Atlantic Psych Associates
1518 Savannah Road, Lewes, DE 19958
www.atlanticpsychassociates.com
Phone: 302-448-4266 Fax: 302-448-4193
Forensic Coordinator: 302-450-6441

HIPAA

Offered and accepted copy of HIPPA (Initials, Date)_____

Offered but declined copy of HIPAA (Initials, Date) _____

DEMOGRAPHICS

Patient's Last Name _____ First Name _____ Middle Initial _____

Nickname (goes by) _____ SSN _____ DOB _____

Address_____

Street City Zip Code

Phone Numbers: Home _____Cell _____Work _____ Ext _____

Email: _____

Patient's Gender (for medical insurance purposes): Male Female.

Patient's Marital Status: Single Married Widow(er) Other_____

Patient's Employment Status: Employed Retired Student Other_____

Patient Referred by: PCP Friend Attorney Ins. Co. Found on internet

If applicable, referrer's name:

_____

Emergency Contact (name and number)_____

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EMPLOYMENT

Employer _____

Address _____

Street City Zip

MEDICAL

PCP Name _____Practice/Clinic Name_____

Address _____

PCP Phone_____ PCP Fax _____

Allergies _____

Do you see a psychiatrist or similar practictioner? Yes No

Psychiatrist Name _____Practice/Clinic Name_____

Address _____

Psychiatrist Phone_____ Fax _____

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INSURANCE: Yes None

Primary Insurance ID#_____Group #_____

Insurance Company _____

Patient's Relationship to Insured: Self Spouse Child Other

Insured's Name (Last, First, MI) _____

Insured's Address _____

Street City Zip

Insured's Phone Number _____Insured's Employer _____

Insured's Gender Male Female Insured's DOB _____

Secondary Insurance: Yes None

ID#_____ Group #_____

Insurance Company

_____

Patient's Relationship to Insured ( )Self ( )Spouse ( )Child ( )Other

Insured's Name (Last, First, MI) _____

Insured's Address _____

Street City Zip

Insured's Phone Number _____ Insured's Employer _____

Insured's Gender: Male Female Insured's DOB _____

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Appointment Reminder Preference

I _____ would prefer to be notified of my appointments / the appointments for

_____via:

Patient Name

( ) Automated phone call from Atlantic Psych Associates to _____.

Phone number

( ) Text message from Atlantic Psych Associates to _____.

Phone number

My cell carrier is: AT&T Metro PCS Sprint T-Mobile Verizon Other _____

Print name of carrier

I understand that an appointment reminder is a courtesy, and that if the preference indicated above isn't working (for example, number no longer in service, etc.) the staff at Atlantic Psych Associates will not be able to leave an appointment reminder. All no-show fees will still be applicable.

_____

Print Name

_____ _____

Signature Date

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Patient Information Disclosure Authorization

to/from Primary Care Physician

I understand that my records are protected under the applicable law(s) governing health care information that relates to mental health services and under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

I, _____hereby authorize_____

(Patient's Name) (Treating Clinician's Name)

PLEASE CHECK ALL THAT APPLY:

_____ To release any applicable information to my Primary Care Physician

_____ To obtain any applicable information from my Primary Care Physician

_____

Signature of Patient or Legal Guardian Date

_____

Print the name signed above

Primary Care Physician: _____

Telephone: _____

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Adult History Form Today's Date:

Patient Name: _____

Date of Birth:_____ Age:_____

Person Completing Form: Self Parent/guardian Son/Daughter Other

Name of Person Completing Form:_____

Is there a doctor other than your family doctor involved in your treatment? Yes No

(Please answer the following information about the patient if you are completing this form for someone other than yourself)

Medical History:

Do you take any medications, including birth control pills, vitamins, and non-prescription drugs?

Yes No

Current Medications:_____

_____

_____

Do you have any known allergies to medications? No Yes

Medication allergies: _____

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Have you had any surgeries, major illnesses or injuries? No Yes

Please list:_____

_____

When did you last have a physical examination? _____

Psychiatric History:

Have you ever received psychiatric or psychological treatment of any kind before? No Yes

Please list previous psychological treatment below:

Year	Problem	Psychiatrist, Therapist, or Clinic	How long?
____	_____	_____	_____
____	_____	_____	_____
____	_____	_____	_____
____	_____	_____	_____

Have you deliberately hurt yourself, overdosed, or attempted suicide? No Yes

If Yes, when, how often, and what did you do?

