7000 Houston Rd building 200 suite #21
Florence, KY 41042
Phone: 859-282-0180 Fax: 859-282-0862

DATE: ___________

PATIENT INFORMATION

Name: ____ Gender: M - F – Other

DOB: ____/____/____ AGE: _______

ADDRESS: _______________________ CITY: ________________STATE: _______ ZIP: ____________

STUDENT - MARRIED - DIVORCED - WIDOW - OTHER EXPLAIN_____________________

PHONE: CELL____________________HOME__________________OFFICE_____________________

IS IT OK TO CALL YOU AT THE NUMBERS ABOVE: YES - NO

EMERGENCY CONTACT: ________________PHONE: _______________RELATIONSHIP:____________

EMAIL: _____________________________________IS IT OK TO EMAIL YOU AT THIS EMAIL? YES/NO

Who referred you: ______________________ Primary care physician: _________________________

What is the reason you are seeking treatment:________________________

GUARDIAN INFORMATION

GUARDIAN NAME: ___________________________ RELATIONSHIP TO PATIENT______________________

DOB:____/____/____ AGE:_______ SS#__________________ GENDER: M F OTHER

MARRIED - DIVORCED - WIDOW - OTHER EXPLAIN: __________________________________

ADDRESS: __________________________________CITY: ________________STATE: _____ZIP: _________

PHONE: CELL___________________HOME: ___________________OFFICE: _____________________

IS IT OK TO CALL YOU AT THE ABOVE PHONE NUMBERS? YES / NO ARE YOU EMPLOYED: YES / NO

EMPLOYER: ____

EMAIL: ____

IS IT OK TO EMAIL YOU AT THIS EMAIL: YES NO

RESPONSIBLE PARTY INFORMATION

NAME: ___________________________ RELATIONSHIP TO PATIENT______________________

DOB:____/____/____ AGE:_______ SS#__________________ GENDER: M F OTHER

MARRIED - DIVORCED - WIDOW - OTHER EXPLAIN: __________________________________

ADDRESS: __________________________________CITY: ________________STATE: _____ZIP: _________

PHONE: CELL___________________HOME: ___________________OFFICE: _____________________

IS IT OK TO CALL YOU AT THE ABOVE PHONE NUMBERS? YES / NO ARE YOU EMPLOYED: YES / NO

EMPLOYER: ____

EMAIL: ____

IS IT OK TO EMAIL YOU AT THIS EMAIL: YES NO

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CHILD/ADOLESCENT CLIENT INFORMATION QUESTIONAIRE

CHILD'S NAME_______________________________________DOB____/____/_____

MOTHER'S NAME_______________________ FATHER'S NAME_________________________

MARITAL STATUS: SINGLE ____ MARRIED____ DIVORCED____ SEPARATED ____ WIDOWED ____

IF NOT MARRIED, CUSTODIAL AGREEMENT:

_______JOINT CUSTODY: W/JOINT LEGAL MEDICAL DECISION-MAKING W/ONE PARENT LEGAL MEDICAL DECISION-MAKING

_______ SOLE CUSTODY: W/JOINT LEGAL MEDICAL DECISION- MAKING W/ONE PARENT LEGAL MEDICAL DECISION-MAKING

IS THE PATIENT CURRENTLY, OR IN THE FORESEEABLE FUTURE, SUBJECT OF A CUSTODY/VISITATION ACTION? YES NO

PLEASE INCLUDE A COPY OF ALL COURT/LEGAL DOCUMENTS FOR CUSTODY/ VISITATION/ AND DECISION MAKING ACTIONS

PERMISSION TO TREAT

I UNDERSTAND THE LIMITATIONS OF TREATMENT AND I AUTHORIZE STEVE HOERSTING, M.Ed. TO PROVIDE OUTPATIENT PSYCHOLOGICAL SERVICES FOR:AND I AM LEGALLY ABLE TO DO SO. (sole custody or married joint custody)

*SIGNATURE ____ Date __________________

PRINTED NAME ____

Witness signature _______________________________________ Date _________________

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OFFICE POLICY STATEMENT (please initial next to each statement)

_____ APPOINTMENT PROTOCOLS

Therapy appointments are typically scheduled for 40-45 minutes. You and your therapist will arrange the frequency of appointments that best suits your needs. Your insurance company may only allow for a specific number and frequency of appointments (e.g., every two weeks) Should you wish to make a change in the frequency of appointments please discuss it with your therapist. You must notify the office of termination of services. For this reason, cancellations with less than 48 hours prior notice or missed appointments will be billed directly to you at $85 per occurrence. Since insurance companies will not reimburse for lost time. Effective January 1, 2022 and due to increased demand for services in our office, if you do not show up for your first appointment without prior notice, <u>you will NOT be rescheduled</u>. If you are a current patient and do not show up twice for your appointment without prior notice, you will NOT be rescheduled and referred out to other sources in the area. We will provide appointment reminders (text message or call) 2 business days prior to your appointment unless you make a specific request to the contrary.

______ COVID-19 DISCLOSURE

To continue services in person, you agree to take certain precaution which will help keep everyone (you, me, our staff, and other patients) safer from exposure, sickness, and possible death. If you are feeling sick, you MUST cancel your appointment OR change your appointment to a virtual visit. You must follow CDC guidelines of social distancing, hand washing, and sanitizing within our office space. We reserve the right to refuse treatment to anyone who does not adhere to the safety protocols.

______ INSURANCE COVERAGE

If you have health insurance, part of your expenses may be covered. <u>Please call your insurance customer service by locating the customer service number located on the back of your insurance card prior to your appointment to verify services covered.</u> We will submit Insurance claim forms for you. Effective June 1, 2017, we will no longer bill secondary Insurance companies. We will provide the documents necessary for the patient or guardian to file the secondary insurance if you wish to do so. Effective January 2020, we will no longer be accepting any insurance plans using a "third party administrator". This may include self-funded insurance plans and small business plans. Disclaimer: Insurance is billed as a courtesy. I am responsible for the cost of services if the insurance company denies payment, I am responsible for fees of services provided.

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_______ NO SURPRISE ACT (NSA)

Beginning January 2022, we are required by state law to provide a good faith estimate for items and services for uninsured (out of network) and self- pay patients. Psychologists are ethically obligated to discuss fees with patients upfront. We will inform all uninsured and self-pay patients that a good faith estimate of expected charges is available in a written document that is clear, understandable and prominently displayed; orally provided when the service is scheduled or when the patient asks about the costs; and available in accessible formats for patients. We will provide a good faith estimate of expected charges for a scheduled or requested service. Disclaimer: There may be additional items or services recommended as part of the course of care that must be scheduled or requested separately and are not reflected in the good faith estimate. The information in the good faith estimate is only an estimate and the actual services, or charges may differ from the good faith estimate. You have the right to initiate a patient- provider dispute resolution process if the actual billed charges substantially exceed the expected charges included in the good faith estimate.

______ TESTING

Please note that not all types of testing are covered by medical insurance. Educational testing; ie; Dyslexia, Dysgraphia, Dyscalculia or non-verbal learning disorder are typically not considered medically necessary and therefore not considered eligible for reimbursement through your medical insurance plan. ADHD and ADD testing are both considered necessary and eligible under most plans. Out of pocket cost for learning disability testing will be discussed before any testing appointments are made.

______ PAYMENTS

Effective June 1, 2017, we will no longer split payments for patient visits. We have been experiencing increasing complications due to parental disputes regarding the costs associated with treatment. * THE PARENT INITIATING TREATMENT AND BRINGING THE PATIENT IS FULLY RESPONSIBLE FOR THE COSTS OF TREATMENT. we will no longer bill any other non-insurance entity;(ie other parent) It will be up to the parent bringing the patient to obtain reimbursement from the other parent.

_______ NOTICE OF PRIVACY PRACTICES (please ask front desk for a copy or view the posted documents in the office lobby)

Overview: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to offer you a written notice about our privacy practices and new terms of our notice effective for all health information we maintain.

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MISCELLANEOUS FEES AND INTEREST(S)

** $15 will be charged for patient requested forms (FMLA, Disability, School forms including IEP, ALP, and 504 plans, OHI etc).

** $25 will be charged for requested brief letters (including legal, physician or school letters).

**We have a $35 returned check fee. In addition, there will be 35% interest added to the balance of your bill if we are forced to send your account collections.

UNDERSTANDING OF OFFICE POLICY STATEMENTS

I have read the above office policy statements including information regarding appointment protocol, billing, insurance coverage and payments, miscellaneous fees, COVID 19 disclosures and notice of privacy practices and understand the contents. (If you have not received a copy, please ask for one)

*SIGNATURE ____ Date ______________________

PRINTED NAME ____

Witness signature _______________________________________ Date ____________________

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NO SURPRISE ACT 2022

We are required by state law to provide a good faith estimate for items and services for uninsured and self- pay persons. Psychologists are ethically obligated to discuss fees with patients upfront. This new requirement builds on that by adding more structure and specific timeframes for action. We will inform all uninsured and self- pay patients that a good faith estimate of expected charges is available in a written document that is clear, understandable, and prominently displayed; orally provided when the service is scheduled or when the patient asks about the costs; and available in accessible formats for patients. We will provide a good faith estimate of expected charges for a scheduled or requested service. That estimate will be provided within specified timeframes: If the service is scheduled at least three business days before the appointment date, but no later than business day and after the date of scheduling; If the service is scheduled at least 10 business days before the appointment date, no later than three business days after the date of scheduling; or if the uninsured or self-pay patient requests a good faith estimate (without scheduling the service,) no later than three business days after the date of the request. A new good faith estimate must be provided, within the specified timeframe, if the patient reschedules the requested item or service. If any information provided in the estimate changes, a new good faith estimate must be provided no later than 1 business day before the scheduled care. A good faith estimate is based on a notification of expected charges for a scheduled or requested service. The "expected charge" for a service is either the cash pay rate or rate established by the provider for an uninsured (or self- pay) patient, reflecting any discounts for such individuals; or the amount the provider would expect to charge if the provider intended to bill a health care plan directly for such service. The information provided in the good faith estimate is only an estimate, and the actual services or charges may differ from what is included in the good faith estimate. However, uninsured or self-pay individuals may challenge a bill from a provider through a new patient-provider dispute resolution process if the billed charges substantially exceed the expected charges in the good faith estimate of an amount that is at least $400 more than the expected charges listed on the good faith estimate for a specific provider.

Disclaimer: There may be additional items or services recommended as part of the course of care that must be scheduled or requested separately and are not reflected in the good faith estimate. The information in the good faith estimate is only an estimate and the actual services, or charges may differ from the good faith estimate. You have the right to initiate a patient- provider dispute resolution process if the actual billed charges substantially exceed the expected charges included in the good faith estimate. The initiation of a patient-provider dispute resolution will not adversely affect the quality of health care services furnished to the patient-The good faith estimate is not a contract and does not require the uninsured or self-pay individual to obtain the services from our office in the estimate. The Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for a service. The estimate is based on information known at the time the estimate was created. The Good Faith estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill. If you are billed for more than this Good Faith estimate, you have a right to dispute the bill. You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial

assistance available. You may also start a dispute resolution process with the US department of Health and Human Services (HHS) If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call them. Keep a copy of your Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.