proceed knowing that coverage for services may be denied, should I seek insurance reimbursement, and I may be billed and will be responsible for payment for these services.*

____*I choose to proceed without using any insurance, and I will be billed and will be responsible for payment for all services as described above.*

By signing and initialing this document, I acknowledge that I have had the opportunity to read and ask questions about this document and I understand and agree to the information above.

Patient or Parent/Guardian Signature and Printed Name Date

Please return documents to this email: poynermentalhealthservices@protonmail.com

Insurance Verification Sheet for Testing/Assessments

Please call your insurance company using the phone number on your insurance card and complete this form. This will help you to understand your responsibilities as a patient and help you make informed choices for your health care with Poyner Mental Health Services.

Name of Insurance covering Mental Health benefits _____

United Healthcare/Optum does NOT cover testing by Kim Woodhouse, LPC or Helen Allred, LPC

Please ask the questions below and notate the answers:

1. Are Gail Poyner, Ph.D. (NPI 1932141439), *Kim Woodhouse, LPC* (NPI 1114427267), and *Helen Allred, LPC* (NPI 1508189465) of Poyner Mental Health Services (Tax ID 83-4694411) **in-network**?

The following CPT codes will be used for psychological testing: 90791, 96136, 96137, 96138, 96139, 96130, 96131

2. Do I have an individual or family deductible that psychological testing will apply to? If yes, how much is it?

3. Do I have a co-payment and/or co-insurance percentage I am responsible for? If yes, how much?

4. What is my out of pocket amount and has it been met? Is there a different amount for my family?

5. Do the above codes need to be pre-authorized? Do I need a referral from my PCP to authorize testing?

6. Is there a maximum number of hours authorized for testing with this plan?

7. Will my plan cover testing/assessments conducted by a master's level provider **(**not a psychologist**)?**

8. Name of Customer Service Representative: _____

9. What is a reference number for this call: _____

You are ultimately responsible for the cost of testing. This form is to help you understand the potential cost of psychological testing with your insurance benefits.