Valley Psychological Group
2100 E Street
Bakersfield, CA 93301
PH: (661) 327-4252 Fax: (661) 327-3409

Patient Registration

Patient Name			
Date of Birth		Age	
Sex (circle one)	Male Female Prefer not to answer	SS #	
Address			
Zip Code			

Communication					
Preference?	Home Cell Work (circle one)				
Home Phone #		Work Phone #		Extension	
Cell Phone #					
Email					

Information			
Primary Language		Special Needs	
Race (biological)		Ethnicity (identity)	
Marital Status		Mother's Maiden Name	
Occupation		Employer	

Account Responsible (the personal who carries the insurance policy)					
Responsible			Salutation		
Relationship			SS #		
Address					
Home Phone #		Work Phone #		Extension	
Email					

Primary Insurance			
Name		Group Name	
ID #		Group #	
Address			
Phone			
Insured		Date of Birth	

Secondary Insurance (if applicable)			
Name		Group Name	
ID #		Group #	
Address			
Phone			
Insured		Date of Birth	

Emergency Contact										
Sal	First	Middle	Last	Relation	Home#	Cell#	Work#	Ext	Organization	Title

Attorney (If applicable)	
Name	
Address Phone	

VALLEY
PSYCHOLOGICAL
GROUP

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2100 E Street
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PH: (661) 327-4252 Fax: (661) 327-3409

Welcome to Valley Psychological Group!

The following document is designed to give you information about our professional services and business policies. Please read this carefully. If you have any questions or concerns, please bring them to us. Please note, by signing this form, it represents an agreement between you, the patient, and us, Valley Psychological Group.

Patient Name:	
Date of Birth:	

1. Consent for Treatment:

I authorize and request my therapist/doctor at Valley Psychological Group carry out psychological examinations, assessments, diagnostic procedures, and/or treatments that are advisable and standard of practice now or during my care as a patient. I understand the purpose of any procedure will be explained to me and be subject to my agreement. All treatment recommendations will only be carried out with my understanding and verbal approval. Furthermore, I understand that maximum benefit will occur with consistent attendance and compliance with treatment as suggested by my therapist/doctor.

2. Termination of Therapy:

The provider reserves the right to terminate therapy at his/her discretion. Reasons for termination include, but are not limited to, untimely payment of fees (you have failed to pay for more than two sessions, failure to comply with treatment recommendations, excessive missed appointments (more than 2 consecutive no-shows), conflicts of interest, failure to participate in therapy, if the patient's needs are outside the providers scope of competence or practice, or patient is not making adequate progress in therapy.

The patient has the right to terminate therapy at his/her discretion.

Upon either party's decision to terminate therapy, the provider can recommend, if needed, a referral to another provider.

3. Minors and Parents:

Patients under 12 years of age who are not emancipated require parental consent to begin treatment. Parental consent must come from a parent or guardian with legal custody. If a minor is subject of a divorced union and treatment involves custody issues, the provider will require a copy of your most recent custody agreement to initiate consent for treatment.

4. Insurance:

To bill your insurance, information must be conveyed to them. This information includes, but is not limited to, patient's name, address, date of birth, insurance ID#, marital status, dates of service, type of therapy, amount due, and a diagnosis. The diagnosis helps the insurance company know what symptoms you are experiencing. This can include full access to your records. If your records are requested, we will make every effort to release only the minimum information necessary. Though all insurance companies vow to keep information confidential, we have no control over what they do once it is in their hands. If you are uncomfortable with your insurance company having your mental health information, you can choose to pay the fees yourself and leave the insurance company out of the equation.

*** Pre-authorization Requirements:** If I choose to use my insurance, I accept the responsibility to obtain all referrals or pre-authorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of Valley Psychological Group charges.

*** Assignment for Direct Payment:** I authorize that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to Valley Psychological Group.

Please initial here that you have read and understand page #3: _____

5. Authorization for Release of Information:

Valley Psychological Group may release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, **Valley** Psychological Group is no longer responsible for the confidentiality of any information known or possessed by the payer. By signing below, you are permitting Valley Psychological Group to release information to your insurance/managed care/EAP company to obtain authorization for sessions and/or payment of claims. If you have any questions or concerns, please let us know and we will be happy to discuss them with you. **6**

6. Confidentiality:

All information obtained in this office will be held in the strictest manner. The information disclosed by the patient is generally confidential and will not be released to any third-party without written authorization from the patient, except where required or permitted by law. **Exceptions to confidentiality include, but are not limited to:** reporting child, elder, and dependent adult abuse, when a patient makes a serious threat of violence towards a reasonably identifiable victim, or when a patient is dangerous to him/herself or the person or property of another. In certain legal situations, such as in child custody, workers compensation, or personal injury case, the judge may order the therapist/doctor to testify. Lastly, if an account goes unpaid, it is legal for us to disclose your name, dates of sessions, and amount due to a collection agency, or small claims court as necessary. All staff and providers at Valley Psychological Group are bound by the same rules of confidentiality. Federal Law under the Patriot Act states that when a federal government believes an individual to be a threat to national security, the government may access an individual's records with a federal warrant. In the unlikely event that this occurs, we will NOT disclose to the patient that this event has happened.

