NEW OBJECTIVES
Psychology, Counseling & Neurofeedback Center

PATIENT INFORMATION

Patient Name: _____

Address: _____
STREET

_____
CITY **STATE** **ZIP**

Phone#: _____ Alternate#: _____

May we call and leave a message: Yes____ No____

Male ( ) Female ( ) Age: _____ Date of Birth: _____

Marital Status: S_____ M_____ D_____ W_____ Sep_____

Employer _____
(parent's employer, if patient is a minor)

Occupation: _____

Next of Kin: _____ Relationship: _____ Phone: _____

Whom may we thank for referring you to this office?

_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION TO PROCESS ANY INSURANCE FORM OR TO OBTAIN AUTHORIZATION FOR SERVICES

SIGNATURE: _____ DATE: _____
(Parent or Guardian, if patient is a minor)

Consent For Treatment

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and the patient and the particular problems that need to be addressed. There are many different methods that may be used to deal with these problems. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on the patient's part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Because therapy often involves discussing unpleasant aspects of the patient's life, individuals may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. However, although the process can be challenging, psychotherapy has been shown to have significant benefits for people leading to better relationships, significant reductions in emotional difficulties and decreased feelings of distress.

The first few sessions involve evaluating the patient's therapy needs, obtaining history, determining goals for treatment and making sure that the therapist expects to be able to help the patient achieve their goals. Additionally, during those first few sessions, the patient is deciding whether they feel comfortable working with the therapist and that it feels like a good fit for them.

Therapy involves a commitment of time, money, and energy and you should be comfortable with the therapist. If questions or concerns arise about practice procedures or the therapy being provided, we encourage you to talk with your therapist about them.

I, the undersigned, hereby authorize New Objectives Psychology, Counseling & Neurofeedback Center, Inc. and its associates to administer an assessment and/or therapy services. I further understand that this consent can be revoked orally or in writing prior to or during the treatment period.

I have read and fully understand the above Consent For Treatment and understand that no guarantee or assurance has been made to me as to the results that may be obtained.

_____ _____

Patient's Name (please print) Date of Birth

_____ _____

Patient's Signature (or parent/guardian, if patient is a minor) Today's Date

LIMITS OF CONFIDENTIALITY

Although confidentiality and privileged communication remain rights of all patients of psychologists and psychotherapists, according to state law, there are a few situations in which the law requires information to be disclosed.

The courts have held that if an individual is at risk of harming themselves or another person, it is the therapist's duty to warn the person, the family of the patient, other responsible parties, or the authorities (e.g. police) of risk in order to prevent harm. The therapist, if at all possible, will not inform such parties without first sharing that intention with the patient. Every effort will be made to resolve the issue before such a breach of confidentiality would take place.

Additionally, it is also the legal responsibility of the therapist to report any known or suspected cases of neglect or abuse of minors or the elderly.

In most legal proceedings, the patient has the right to prevent their therapist from providing any information about their treatment. However, a judge may order the therapist's testimony or records and the therapist must comply with that court order unless the patient's attorney can obtain a reversal.

Lastly, if utilizing insurance, in rare occasions the insurance company will require records (i.e., notes, treatment plan etc.) to confirm medical necessity. This will always be discussed with the patient prior to ever disclosing information.

Working with children or adolescents: Therapy is most effective when a trusting relationship exists between the therapist and the patient. Privacy is especially important in earning and keeping that trust. It is important for children to have a "zone of privacy" where children feel free to discuss personal matters without fear that their thoughts and feelings will be communicated to their parents.

It is New Objectives, Psychology Counseling & Neurofeedback Center's policy to provide you with general information about your child's treatment, but NOT to share specific information your child has disclosed without your child's agreement. This includes activities and behavior that you may not approve of or might be upset by but that do not put your child at risk of serious or immediate harm.

Confidentiality will *not* be maintained if the therapist believes that the child plans to cause serious harm or death to themselves or to someone else, are doing things that could cause serious harm to themselves or someone else (even if they do not intend to or think it will cause harm) or, if the therapist has reason to believe the child is or has been neglected or abused physically, sexually or emotionally.

