Christopher D. Watson, Psy.D. & Associates, PC

NEW CLIENT REGISTRATION FORM

Client Information (please print clearly) Date:

Client Name____ Client home phone ( )__________
Client Home Address Client work phone ( )___________
____ Client cell phone ( )__________
____ Client date of birth ___/___/_____
____ Client SS # _____-___-_______

Client gender: ☐ Male ☐ Female Client marital status: ☐ Single ☐ Married ☐ Other

Client employed: ☐ Employed ☐ Student Employer/school:_____________________________

Billing Information:
Name of responsible party: *____
Last First Middle Initial
Address: ______________________________________ Home phone ( )______________
______________________________________ Work phone ( )______________
____

*No third party billing. Responsible party must be present to sign for financial responsibility

Billing Information: Bill my insurance? ☐ Yes ☐ No Please provide a copy of your ins. card
PRIMARY INSURANCE
Insurance co. name: ________________________________ Insured's name: ________________________
Insurance co. address: ______________________________ Insured SS # _____-____-________
______________________________ Insured's employer: ____________________
Insured's date of birth ___/___/______ Group # or name:_______________________
Insured's phone number ( )_________________ Policy #: _____________________________
Authorization #:_____________________ Client's relationship to insured: ☐ Self ☐ Spouse ☐ Child

Billing Information: Bill my insurance? ☐ Yes ☐ No Please provide a copy of your ins. card
SECONDARY INSURANCE
Insurance co. name: ________________________________ Insured's name: ________________________
Insurance co. address: ______________________________ Insured SS # _____-____-________
______________________________ Insured's employer: ____________________
Insured's date of birth ___/___/______ Group # or name:_______________________
Insured's phone number ( )_________________ Policy #: _____________________________
Authorization #: Client's relationship to insured: ☐ Self ☐ Spouse ☐ Child

OFFICE USE ONLY: ☐ Self Pay ☐ Insurance
Therapist's Name: ___________________________ Account #: ___________________________________
Diagnosis Code: ______________________________ Statement sent to home? ☐ Yes ☐ No
Referral Source: ______________________________
Special Notes: ________________________________

Christopher D. Watson, Psy.D. & Associates, PC

RELEASE OF INFORMATION FOR PROCESSING BENEFITS

I hereby authorize Christopher D. Watson, Psy.D. and Associates, PC to release any of the following requested information for the purpose of obtaining reimbursement of treatment services provided directly to my dependants or me. Information may include: Admitting Diagnosis; Final Diagnosis; Discharge Summary; Designated clinical records (e.g., treatment plans, progress notes, test results, etc.)

Information may be released to any or all of the following as needed: Any third party payer having responsibility for payment of charges for treatment; Review agents/auditors; Managed Care agents.

This consent is valid until such time that all claims have been settled to the satisfaction of Christopher D. Watson, Psy.D. and Associates, PC or up to one year from the date of discharge from treatment, whichever is longer.

I understand that in some cases I and/or my dependants may be receiving services for which I am not the insured or for which there is more than one insured. In this case, I authorize Christopher D. Watson, Psy.D. and Associates, PC to contact the actual or additional insured (e.g., my spouse) and to share information necessary to obtain reimbursement for services.

I understand that I may revoke this consent at any time and that I may inspect and copy the information to be disclosed. I further understand that I can invalidate the consent any time before the expiration date so long as I submit my revocation in writing this office. Finally, the agency reviewing the clinical information and/or records will be advised not to re-disclose my records to any other agency/person without my written consent.

I understand that I am ultimately responsible for any and all charges not paid for by my medical insurance, and that if I refuse to sign this Release of Information, I will likely have to pay for any and all charges incurred.

I certify that I am the client and that I have received a copy of this form. If I am not the client, I certify that I am duly authorized as the client's general agent to execute the above and accept its terms.

Client's Name:________________________ Signature:____________________________ Date:______
(client or authorize representative)

Witness: ___________________________________ Date:________

Christopher D. Watson, Psy.D. & Associates, PC

121 S. Wilke Rd* Arlington Heights, IL 60005
(847) 577-0904 * christopher@discoveryourstrengths.net

Notice of Privacy Practices- Brief Version

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

Our Commitment to Your Privacy

Please note that Christopher D. Watson, Psy.D. and Associates, PC is providing this document to you subsequent to the Health Insurance Portability and Accountability Act (HIPAA). Our office has always and will continue to maintain the highest standards regarding our patients' personal information. You can be assured that our practice goes beyond what is required by HIPAA. Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional care. We are also required by law to keep your information private. These laws are complicated, but we must give you this important information. This form is a summary of the full NPP which is available if you would like more information.

We will use the information regarding your health, which we obtain from you or from others mainly to provide you with treatment, to arrange payment for our services and for some other business activities which are called, in the law, health care operations. After you have read this NPP and discussed it with your doctor and/or therapist we will ask you to sign a Consent Form to allow us to use and share your information as needed. Please not that Christopher D. Watson, Psy.D. and Associates, PC will continue to have you complete releases of information in addition to this document. If you do not consent and sign this form, we cannot treat you.

Christopher D. Watson, Psy.D and Associates, PC utilizes an electronic billing service to process claims via the internet. Rest assured that our office has taken great care in selecting the billing company with whom we have contracted. Each step in the process is encrypted to ensure the highest standard in privacy regarding sensitive personal information.

If there is a need to disclose (send, share, release) your information for any other purposes we will discuss this with you and ask you to sign an authorization form to allow this.

Of course we will keep your health information private, but there may be times when the law requires us to use or share it. For example:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization which is able to help prevent or reduce threat.
2. Some lawsuits and legal or court proceedings.
3. If a law enforcement official requires us to do so.
4. For Workers Compensation and similar benefit programs.

There are some other situations like these which do not happen very often. They are described in the longer NPP.

Your Rights Regarding Your Health Information

1. You can ask us to communicate with you about your health and related issues in a particular way or at a certain place whichever is more private for you. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as you ask.

2. You have the right to ask us to limit what we tell people involved in your care or the payment for your care, such as family members and friends. While we do not have to agree to your request, if we do agree, well will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you

3. You have the right to look at the health information we have about you such as your medical and billing records. You can even get a copy of these records. A fee may be associated with this service. Contact our Privacy Officer to arrange to see your records.

4. If you believe the information in your record is incorrect or missing important information, you can ask us to make changes (called amending) to your health information. You must make this request in writing to your doctor and/or therapist or our Privacy Officer. In your request, you must tell us the reason(s) you want to make the changes.

5. You have the right to a copy of this notice. If we change the NPP we will notify you as soon as possible and you can always get a copy of the NPP from our Privacy Officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer, Dr. Christopher Watson. He can be reached by phone at
(847) 577-0904.

The Effective date of this notice is April 14, 2003.

Christopher D. Watson, Psy.D. & Associates, PC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I, hereby acknowledge receipt of Christopher D. Watson, Psy.D. and Associates, PC Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential health information.

I understand that Christopher D. Watson, Psy.D. and Associates, PC has reserved the right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

- ☐ Christopher D. Watson, Psy.D. and Associates, PC may leave a message on client's/family voicemail confirming your appointment and/or information you request regarding your treatment.

- ☐ Christopher D. Watson, Psy.D. and Associates, PC may **not** leave a message on client's/family voicemail.

Signature of Client:______________________________ Date:____________

Parent/Guardian:________________________________ Date:____________
(Please specify relationship to client)

Signature of Clinician:________________________________ Date:___________

Christopher D. Watson, Psy.D. & Associates, PC

The Rights and Responsibilities of Test Takers: Guidelines and Expectations

As a test taker, you have the right to:

1. Be informed of your rights and responsibilities as a test taker.
2. Be treated with courtesy, respect, and impartiality, regardless of your age, disability, ethnicity, gender, national origin, religion, sexual orientation or other personal characteristics.
3. Be tested with measures that meet professional standards and that are appropriate, given the manner in which the test results will be used.
4. Receive a brief oral or written explanation prior to testing about the purpose(s) for testing, the kind(s) of tests to be used, if the results will be reported to you or to others, and the planned use(s) of the results. If you have a disability, you have the right to inquire and receive information about testing accommodations. If you have difficulty in comprehending the language of the test, you have a right to know in advance of testing whether any accommodations may be available to you.
5. Know in advance of testing when the test will be administered, if and when test results will be available to you, and if there is a fee for testing services that you are expected to pay.
6. Have your test administered and your test results interpreted by appropriately trained individuals who follow professional codes of ethics.
7. Know if a test is optional and learn of the consequences of taking or not taking the test, fully completing the test, or canceling the scores. You may need to ask questions to learn these consequences.
8. Receive a written or oral explanation of your test results within a reasonable amount of time after testing and in commonly understood terms.
9. Have your test results kept confidential to the extent allowed by law.
10. Present concerns about the testing process or your results and receive information about procedures that will be used to address such concerns.

As a test taker, you have the responsibility to:

1. Read and/or listen to your rights and responsibilities as a test taker.
2. Treat others with courtesy and respect during the testing process.
3. Ask questions prior to testing if you are uncertain about why the test is being given, how it will be given, what you will be asked to do, and what will be done with the results.
4. Read or listen to descriptive information in advance of testing and listen carefully to all test instructions. You should inform an examiner in advance of testing if you wish to receive a testing accommodation or if you have a physical condition or illness that may interfere with your performance on the test. If you have difficulty comprehending the language of the test, it is your responsibility to inform an examiner.
5. Know when and where the test will be given, pay for the test if required, appear on time with any required materials, and be ready to be tested.
6. Follow the test instructions you are given and represent yourself honestly during the testing.
7. Be familiar with and accept the consequences of not taking the test, should you choose not to take the test.
8. Inform appropriate person(s), as specified to you by the organization responsible for testing, if you believe that testing conditions affected your results.
9. Ask about the confidentiality of your test results, if this aspect concerns you.
10. Present concerns about the testing process or results in a timely, respectful way, if you have any.

Christopher D. Watson, Psy.D. & Associates, PC

CONSENT FOR PSYCHOLOGICAL EVALUATION

I, ________________________, freely give my consent to take part in psychological evaluation.

I believe I understand the basic ideas, goals, and methods of the evaluation process. I understand that the purpose of this evaluation is to provide greater diagnostic clarity so that empirically validated treatment can be tailored to my specific needs. The evaluator has addressed my questions and/or concerns regarding confidentiality and the assessment process. I have been provided with a form detailing the Rights and Responsibilities of Test Takers. I understand that no guarantees regarding the outcome of the evaluation can be given. I understand that the results, interpretations, diagnoses, and resulting treatment plan will only be as accurate as I am willing to fully engage in the evaluation process.

With enough knowledge, and without being forced, I enter into evaluation. I understand that I have the right to withdraw my participation in the evaluation at any time. I further understand that in some circumstances (e.g., court mandated evaluation) there may be adverse consequences for my refusal to cooperate with evaluation.

This agreement shows this evaluator's willingness to use and share his or her knowledge and skills in good faith. I understand that the evaluator has the responsibility to adequately inform me of the estimated costs of the evaluation and to use only those procedures which are appropriate for my age, ethnicity, gender and differential diagnosis.

This agreement also shows my commitment to pay for services. I agree to pay $200.00 per hour for evaluation, and to pay my contracted portion at the time of the evaluation. I understand and accept that I am fully responsible for this fee, but that my evaluator will help me in obtaining payment from any insurance coverage I have. I also understand that in order to bill a third party (insurance) confidential information such as my diagnosis and treatment plan may have to be released to the third party. I understand that my insurance company has the right to refuse payment for services they have pre-certified. I understand that in this event, I am fully responsible for all charges not covered by my insurance.

I understand that the evaluation may take several sessions and that 24-hour notice is required for the cancellation of a session. If 24-hour notice is not given, I understand that I am responsible for a fee of $50, which is not reimbursable by my insurance. I understand that this charge is due in full at the time of my next session. The only exceptions are unforeseen or unavoidable situations arising suddenly.
My signature below means that I understand and agree with the points above

Signature of Client:_________________________________ Date:___________

I have discussed the issues above with this client. My observations of this client's behavior and responses give me no reason, in my professional judgment, to believe that this person is not fully competent to give informed and willing consent.

Signature of Evaluator: _____________________________ Date:___________

This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

Christopher D. Watson, Psy.D. & Associates, PC

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, ________________________, hereby authorize **Christopher D. Watson, Psy.D. & Associates, PC** to release regarding any and all records or information regarding_________________________
Name of Patient

____

____

(SPECIFIC NATURE OF INFORMATION TO BE DISCLOSED)

The following items must be checked and initialed to be included in the use and/or disclosure of other health information:

☐ ______ HIV/AIDS related treatment ☐ ______ Mental Health Information ☐ ______ Psychology Notes
☐ ______ Sexually Transmitted Diseases ☐ ______ Drug/Alcohol Diagnosis, Treatment/Referral

TO: ____
(Receiving Agency or Person)

Phone:____ Fax: ______________________________

Address: ____

FOR THE PURPOSE OF: (Check All That Apply)

☐ ______ Continuing Mental health/alcohol and/or drug abuse Treatment or care and continuity of care
☐ ______ Therapist transition
☐ ______ Housing and other arrangements and services
☐ ______ Billing, payment and financial matters and arrangements
☐ ______ Consultation, advise and representation Regarding my condition and needs
☐ ______ Other ___________________________
____

This consent is valid until (Calendar Date): __________________________

I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use the information only for the purposes outlined above and may not redisclose it without my written authorization

I also understand that if I refuse to consent to the release of information the following may occur: ______________________

________________________________ ________________________________ ____________
(Minor Recipient, 12-17 years. Inclusive) (Signature of Adult Patient or Parent) (Date)

WITNESS:____ DATE:____________

NOTICE TO PATIENT AND RECEIVING AGENCY

Under the provisions of the Mental Health and Developmental Disabilities Act, HIPPA, and applicable Federal and State Alcohol and Substance Abused Confidentiality Acts, there may not be redisclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure. **A separate release is required for psychotherapy notes.**

Christopher D. Watson, Psy.D. & Associates, PC

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TO: ____
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FOR THE PURPOSE OF: (Check All That Apply)

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☐ ______ Therapist transition

☐ ______ Housing and other arrangements and services

☐ ______ Billing, payment and financial matters and arrangements

☐ ______ Consultation, advise and representation Regarding my condition and needs

☐ ______ Other ____________________________
____

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