7. Records and Record Keeping

The provider may take notes during the session and will also produce other notes and records regarding the patient's treatment. These notes constitute the provider's clinical and business records, which by law, they are required to maintain. Such records are the sole property of the provide and he/she will not alter the normal record keeping process at the request of a patient. Should the patient request a copy of their records, such request must be in writing, and a fee of $25 must be paid before said records are released. The provider reserves the right, under California Law, to provide a patient with a treatment summary in lieu of actual records. The provider may also refuse to produce a copy of the records under certain circumstances, but may, as requested, provide a copy of the record to another treating health care provider. Records will be maintained for 7 years following termination of therapy, or as California Law dictates, after which time they will be destroyed in a manner which preserves patient confidentiality.

8. Patient Rights:

HIPAA provides you with several new or expanded rights about your clinical records and disclosures of protected health information. These rights include requesting amendment to your record; requesting restrictions on what information from your clinical record is disclosed to others; requesting and accounting of most disclosures of protected health information that you have neither consented to, nor authorized, determining the location to which protected information disclosures are sent; having any complaints you make about this practice or your provider and procedures in your records; and the right to a paper copy of this agreement, the attached notice form, and our privacy policies and procedures.

Please initial here that you have read and understand page #4: _____

9. Financial Agreement:
I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Valley Psychological Group which are not paid for by my health insurance or other payer. We will bill your insurance company directly. If you have a co-payment or co-insurance, it is due at each session. Although your insurance company will be billed, you are responsible for any portion not reimbursed by the carrier (deductibles, canceled session, non-covered benefits/services, etc.). If you receive a statement from us, all charges are due and payable as indicated on the bill. If payment is not made within 90 to Valley Psychological Group, I understand that the account will incur an 18% late fee and will then be sent out for collection. I will not be notified that my account has been sent to collection, nor does the law require that I be notified. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Valley Psychological Group. If my check is returned, I understand that I am responsible for a $25.00 returned check fee in addition to the original check amount.

10. Missed sessions and cancellation policy: If you are more than 15 minutes late to your appointment, it will be considered a missed appointment, and the $45.00 fee will apply. I understand that 24-hour notice is required for canceling an appointment, and I will be charged a $45.00 fee for any missed appointment without required notification. I also understand that I will be responsible for this charge and that my insurance company will not be billed for that day.

10. Patient Litigation: A provider may communicate with a patient's attorney, upon request of the patient, with a signed release or information, at the expense of the patient. There will also be a fee for any letters, reports, declarations, or affidavits furnished by the provider to be used in a patient's legal matter. Should a provider be subpoenaed, or ordered by a court of law, to appear as a witness in an action involving the patient, the patient agrees to pay the therapist/doctor fees for any time spent in preparation, travel from portal to portal, or other time spent on appearance at the customary rate of $150 - $250.00 per hour, with a minimum (2) hour charge.

Please initial here that you have read and understand page #5: _____

11. Acknowledgment:

I acknowledge that:

- **I have read this form in its entirety, and I understand its contents.**
- **I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.**
- **I am responsible for the payment and/or co-payment that is due at the time of service.**
- **I have received a copy of Valley Psychological Group HIPAA Policy.**

_____ _____

Signature of Patient or Legally Responsible Person | Name (Please print)

_____ _____

Relationship/Reason Why Patient Is Unable to Sign | Date

HIPAA Notice of Privacy Practices

Valley Psychological Group Inc. 2100 E Street., Bakersfield, CA 93301 P: 661.327.4252 F: 661.327.3409

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that is related to your past, present, or future physical and mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your therapist, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, and training of medical/mental health professional students that see patients at our offices. In addition, we may use your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases; Health Oversight: Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings, Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; required uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Discloses will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your therapist or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for the notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction request and to whom you want the restriction to apply. Your therapist is not required to agree to a restriction that you may request. If the therapist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to obtain a paper copy of this notice from us: Upon request, if you have agreed to accept this notice alternatively, i.e., electronically.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our private contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before April 14, 2003. We are required by law to maintain the privacy of individuals and provide them with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main office phone number.

The following comprises a list of exclusions to the Health Information Portability and Accountability Act that allows for a more efficient use of your time and the provider's time. Please initial the specific exclusions you would agree to. If you do not want to authorize permission for anyone or all, simply leave it blank.