Parents who have shared custody of the minor have the right to know if and when their child is being seen for therapy. If at any point, either parent expresses to the therapist that they are unwilling to allow the child to participate in treatment, the therapist will attempt to gain/maintain consent. However, if consent is refused, the therapist will need to cancel the initial session or discontinue treatment that has begun. The therapist will request the option of having a closing session with your child to appropriately end the treatment relationship.

I have read the above and understand the legal responsibility and agree that New Objectives Psychology, Counseling and Neurofeedback Center, Inc. and its associates will make such decisions to disclose information when necessary.

Patient's Name _____ Date of Birth _____

Patient's Signature _____ Today's Date _____
(Parent/Guardian, if patient is a minor)

www.NewObjectivesCenter.com 407-339-1159 407-339-2405 370 Center Pointe Circle, Ste. 1160, Altamonte Springs, FL 32701

OFFICE FEE AND INSURANCE POLICY

We are committed to providing you with the best possible care. If you have medical insurance, we are happy to help you receive your maximum allowable benefits and request your understanding of our policy.

Billing of Insurance/Assignment of Benefits/Payments
If we are a provider for your insurance company, we will file your claim for you. You will be responsible for any deductible, co-pays, co-insurance and any denied claims. If we are not a provider for your insurance, at your request, we will provide you with the necessary documentation you will need to file your claim with your insurance company.

Insurance benefits vary among plans. Prior to your initial session, we will verify your insurance, obtaining what they state is your copay, deductible etc. However, insurance companies will NOT guarantee to us that this information is accurate until the claim has been submitted for review. Additionally, insurance companies frequently reimburse inaccurately and will later request a refund from our office for overpayment. Lastly, over time, your insurance plan may change your benefits. They do not notify us of these changes. We do not have the ability to re-verify insurance with each session or each time a claim comes in differently than we were originally told. Therefore, it is your responsibility to inform us if there are any discrepancies in payment or changes to your plan.

If after receiving payment from your insurance company, there is a balance due, we will apply that balance to your credit card below. This may include a co-pay, deductible, claim denial or a recovery of funds from your insurance company.

Missed Appointment Policy
A *significant* amount of time is blocked out of the therapist's schedule for each session. When appointments are not cancelled in advance, it prevents us from being able to offer that appointment time to others. Therefore, a fee of $25.00 is charged for each missed session NOT cancelled by the business day PRIOR to the appointment (if you have two scheduled sessions on the same day, the charge will be $50.00)

Please Note: *If 3 missed appointment occur within a 12-month period, your account will be charged for any further missed appointments at the therapist's full session rate.*

Credit Card Authorization: Permission is granted to charge my card for the copay/deductible for sessions and for any remaining balance after insurance has paid their portion that remains due on the account.

MC / Visa / Discover # _____

Exp_____ Security Code on Back_____ Billing Address Zip Code_____

Name on Card_____

Cardholder's Signature_____ Today's Date_____

I have read and understand the office fee policies and assign insurance benefits to New Objectives Psychology, Counseling and Neurofeedback Center.

_____	_____	_____
Patient Name	Patient's Signature (Parent/Guardian, if a minor)	Date

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NEW OBJECTIVES
Psychology, Counseling & Neurofeedback Center

Please fill out this form if you are wanting a copy of your treatment summary sent to your PCP.
If you are not wanting it sent, please print your name at the bottom and write "Refused" on the signature line.

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby give permission to:
New Objectives
Psychology, Counseling & Neurofeedback Center
and its associates at
370 Centerpointe Circle, Suite 1160
Altamonte Springs, FL 32701
T: (407) 339-1159 NewObjectivesCenter@gmail.com F: (407) 339-2405

to release to/communicate with: _____
Primary Care Physician

_____
Address

_____
City, State, Zip

_____
Phone# Fax#

and for the above named to release to/communicate with New Objectives Psychology, Counseling & Neurofeedback Center, Inc. and any of its associates any information regarding my treatment, diagnosis, progress and records of any treatment or assessment rendered to me

for the purpose of:_____Coordination of Care_____

I understand that my records are protected under the Federal Confidentiality Regulations as well as Florida State Law. My records cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time by so informing the above named parties in writing; however, such written revocation will have no effect on actions taken prior to the revocation. If I do not revoke this release, it will expire one year after I terminate treatment with the above named parties. I hereby release New Objectives Psychology, Counseling & Neurofeedback Center, Inc. and any of its associates from any and all liability that may arise from the release of information as I have directed.

Patient's Name_____ Date of Birth _____
(Please Print)

Patient's Signature_____ Date Signed_____
(If a minor, Parent/Legal Guardian)

NEW OBJECTIVES
Psychology, Counseling & Neurofeedback Center

Acknowledgement of Receipt of "Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information"

The federal government mandated that as of April 14, 2003, all health care patients are to receive from their clinicians a notice (hereafter referred to as "Notice") regarding the protection of their private health care information in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 C.F.R. parts 160 and 164).

This acknowledgement documents that New Objectives Psychology, Counseling and Neurofeedback Center, Inc. (hereafter known as NOPCNC) has given you the "Notice" that is required. HIPAA covers what is called "protected health information" (PHI) that is used for treatment, payment and health care operations. PHI is information in your health record that could identify you.

The Notice contains basic information about:

- How your PHI may be used and disclosed for treatment, payment and health care operations (these terms are defined in the Notice).
- Which uses and disclosures require authorization from you and which don't.
- How you may revoke an authorization you have made.
- Certain rights you have to restrict use and disclosure of PHI, to receive confidential communications by alternative means and at alternative locations, to inspect and copy your records, to amend your records, to have an accounting of disclosures.
- A list of my duties to protect the privacy of your PHI, my right to change the privacy policies and practices described in the Notice, and how I will inform you of changes.
- What you can do if you have any complaints about violations of your privacy rights, about decisions about access to your records I may make.
- Any restrictions and limitations you or I wish to put on the use and disclosure of you PHI.

The Privacy Notice is a few pages in length. Generally, this Notice is given on a patients' first visit unless there is good reason to delay. A copy of this Notice is available in my waiting room and will be on my website if I create one. I will also give you a copy of this notice. This page documents that I have given you a copy of the Notice.

Date _____

_____ _____

Patient Name Patient Signature

_____ _____

Parent/Legal Guardian Name (If patient is a minor) Parent/Legal Guardian Signature (If patient is a minor)

Relationship to Patient _____

NEW OBJECTIVES
Psychology, Counseling & Neurofeedback Center

Consent to Telehealth

I hereby consent to the use of telehealth with New Objectives Psychology, Counseling & Neurofeedback Center, Inc. I understand that telehealth involves the communication of my medical information, both orally and visually, to providers involved in my treatment who are located at a different site than I am. I understand I have all of the following rights with respect to telehealth:

Patient Choice--I have the right to withhold or withdraw my consent to telehealth at any time without affecting my right to future treatment.

Access to Information--I have the right to inspect and receive copies of any medical information transmitted during a telehealth consultation.

Confidentiality--I understand that the laws which protect the confidentiality of medical information apply to telehealth, that I will not be recorded, and that no information from my telehealth consultations which identifies me will be disclosed to third parties without my consent.

Potential Risks--I understand that there are potential risks associated with telehealth, including disruption or distortion in the transmission of medical information and unauthorized access to medical information generated, transmitted and stored pursuant to the telehealth consultation. I understand that telehealth is an alternative to in-person treatment and my doctor may recommend I discontinue telehealth and receive in-person treatment in certain circumstances. I understand that telehealth does not negate or minimize the risks that may be inherent to my illness or condition and that there may be other risks associated with telehealth that are not listed here.

Benefits--I understand that I can expect benefits from telehealth, but that no particular results can be guaranteed. I understand that telehealth may provide me with access to psychological services that otherwise would not have been available to me.

Residing in Florida--I understand that I must be physically residing in Florida during my telehealth appointments. I agree to notify the front office staff or my provider if I will be out of the state during my scheduled telehealth appointment so that the appointment can be rescheduled.

I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

Patient Name_____ Date of Birth_____

Patient Signature_____ Today's Date_____
(Parent or Guardian, if patient is a minor)