Contact Information Sheet

Dr. Raymond M. Fuchs, Ph.D.

Suite 518 Midtown Plaza

330 W. Gray

Norman, Ok

Office (405)217 2964

Fax (405) 217 2408

Must Have Before Leaving:

1. This form filled completely.
2. Copy of Insurance Card
3. Copay/Payment

Patient Information

Patient Name: _____ Date of Birth: _____

Social Security #: _____ - _____ - _____ Gender: M F

Marital Status: _____ Employment or Student Status:_____

Address: _____

City: _____ State: _____ Zip: _____Mobile Phone Number: ( ) _____

Home Phone: ( ) _____ Email: _____

Primary Insurance

Insurance: _____ Insurance ID#: _____

Insurance Policy Group: _____ Insurance Plan Name: _____

Insured Name: _____ Gender: M F Insured DOB:_____

Address: _____

City: _____ State: _____ Zip: _____Insured Phone Number: ( ) _____

Insured Employer: _____ Insured Relationship to Patient:_____

Secondary Insurance

Insurance: _____ Insurance ID#: _____

Insurance Policy Group: _____ Insurance Plan Name: _____

Insured Name: _____ Gender: M F Insured DOB:_____

Address: _____

City: _____ State: _____ Zip: _____Insured Phone Number: ( ) _____

Insured Employer: _____ Insured Relationship to Patient:_____

Billing & Responsible Party

Responsible Party for Payment:_____Relationship to Patient:_____

Responsible Party Address:_____

City:_____State:_____ Zip:_____Phone Number: ( ) _____

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Notice of Privacy Practices and Financial Responsibilities

THIS NOTICE DESCRIBES HOW MEDICAL/PSYCHOLOGICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your individually identifiable health information (also called *protected* health information, or PHI). We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI.

How The Psychologist Or Others May Use Or Disclose Your Health Information.
For Treatment. The report may make recommendations for services, assistance or treatment. For Prevention. If the psychologist's assessment includes a conclusion that a high risk of danger or harm to someone exists, the risk would be reported. For Payment. An invoice is sent to your paying party. As Required By Law. Information will be disclosed as required by law. Examples could be the following: To report information related to victims of abuse, neglect or domestic violence, To assist law enforcement officers in their duties, To report a major felony, To comply with a court order. For Appointments. Your report may have a recommendation for more information that may require other appointments. To Assess For Public Health Risks. Your health information may be used or disclosed for public health agencies/authorities to prevent or control diseases, injuries or disabilities. For Health Oversight Activities. Your information may be disclosed to federal agencies such as Medicare and the State Department of Health for activities related to the health care system or health benefit programs. For Health and Safety. Information may be disclosed if a threat to your health and safety or a threat to someone else's health and safety is thought to exist. For Government Functions. Information may be used or disclosed to protect government employees or the public in general such as a terrorist threat.

Your Health Information Rights.
You have the right to request a restriction or limitation on the information that is used or disclosed. To make such a request, do so in writing and have it arrive in this office within one week of the interview. If the uses and disclosures are changed, the revisions can be obtained through this office. The procedures on the uses and disclosures of the information as described above may also be changed and the new procedures would be available through this office.

Release of Records.
If you would like your records released to any other party for further mental health services, or other health services, etc. You must provide written disclosure authorization filled out in person or verified through personal contact i.e. our office calling you with the contact information provided on our records, to verify of your wish to disclose your records. This is to protect you and your records. However, as often the case, some mental health records may be damaging to self and or others if not reviewed and evaluated by mental or medical health certified professionals, in such cases the practitioner may require the release of certain mental health records only to mental or health care certified professionals.

Patient Financial Responsibility.
Some Insurance Companies require prior authorization for Psychological testing or psychotherapy, in addition some services are not covered or covered unless the provider is In-Network, while our office tries to continually add to the insurance carriers we are In-Network for, we are not a provider for all Insurance Companies. Patients are self responsible for obtaining prior authorization from their insurance carrier. If prior authorization is not obtained or patient does not know what coverage's they have specifically, regarding mental health services, it is the patient's responsibility to contact their insurance company. As a courtesy, the Practitioner's office will bill patient insurance, however, patient's are ultimately responsible for co-payment amounts, deductibles, and or non covered services, as set by patient benefit plan, this is why we advocate patient Insurance Benefit education and in obtaining prior authorization, deductible amounts and co-pay information prior to services, this will also help the patient plan financially for possible other future mental health services. Missed appointments are not covered by insurance and patient will be responsible for $50.00 fee if 2-hour notice is not given for missing a scheduled appointment.

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Notice of Privacy Practices Acknowledgement and Patient Payment Responsibility Acknowledgement

I understand that, under the Health Insurance Portability & Accountability act ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

-conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
-obtain payment from third-party payers.
-conduct normal healthcare operations such as quality assessments and customer services.

I have received, read, and understand your Notice of Privacy Practices containing more complete description of the uses and disclosures of my health information. I am aware that I have the right to review the Notice before I sign the consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address listed in the Notice to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. (A Restriction Request Form will be provided upon request). I also understand that you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I can revoke my consent in writing, but such a revocation does not affect any use or disclosure that has already occurred consistent with the consent.

Financial Responsibility

I understand that I am responsible for obtaining prior authorization from my insurance carrier. If prior authorization is not obtained or I do not know what coverage's I have specifically regarding mental health services, I understand it is my responsibility to contact my insurance company before services are rendered, if I need time to do so I will take the time before completing interview and testing so a payment arrangement can be made before services rendered. I understand certain information regarding my health will be released to insurance companies in order for the practitioner to receive payment. I understand the practitioner's office will bill my insurance, however, that I am ultimately responsible for co-payment amounts, deductibles, and or non covered services, as set by my benefit plan. Missed appointments are not covered by insurance and the charges associated with them are my responsibility which is based on an occurrence rate of 50.00 per missed appointment without 2-hour notice. I understand co-payment amounts are set by my benefit plan and are due in full at the time of my appointment in cash or check. I hereby authorize the practitioner to release any information acquired in the course of my evaluation of treatment to any pertinent Insurance Company. I shall be personally liable for any unpaid balance.

_____
Printed name of Patient/Legal Guardian

_____ _____
Signature of Patient/Legal Guardian Date

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Disclosure Authorization

I am completing this form to allow the use and sharing of protected health information about:

Patient name: _____ Date of Birth: _____

I authorize **Dr. Raymond M. Fuchs, Ph.D.** to release documents listed below:

To Name of Facility or persons:_____

Above Persons Contact Ph#:_____Fax#_____

Above Persons Address: _____

City_____State_____Zip_____

Dates of care included: From _____ to _____

The information will be used/disclosed for the following purposes:
_____
_____

I understand and agree that this Authorization will be valid:

valid from (date):_____expire on (date):_____

I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one. I understand that I may inspect and review a copy of the health information described in this authorization. There may be a cost for this copy or other services. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed and no longer protected by those regulations. I affirm that anything in this form that was not clear to me has been explained adequately for my understanding. I have also received a copy of this completed form.

_____
Printed name of Patient/Legal Guardian

_____ _____
Patient Signature/Legal Guardian Date