Stuart J. Nathan, Ph.D.
AND ASSOCIATES

2450 Fondren Rd. suite 312
Houston, TX 77063-2323
Phone: 713-789-7560
Fax: 713-789-7351

Registration Information

Date_____

Patient Name _____, _____
Last First

If Minor, Custodial Parent(s)/Guardian Name _____

Phone _____

Contact Information:

	Preferred method of contact?	*Okay to leave msg?*
Home Phone: _____	Yes / No	Yes / No
Cell Phone: _____	Yes / No	Yes / No
Email Address: _____		

Driver's License #:_____ If Minor, Parent's TDL:_____

Social Security #:_____ Sex: M F Age:_____ Date Of Birth: _____

Home Address: _____

City:_____ State:_____ Zip:_____

Marital Status: Please Circle:

Single Married Widowed Divorced Separated Partner

Employment Status: Please Circle:

Actively Employed Unemployed Retired Disability Student

If Employed, Patient/Parent Employer: _____

Employer Address: _____

Occupation: _____ Work Phone: _____

Spouse's Name:_____ Spouse's Employer:_____
(Or responsible party, if patient is a minor)

Occupation:_____ Bus/Cell Phone: _____

Social Security #:_____ Driver's License #: _____

Patient Referred To Practice By: _____

Medical Insurance Information:

Insurance Company Name:_____

Name Of Insured:_____

Group/Policy/Account #_____

Insurance Company Phone Number: _____

(Please present insurance card to be copied)

In Case Of An Emergency, Please Contact:

Name:_____ Relationship: _____

Contact Number: _____

Regarding HIPAA Regulations

Stuart J. Nathan, Ph.D. & Associates is required to provide you notification of HIPAA guidelines and your rights under the Privacy Act. **Your signature below indicates you have received the HIPAA terminology definitions and psychotherapy-patient service agreement (tri-fold pamphlet provided for your review during completion of patient registration).** If you would like to keep a copy, please take one from the plexiglass holder at the front desk/window.

Please Sign Below.

_____ _____

Signature Date
Guardian or
Legal Representative

Office Manager: Pamela S.
Receptionist: Jackie A.

Stuart J. Nathan, Ph.D. and Associates is a HIPAA-compliant entity. Documents will be provided for your review of policies and practices to protect the privacy of your health information (PHI).

Pamela S.
HIPAA Compliance Manager

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Release of Information

Stuart J. Nathan, Ph.D.
Karen E. West, Ph.D.
Steven S. Callahan, Ph.D.
Michelle Marion Rhodes, Ph.D.
Vanessa H. Bayer, Ph.D.
Cathy Binstock, LMSW
Sharon Larsen, L.P.C.
Steve Caloudas, Ph.D.
Sarah Helen Gillis, LMSW
Josue Maymi, M.Ed., LPC
Timothy R. Spears M.Ed., LPC

Stuart J. Nathan, Ph.D. and Associates require permission from you to discuss your treatment with our clinic. We also need your permission to obtain information from other sources. The following is your agreement to do so if appropriate.

The following authorization is regarding _____.
Patient Name

_____ Initials — I authorize Stuart J. Nathan, Ph.D. and Associates to release records to individuals/entities listed below.

_____ Initials — I authorize Stuart J. Nathan, Ph.D. and Associates to obtain records from the individuals/entities listed below.

	Name	Relationship	Phone	Fax

I authorize release of the following (please check all that apply):

_____ assessment reports _____ treatment summary _____ progress notes
_____confirmation of treatment _____ session attendance _____ verbal updates

I authorize this release for the following time period: _____ to _____.
date date

I understand this authorization can be revoked by me in writing at any time. In addition, I may also add individuals/entities as needed in writing at any time.

_____ _____
Patient/ Guardian Signature **Date**

_____ _____
Witness **Date**

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Patient Information Regarding Professional Fees

The purpose of this agreement is to allow us to focus on what is most important to all of us, helping **you**. It will also help in maintaining a lower fee schedule and clarifying your responsibilities.

Our Office Policy:

We collect any co-payments or fees for services at the time of the appointment.

We reserve the right to charge for appointments cancelled with less than 24 hours notice as well as any missed appointments.

We accept credit cards, or debit cards as forms of payment, and accept cash or checks only (no temporary checks accepted).

For all unpaid claims, although interest is not charged routinely, we reserve the right to charge interest at the rate of 10% per annum and bill for all expenses incurred if your account has to be turned over to collections and/or an attorney.

_____ Initials — I understand that SJN & Associates has the right to charge me for missed appointments, and cancellations with less than 24 hours notification.

_____ Initials — I am aware that a fee of $25.00 will be incurred for non-emergency calls when a message is received through the live operator.

_____ Initials — I am aware that insurance **will not** cover charges for missed appoints or late cancellations. Fee for missed appointment is $140, which will have to be paid before my next appointment.

_____ Initials — I am aware that this office accepts checks or cash and any form of credit card, debit card, or FSA card as a form of payment.

_____ Initials — I am aware that a fee of $50.00 will be charged to me for returned checks for any reason, along with a $6.50 fee for Return Receipt of Signature and Certified Mail expense for a total of $56.50. Fees can also be charged to cover copies, bank fees, filing documents to court and for any court appearances, which may be necessary.

Our Office Policy: Claims are processed at the time received by your insurance company and according to your benefits on that date. Quotes of benefits by your insurance carrier are not a guarantee of payment.

_____ Initials — I understand that I am financially responsible for serviced provided. Any service charges, which are not covered by my insurance company, are my responsibility. I understand that my insurance will be billed directly as a courtesy.

_____ Initials — When required, I will contact my preferred provider organization such as (MEDICARE/MEDICAID/PPO/HMO/EAP) manages care company to obtain precertification or provide updated information when required.

_____ Initials — I agree to advise the receptionist when I come in of any change in my address, phone number, marital status, insurance or responsible party that has occurred since my last appointment.

_____ **Patient/ Guardian Signature**

_____ **Date**

Patients Exempt From Professional Fee Policies

For Workers' Compensation Patients Only

Our Office Policy: Anyone covered by Workers' Compensation is exempt from responsibility for the fees associated with services provided to them. This office will bill the insurance company directly for all services provided. You will not receive a bill and are not considered personally responsible for any charged incurred. However, if the injury is not accepted by the insurance company or DWC/TDI (Division of Workers' Comp-Texas Department of Insurance) the responsibility becomes the patient's as per Texas State Law.

However, we reserve the right to charge for late cancellations, or no show appointment, which is not covered by the workers' compensation insurance carrier.

_____
Initials

I understand that I may be charged for late cancellations, and missed appointments. I understand that the fee charged is $140.00, and is not covered by my workers' compensation carrier.

For VAMC/QTC Patients Only

Our Office Policy: Any veteran being referred for evaluation by QTC related to compensation and benefits review is exempt from responsibility for the fees associated with services provided to them. This office will bill QTC directly for all services provided.

Records for all services provided are sent on to QTC, and are property of the Department of Veterans Affairs. As a result, Release of Information is considered implicit back to QTC and the Department of Veterans Affairs. This office does not maintain those records or provide follow up intervention related to the mental condition being evaluated.

_____
Initials

I understand that the Department of Veterans Affairs has access to all records related to my evaluation. If I need a copy of my records, I will notify my case manager with the VA and understand that this office is not authorized to release records back to me.

_____ _____

Patient/ Guardian Signature **Date**

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Patient Request for Accounting of Disclosures of Their Health Information/Medical Records

Please Read: Complete Areas Highlighted Below

I have been made aware that I may request a copy of my medical records within the first year of my initial visit at no charge. Any subsequent years following, there will be a charge of $5.00 for the request of medical records. I also understand records can only be retrieved for up to 7 years after the initial date of service.

I understand that I may receive an accounting of disclosures (copies of my records sent) for a period of up to 6 years from the date of the request for disclosures or the date of my initial visit.

I understand that Stuart J. Nathan and Associates will notify me if a request for release of records is made by/for:

- A physician's office, hospital or healthcare entity requesting my treatment, payment or health care operations,
- Department of Homeland Security for national security of intelligence purposes (as specified in the Notice of Privacy Practices), or
- Correctional institutes and/or law enforcement officials under certain circumstances.

I may receive an accounting of disclosures/copy of my records for a period of up to 6 years from the date of this request for disclosures. (Date of initial visit)

A response to your request for the accounting of disclosures/copy of your medical records will be made within 30 days.

Given the aforementioned conditions, I *(Patient Name)*_____, hereby give permission for disclosures of my protected health information/medical records.

_____ _____

Patient/ Guardian Signature **Date**

For Office Use Only

Date:_____

Records related to:

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Purpose:_____

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Confidentiality in Psychotherapy:

All aspects of your participation in services at Stuart J. Nathan, Ph.D. & Associates, including the scheduling of appointments, contents of assessments and therapy or counseling sessions, outcomes of services, and all contents of your records are confidential by state law. A confidential record of the services provided to you will be maintained as required by state law. Only the specific individual may have access to his or her file with the exception of records of a minor as defined by state law. Your record consists of both paper file and electronic record components. All parts of your record are highly secured, physically and/or electronically, and are protected by the same confidentiality and privacy laws.

Stuart J. Nathan, Ph.D. & Associates operates as a single entity, which means that psychologists and other clinicians within may share your information in order to consult with each other in order to provide you the most effective services. Only professional clinicians may access clinical progress notes, test data, or other clinical information in your file. Support staff may have access only to contact and demographic information, diagnostic codes, and funding information for billing and office management purposes. Stuart J. Nathan, Ph.D. & Associates, retains ownership of all physical records and is responsible for establishing policies regarding retention of records. No information may be released without your written permission, with the following exceptions.

Exceptions to Confidentiality:

Stuart J. Nathan, Ph.D. & Associates staff may use or disclose personal health information (PHI) without your consent or authorization in the following circumstances:

- *If a clinician learns of or has strong suspicions of abuse or neglect of a child, an elderly person, or person with a disability each as defined by Texas state law. Clinicians must file a report with the appropriate protective service agencies.*
- *If a clinician assesses that you pose an imminent danger to yourself or others. Clinicians may do what is necessary to protect life within the limits of the law.*
- *In the case of a court-ordered subpoena. Such orders may require the release of records or a clinician testimony at a court hearing.*
- *We may disclose your health information to authorized federal officials who are conducting national security and intelligence activities or providing protective services to the President or other important officials. By law we cannot reveal when we have disclosed such information to the government.*
- *If a clinician learns of client abuse or sexual exploitation by a previous therapist. While client anonymity may be protected, clinicians must report such instances to the appropriate county district attorney and licensing board.*

My signature below indicates that I have read and understand the above-mentioned policies regarding confidentiality.

_____ _____

Signature ***Date***

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Neuropsychological Assessment
Late Cancellation/No Show

The following only applies to patients who are being referred for a **Neuropsychological Assessment**. Stuart J. Nathan, Ph.D. and Associates has determined that our practice needs to implement a policy to protect the psychologist's time that has been reserved specifically for your assessment. **A neuropsychological assessment requires that the psychologist block a period of no less than 6-8 hours in their schedule for the purpose of reviewing records, completing the clinical interview, conducting the assessment and then providing an in depth report for your referring physician.** Our practice generally maintains a waiting list for scheduling these appointments of approximately 3 months. We want to be able to provide this service as quickly as possible, knowing that your physician is waiting to make treatment decisions based on the results. Cancelling an appointment within a minimum of 48 hours, allows our office staff to contact and schedule other patients waiting to be seen. However, when not given adequate notification, our administrative staff is unable to fill the time slot specifically reserved for your assessment.

Therefore, the following policy is being implemented in our office. *Effective June 1, 2017*, **we reserve the right to charge a $250 fee for a "no show" appointment or for cancelling an appointment, less than 48 hours in advance, to cover a portion of the time we have reserved for you with the psychologist**. Our office may take into consideration certain unforeseen circumstances once we are notified of the situation.

Stuart J. Nathan, Ph.D. & Associates is implementing the no show policy, following the ruling by Medicare, which went into effect on October 1, 2016. The policy 30.3.13 reads as such:

> *CMS's policy is to allow physicians and suppliers to charge Medicare beneficiaries for missed appointments, provided they do not discriminate against Medicare beneficiaries but also charge non-Medicare patients for missed appointments. The charge for a missed appointment is not a charge for a service itself but rather is a charge for a missed business opportunity.*

At the time your appointment is scheduled, a credit/debit card will be obtained to be used in the event of such an occurrence, as described above. **No charge will be incurred unless you fail to show up for your appointment or cancel less than 48 hours in advance. Our office staff will notify you if such a charge is incurred and the specific reason. Please note, insurance does not cover fees related to late cancellation or failure to keep your scheduled appointment.**

Your understanding and cooperation are very much appreciated. We regret that such an action has become necessary to protect the integrity of time blocked for the purpose of performing your evaluation. However, we are no longer able to provide these specialized services without such a policy.

_____ _____

Signature **Date**