Have you ever known anyone who committed suicide? No Yes

If Yes, who?_____

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Family History:

Your family growing up:

Relationship:	First name:	Personality/mental health issues:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who lives with you now?

Relationship:	First name:	Personality/mental health issues:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there any other family members (parents, siblings, grandparents, aunts, uncles, or cousins) who have emotional, mental health, substance abuse difficulties, behavior or school difficulties, and seizures/epilepsy?

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How many times have you been married? _____

How old were you at the time of your marriage(s)? _____

Is there any violence in the home or by your romantic partner? _____

Are you satisfied with your romantic life? _____

Briefly describe any problems in your current or past marriages or cohabitation relationships:

_____
_____
_____
_____

How do you spend personal time? (hobbies, sports, clubs, groups, family activities, etc.)

_____

How many contacts do you have each month with friends outside of work or school?

_____

Who can you talk with about personal feelings or private matters?

_____

Briefly describe concerns about your relationships with partners and/or friends:

_____
_____
_____
_____

Employment History:

Are you currently…. ( ) working ( ) In school ( ) both ( ) neither

Highest level of education: _____

How many hours per week are you working? _____

In what field do you usually work? _____

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What is your current or most recent job title? _____

How long have you been in this position? _____

Briefly describe any issues/concerns with your employment or school:

_____
_____
_____
_____

HABITS:	Amount Currently Using	Most Ever Used
Caffeine(coffee/tea/soda)	_____	_____
Tobacco(cigarettes/snuff/pipes)	_____	_____
Alcohol	_____	_____

SUBSTANCE USE HISTORY

Have you ever used or abused drugs or alcohol? No Yes

If Yes, please describe:

Substances	Amount	Frequency	When? (First use; Last use)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If Yes, have you ever received substance abuse treatment of any kind before? No Yes

History of blackouts, seizures or withdrawal symptoms? No Yes

How often do you drink alcohol: never 1x/month lx/week more than lx/week

Have you ever been arrested for DWI: never once more than once

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PRESENTING PROBLEM(S):

Please describe your reasons for seeking counseling (include date/month the problem started):

Was there an event, which made these issues or problems surface? No Yes

If Yes, please describe:

What other things would be helpful to know about you?

Please circle any symptoms/concerned experienced recently:

Anxiety	Depression	Sleep Problems	Unusual thoughts
Panic	Anger outbursts	Changes in weight	Sexual Problems
Memory Problems	Relationship Difficulties	Shyness	Frequent pain
Concentration Problems	Nausea	Low Energy	Restlessness
Crying spells	Eating Disorder	Legal Difficulties	Drug Use
Drinking Problem	Feeling inferior	Feeling Misunderstood	Religious concerns
Stress	Treated Unfairly	Work Problems	Thoughts of hurting others
Unusually sensitive	Thoughts of suicide	Suspicion	Guilt Feelings
Loneliness	Troublesome thoughts	Hearing strange voices	Worry
Compulsions	Difficulty with Decisions	Mourning	Specific fears
Physical illness	Poor motivation	Perfectionism	Meaninglessness
Impulsive	Irritable	Social Withdrawal	Work Problems
Feeling abandoned	Confusion	Disappointment	Boredom
Irrational thoughts	Mood swings		
No problems or concerns	Other:_____		

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How much sleep do you get each night? _____

Recent stresses/life changes:

_____

Please indicate how your life and functioning are being impacted:

	No Effect	Little effect	Some effect	Much effect	Significant effect	
Marriage/Relationship/Partner	1	2	3	4	5	N/A
Family	1	2	3	4	5	N/A
Job/School performance	1	2	3	4	5	N/A
Friendships	1	2	3	4	5	N/A
Hobbies	1	2	3	4	5	N/A
Financial situation	1	2	3	4	5	N/A
Health	1	2	3	4	5	N/A
Anxiety level/Nerves	1	2	3	4	5	N/A
Mood	1	2	3	4	5	N/A
Eating habits	1	2	3	4	5	N/A
Sleeping Habits	1	2	3	4	5	N/A
If your sleeping habits are affected, describe how: _____						
Sexual Functioning	1	2	3	4	5	N/A
Ability to Concentrate	1	2	3	4	5	N/A
Ability to Control Temper	1	2	3	4	5	N/A
Spirituality	1	2	3	4	5	N/A

Thank you for taking the time to complete this form.

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Client Name:

D.O.B. :

Patient Rights & Responsibilities:

If any of these rights and responsibilities is unclear, you have the right to have them explained to you. Atlantic Psych Associates does not discriminate on the basis of age, race, creed, sex, ethnicity, color, national origin, marital status, sexual orientation, handicap or religion.

Part 1. The Rights of Patients

1. You have the right to be treated with respect and dignity and receive quality services.

2. You have the right to have your clinical information kept confidential within the constraints of the law.

3. You have the right to an explanation of your condition and treatment.

4. You have the right to participate in decisions involving your treatment. If you decide to refuse treatment or do not follow your treatment plan, you have the right to be told what the possible results could be.

5. You have the right to refuse to take part in any scientific research. If you refuse to take part in any research, your refusal will not in any way, affect your treatment or other services you need.

6. You have the right to have your complaints heard.

7. You have the right to request a male or female therapist and a therapist who understands and speaks your language. We will make reasonable efforts to accommodate such requests.

8. You have the right to request a change of therapist. This right has limits. You may ask for and possibly receive a second therapist.

9. You have the right to receive assistance with respect to knowing and understanding your mental health/ substance abuse benefits.

Part 2: The Responsibilities of Patients

1. You are expected to support the patient therapist relationship. For example, you should exercise courtesy and make every effort to keep scheduled appointments. A "No Show" payment may be applied

Atlantic Psych Associates

if you miss an appointment without notifying the office. A "Late Cancellation" fee may be applied if you cancel an appointment with less than 24 hours notice in advance of your scheduled appointment.

2. You are expected to present true and accurate information when requested and participate actively in the planning of your treatment.

3. You are expected to follow the recommendations of the clinical treatment program and to address any problems or complaints about your treatment to your Therapist or the Network Manager.

4. You may not threaten or endanger the life, health, or social well being of staff members or patients of Atlantic Psych Associates, LLC.

5. You may not engage in illegal acts, such as forging or falsifying staff member's name on any forms requiring a signature.

6. You are expected to pay any necessary fees at the time of your appointment.

7. You are expected to notify your therapist if you decide to stop treatment.

8. You are expected to respect the confidentiality of other patients.

Complaints/Feedback

Feedback, either positive or negative, regarding any services provided by Atlantic Psych Associates, LLC is appreciated. You have the right to file a complaint about any and all services provided and to receive feedback in a reasonable amount of time. We encourage you to discuss any complaints with your Therapist. You may however, contact the Office Manager, Christina Tetrault, to file a complaint or give feedback regarding the services provided at Atlantic Psych Associates, LLC.

I have read the statements above and understand my rights, my responsibilities, and the process to lodge complaints, and agree to comply with these statements.

_____	_____	_____	_____
Patient Signature	Date	Witness	Date

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Patient Contract

CONFIDENTIALITY STATEMENT:

I understand that all information between myself and my therapist is held strictly confidential, and my therapist will not release any information about my therapy unless permitted by law or:

1. I agree in writing to permit such a release,
2. I present a physical danger to myself,
3. I present a danger to others,
4. Child/elder abuse/neglect is suspected.

I understand that in the latter 3 cases, the therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken. If I participate in group counseling, I agree not to discuss any details of the group outside of the counseling sessions.

RELEASE OF INFORMATION:

In addition to releases of information permitted above, I authorize discussion of my case with the referral source and other Atlantic Psych Associates, LLC providers and facilities for purposes of diagnosis and treatment. I further authorize the release of information for claims, certification/case management/quality improvement and other purposes related to the benefits of my Health Plan.

(Releases of information to providers outside of the practice, family, etc., require a separate form.)

FINANCIAL TERMS:

Payment is to be made in full with cash, personal check, or credit card at the time of the session. For those plans which Atlantic Psych Associates accepts assignment upon verification of health plan/insurance coverage and policy limits, my insurance carrier will be billed for me and my Provider will be paid directly by the carrier. I will be responsible for any applicable deductibles and co-payments. I agree to make these payments at each appointment. I understand that if I am not eligible at the time services are rendered, I am responsible for payment, even if the determination is made after services are rendered.

CONSENT FOR TREATMENT:

I further authorize and request that my therapist carry out psychological or psychiatric examinations, treatments, and/or diagnostic procedures that now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request

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and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

CANCELED/MISSED APPOINTMENTS:

I understand that if an appointment is missed or canceled with less than 24 hours notice, I will be billed a no show / cancelation fee that is to be paid prior to my next session. I also understand that repeated no shows or canceled appointments (two or more) could result in termination of my mental health services at Atlantic Psych Associates.

TELEPHONE CONSULTATIONS:

I understand that routine calls for the purpose of scheduling and billing are an expected part of the services at Atlantic Psych Associates and are not billed. Telephone calls that are primarily therapeutic in nature and extend more than five minutes, or are frequent, will be prorated and billed at the usual rate.

TERMINATION OF TREATMENT

I understand that once mental health treatment begins I have the right to withdraw my consent to participate in mental health treatment at any time that seems appropriate. I will make every effort to discuss my concerns about progress of my treatment with my Therapist/Clinician prior to terminating therapy in this way. I understand that treatment will also be considered terminated and my file will be considered inactive once a period of 90 days has passed without contact from me, unless otherwise arranged between my therapist and myself. I understand that treatment may begin again at any time, based upon the availability and discretion of my therapist. I understand that if therapy cannot be reinstated, I will be provided the names and numbers of other qualified treatment providers.

I _____ have read the materials presented in this disclosure statement. My signature indicates that I understand the information presented in this packet and all my questions have been answered to my satisfaction. I agree with the conditions of therapy that are either stated or implied and commit myself to compliance with them.

I also agree that my Therapist/Clinician may discuss information regarding my case with those professionals covering for him/her in their absence. I understand that I have the right not to sign this form and choose to discuss my concerns with my Therapist/Clinician before formal mental health treatment begins.

_____	_____	_____	_____
Signature of Client/Guardian	Date	Signature of Staff/Clinician	Date

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FINANCIAL AGREEMENT

Thank you for trusting Atlantic Psych Associates to partner in your health care. This financial agreement should answer questions regarding patient and insurance responsibility for services rendered. Please read this agreement, ask us any questions you may have, and sign in the space provided. You will be given a copy of this agreement for your records.

Insurance

Your insurance coverage is a contract between you and the insurance company, and it is your responsibility to know your insurance benefits. As a courtesy, we will bill both your primary and secondary insurance companies. We will submit your claims and assist you in any way we reasonably can to help get your claims processed. In order to do this, we must receive all the information necessary to bill. If the information is not supplied, you will be billed, and payment in full will be your responsibility and will be expected within 30 days of receipt of statement.

Medicare (if applicable)

We participate in the Medicare program. You are responsible for your co-insurance, any deductibles that have not yet been met, and services that are identified as patient responsibility on your Medicare Explanation of Benefits. We strive to inform our Medicare patients of services that will not be covered.

Managed Care

Many patients are enrolled in Managed Care Products. In order for us to obtain referrals and/or pre-authorizations for procedures, it is important that we have your current insurance information. Depending on individual policies, your procedure may not be a covered benefit. It is your responsibility to check for optimal coverage and policy limitations, and to obtain referrals as required by your insurance company. Please contact your insurance company with questions regarding your coverage.

Patient Responsibility for Payment

You are responsible for payment of any co-payment, co-insurance, deductible or service not covered by our insurance, handling, collection or attorney fees. If you do not have insurance, you are responsible for payment of all services. Co-payments are due at the time of your service. Patient due balances noted on your monthly statement are due within 30 days of receipt. