Michael Burke, Psy.D. & Associates

Client Information Form

Name: _____ DOB: _____

Parent/Legal Guardian (if under 18) _____

Age: _____ Social Security Number: _____ Male Female

Address: _____

Home Phone: _____ Cell Phone: _____
Work/Other Phone: _____ Email: _____

*Please Note: Email correspondence is not considered to be a confidential medium of communication.

Marital Status: __Single __ Married __ Separated __Divorced __Widowed

Emergency Contact: _____ Phone: _____
Relationship: _____

Primary Insurance

Name of Insured_____
Relationship to Patient_____
Insured DOB_____
Insured Employer_____
Insurance Company_____
Insurance Phone Number_____
Policy Number_____
Group Number_____

Secondary Insurance

Name of Insured_____
Relationship to Patient_____
Insured DOB_____
Insured Employer_____
Insurance Company_____
Insurance Phone Number_____
Policy Number_____
Group Number_____

Consent to Treatment:

By signing this Client Information Form and Consent Form as the Client or Guardian of said Client, I acknowledge that I have read, understood, agreed to the terms and conditions contained in this form. I have been given appropriate opportunity to address any questions or request clarification for anything that is unclear to me. I am voluntarily agreeing to receiving mental health assessments, treatments, and services for me (or any said child that is the client), and I understand that I may stop such treatment or services at any time. NOTE: If you are consenting to treatment of a minor child, if a court order has been entered with respect to the conservatorship of said child or impacting your rights with respect to consent to the child's mental health care and treatment, Michael Burke, Psy.D. & Assoc., P.C. will not render services to your child until the therapist has received and reviewed a copy of the most recent applicable court order.

Signature: (If over 19) or Guardian_____ Date: _____

Relationship: _____

Witness: _____ Date: _____

Tele-reminder Release:

I, _____, give my consent for Michael Burke, Psy.D., & Associates, P.C. to confirm my scheduled appointments through their automated tele-reminder system. Clients able to receive a phone call OR a text message in addition to an email. I understand this system may call/text or email the address provided, and leave an automated message reminding me of my appointment.

Please specify your desired form of receiving reminders (may select only ONE choice between voice and text.)

____Voice Call ____Text ____Email

Preferred phone number: _____ and/or Email Address: _____

___No thank you, I would rather NOT receive tele-reminder calls to remind me of my appointment.

X_____ Date: _____

Telehealth

In the event there are barriers to receiving face to face services. Michael Burke, Psy.D. & Associates, P.C tele-health platform is Doxy.Me or Zoom, which has necessary safeguards to provide secure and HIPAA compliant services.

__I consent, understand, and agree that: (initial)

- I will use a private room for my session.
- My provider is licensed in the state in which I am receiving services. I will report my location accurately during my session.
- I will not hold Michael Burke Psy.D. & Associates, P.C. for lost information due to technological failures.
- I further understand that my providers advice, recommendations, and/or decisions may be based on factors not within his/her control, including incomplete or inaccurate data provided by me. I understand that my provider relies on information that is complete and accurate to the best of my ability.
- I may discuss these risks and benefits with my provider. I have the right to withdraw consent for telehealth at any time without affecting my right to present or future treatment.
- I understand that I will receive the same level of care as face to face to the best of the providers ability.
- The laws of the state in which I am located will apply to my receipt of telehealth services.

Electronic Communication:

Electronic communication is not a confidential means of communication. You may choose to still communicate electronically with Michael Burke Psy.D. and Associates, P.C., but you must acknowledge the risk. ***Please initial below.***

____ I authorize Michael Burke Psy.D. & Associates, P.C. to contact me electronically regarding appointments.

___ I understand that Michael Burke Psy.D. & Associates, P.C. cannot ensure that electronic messages will be received or promptly responded to. Therefore, in case of emergency call 911.

__ I understand that any electronic correspondence may become part of client record.

Acknowledgement of receipt of privacy practices and consent for use and disclosure of Health Information.

Notice of Privacy Practices: You have the right to read our Privacy Policies before you decided to sign this consent. A copy of our Notice and/or this consent is available upon your request. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the users and disclosures we make of your protected health information.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

I have been shown a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my personal health information to carry out treatment, payment activities, and healthcare options.

Patient Name: _____

Parent/Legal Guardian Signature: _____

Relationship _____Date: _____

Coordination of Care:

We believe you should be treated as a whole person. We collaborated with others when it is indicated and authorized. This included managed behavioral health care, primary care physician (PCP, hospitals, and schools. Communication between behavioral health providers and your primary PCP is important to ensure that you receive comprehensive and quality care. This PHI (protected health insurance information) may include diagnosis, treatment plan, and medication if necessary. **This information will not be release without your consent.**

__ Yes, please notify my PCP. I am aware that I will need to sign a release for this.

__ Yes, please notify my Medication Manager Provider. I am aware that I will need to sign a release for this.

__ I waive notification of my PCP that I am seeking or receiving mental health services, and I direct you NOT to notify them.

__ I do not have a PCP and do not wish to see or confer with one.

X_____ Date: _____

INTEROFFICE AUTHROIZATION

_____gives authorization for his/her designated therapist to share session information with other licensed professionals within the office of Michael Burke, Psy.D. & Associates, P.C., **exclusively** for continuity of care.

Information to be released (Check all that apply):

__Social History __Medical History __Diagnosis __Treatment

__Education Records __Test Results __Psychological Assessment

__Other

The purpose of this disclosure is to:

__Assist with evaluation and treatment __Other: _____

I chose NOT to allow disclosure to the following provider:

__Dr. Michael Burke __Dr. David Hof __Derek Schweitzer __Deidre Hollister

__Andrea Darr __Brianna Aden __Kelsey Krieger

I understand that all client information is confidential and cannot be disclosed without my written consent unless otherwise provided for in state of federal law. I understand that I may revoked this authorization at any time, except to the extent that measures have already been taken to comply with it. Without my expressed revocation, this authorization will automatically expire **365 days** from the date signed. Or it will expire:

__Upon receipt of the information requested.

__Six months from the date of signing

__Under the following conditions: _____

I understand that my records may include drug and/or alcohol abuse information, which is protected under the Federal Confidentiality Regulations (42 CFR, Part 2). Any further disclosure of my records other than what is outlined above is prohibited without my written consent, or as otherwise permitted by such regulations.

I further acknowledge that the information being released was fully explained to me and this consent is giving willingly.

Executed this___ day of _____, _____.

Signature of Patient/Guardian_____ Witness_____

Financial Policy

Thank you for choosing Michael Burke, Psy.D. & Associates. Please carefully review our financial policy. Our office manager is available to answer questions you may have regarding our financial policy or your payment responsibilities.

Insurance Services:

As a courtesy to our clients, we will file claims with your provided companies, however, it is your responsibility for the full and timely payment of your account. Please also provide Michael Burke, Psy.D. & Associates with up-to-date contact information, including your home address, telephone number, and emergency contact information.

The clinic will attempt to verify coverage and benefits prior to your visit with the therapist. If we are unable to obtain verification of coverage, you will be asked to pay full, or reschedule your visit to at time the verification can be obtained. This verification will be used to estimate your financial responsibility; however, this verification is not guaranteed by your health plan coverage or payment.

Please be aware that certain diagnoses may not be covered or may be considered, "not medically necessary" by your health plan. You are responsible for payment of these services. Please also be aware that many health plans limit annual coverage. In the event your care exceeds a plan limitation, you will be responsible for the balance. It is your responsibility to know the benefits and limitations of your current health insurance coverage. Michael Burke, Psy.D. & Associates. is NOT responsible for knowing your plan's specific benefits and coverage limitations.

Past Due Accounts:

If your account becomes past due, we will take necessary steps to collect this debt. Please take time to speak with our office to arrange payments to pay your bill.

Returned Checks:

If a check is returned for insufficient funds, accounts closed, or payment stopped, your account will be charged at $35 fee. In the event this happens, you will be asked to use a debit/credit or cash for future visits.

Copays:

All co-pays are due at the time of services. If unable to pay your copay, please contact our office BEFORE your appointment.

Signature (over 19) or Legal Guardian_____ Date: _____

No-Show/Late Cancellation Policy

This policy has been established to provide the highest level of Clinical Services to all our patients. It has been proven consistent attendance provides for the greatest opportunity for success. By providing us notice of cancellation, we may be able to accommodate other patients with your appointments.

- Patients must call at least 24 hours to prior to their scheduled time, when they knowingly are unable to make their appointment.
    - Cancellations within 24 hours of the appointment will be considered a late cancellation.
- A patient will be allowed to continue with their therapy after one no-show/ late cancellation, provided an explanation is supplied to their therapist.
- After two (2) no shows and/or late cancellations, the patient will be charged a minimum of $40 - $230 (up to a full session) and standing appointments will be canceled. Future appointments will be removed from the schedule until the fee is paid in full.
- We do understand that emergencies arise and that it may not be possible to give such notice.

Please be advised that this cancellation/session fee is NOT covered by insurance and will be an out-of-pocket expense.

Patients will receive telephone reminders, SMS texts, and emails of appointment dates and times the business day prior to the schedule's appointment.

_____ _____

Patient Signature Date

Member Rights and Responsibilities

Statements of Member Rights

- Members have the right to be treated with dignity and respect.
- Members have the right to fair treatment regardless of race, religion, gender, age, ethnicity, disability, or source of payment.
- Members have the right to have their treatment and other information kept private. Only when permitted by law may records be release without member permission.
- Members have the right to easily access timely care in a timely fashion.

  Members have the right to know about their treatment choices. This is regardless of cost or coverage by the member's benefit plan.
- Members have the right to share in developing their plan of care
- Members have the right to information in a language they can understand.
- Members have the right to information about Magellan, its practitioners, services, and roles in the treatment process.
- Members have the right to ask their provider about their work history and training.
- Members have the right to give input on the Members Rights and Responsibilities policy.
- Members have the right to freely file a complaint if necessary.
- Members have the right to know of their rights and responsibilities in the treatment process.

Statement of Member Responsibilities

- Members have the responsibility to treat those giving them care with dignity and respect
- Members have the responsibility to give providers information they need so that providers can deliver the best possible care.
- Members have the responsibility to ask questions about their care to help them understand their care.
- Members have the right to follow the treatment plan. The plan of care is agreed up on by the provider and member.
- Members have the responsibility to follow he agreed upon medication plan.
- Members have the responsibility to tell their provider and primary care physician about medication changes, including medications given to them by others.
- Members have the responsibility to keep their appointments. Members should call their provider immediately if they know they will need to cancel their appointment.
- Members have the responsibility to let their provider know whether the treatment plan is working for them.
- Members have the responsibility to let their provider know if they have problems with paying fees.
- Members have their responsibility to report abuse and fraud
- Members have the responsibility to openly report concerns about the quality of care they received.

My signature shows that I have been informed of my rights and responsibilities and that I understand this information.

X_____ Date_____

Patient (over 19) or legal guardian

My signature shows that I have explained this statement to the client.

X_____ _____

Signature of Witness Date

Termination Policy

Also, please be aware of the following conditions regarding discontinuing therapy. You may be discharged as a client:

- If your therapist believes that they are unable to help you, because of the kind of problem you are facing or because his/her training and skills are not appropriate, you will be informed of this fact and referred to another therapist who will best meet your needs.
- If you have two consecutive "no shows" or same-day cancellations for appointments.
- If you have not had and kept an appointment in our office in 60 days and is not part of your treatment plan.
- If you commit an act of violence toward, threaten, or harass any staff or client, you may be immediately terminated.
- If you are terminated from therapy for something other than completing the agreed upon treatment plan, you will be given contact information for other sources of therapy. However, this is not a guarantee for further treatment or services.

My signature below acknowledges that I have read, understand, and agree to the above statements. I understand and authorize supervision of my case, if necessary. I agree to actively participate in my services and I have been oriented into the program. I understand that if I have any questions regarding the above statements, I can talk to my provider or office staff at (308) 234-5644.

_____ _____

Signature (over 19) or Guardian of Patient Date

_____ _____

Witness Signature Date