_____ I give my permission to allow Valley Psychological Group staff to call to remind me by phone of my appointments. The permission extends to allowing Valley Psychological Group to leave a reminder about my next appointment on my answering machine or my voice mail.

_____ I give my permission for the office staff and/or my therapist to use my first name in the waiting room to call me back for my session.

_____I give my permission for my therapist at Valley Psychological Group to send an e-mail to me and to receive e-mail from me. I understand that information transferred over the Internet in this manner is not a secure form of communication.

My e-mail address is: _____

I give permission to fax any essential information to my personal physician, pharmacy, HMO, insurance provider, hospital, attorney, or other medical provider involved in my treatment. No information will be sent without my first signing a separate release of information for each person or agency I approve. Valley Psychological Group must obtain a separate release of information for faxing any information about you. Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name: _____

Signature: _____

Date: _____

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Acknowledgment Of Privacy Practices

Date: _____/_____/_____

I, _____, acknowledge that I have received a copy of the Notice of Privacy Practices from Valley Psychological Group.

I have listed individuals that are authorized to receive my protected health information. I am aware that I can revoke the authorization for any individual at any time but must do so in writing.

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative & Relationship Date
(Required if patient is a minor or an adult unable to sign form)

The following individuals have my authorization to access my Protected Health Information & schedule/re-schedule appointments on my behalf.

Name	Relationship	Date of Birth
Name	Relationship	Date of Birth
Name	Relationship	Date of Birth
Name	Relationship	Date of Birth

Telehealth Consent Form

By signing this form, I understand and agree with the following:
Telehealth/Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists and/or subspecialists, nurse practitioners, registered nurses, medical assistants, and other healthcare providers who are part of my clinical care team. In addition to myself and the members of my clinical care team, my family members, caregivers, or other legal representatives or guardians may join and participate on the telehealth/telemedicine service, and I agree to share my personal information with such family members, caregivers, legal representatives, or guardians. The information may be used for diagnosis, therapy, follow-up and/or education.

Telehealth/Telemedicine requires transmission, via Internet or tele-communication device, of health information, which may include:
• Progress reports, assessments, or other intervention-related documents
• Bio-physiological data transmitted electronically
• Videos, pictures, text messages, audio, and any digital form of data

The laws that protect the privacy and confidentiality of health and care information also apply to telehealth/telemedicine. Information obtained during telehealth/telemedicine that identifies me will not be given to anyone without my consent except for the purposes of treatment, education, billing, and healthcare operations. By agreeing to use the telehealth/telemedicine services, I am consenting to Valley Psychological Group sharing of my protected health information with certain third parties as more fully described in Valley Psychological Group's Privacy Policy. I understand, agree, and expressly consent to Valley Psychological Group obtaining, using, storing, and disseminating to necessary third parties, information about me, including my image, as necessary to provide the telehealth/telemedicine services.

As with any Internet-based communication, I understand that there is a risk of security breach. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Individuals other than my clinical care team or consulting providers may also be present and have access to my information for the telehealth/telemedicine session. This is so they can operate or repair the video or audio equipment used. These people will adhere to applicable privacy and security policies.

Telehealth/telemedicine sessions may not always be possible. Disruptions of signals or problems with the Internet's infrastructure may cause broadcast and reception problems (e.g., poor picture or sound quality, dropped connections, audio interference) that prevent effective interaction between consulting clinician(s), participant, patient, or care team.

I hereby release and hold harmless Valley Psychological Group and all members of my care team from any loss of data or information due to technical failures associated with the telehealth/telemedicine service.

I understand and agree that the health information I provide at the time of my telehealth/telemedicine

service may be the only source of health information used by the medical professionals during my evaluation and treatment at the time of my telehealth/telemedicine visit, and that such professionals may not have access to my full medical record or information held at Valley Psychological Group.

I understand that I will be given information about test(s), treatments(s) and procedures(s), as applicable, including the benefits, risks, possible problems or complications, and alternate choices for my medical care through the telehealth/telemedicine visit.

I have the right to withhold or withdraw consent to the use of telehealth/telemedicine services at any time and revert to traditional in-person clinic services. I understand that if I withdraw my consent for telehealth/telemedicine, it will not affect any future services or care benefits to which I am entitled.

All my questions have been answered to my satisfaction.

I hereby consent to the use of telehealth/telemedicine in the provision of care and the above terms and conditions.

By signing below, I certify that I am the legal representative of the participant or that I am the patient and am 18 years of age or older, or otherwise legally authorized to consent. I have carefully read and understand the above statements. I have had all my questions answered. I understand that this informed consent will become a part of my medical record.

_____

Signature of Patient or Patient's Legal Representative:

_____

Name of Patient or Patient's Legal Representative Relationship to the Patient

Date: _____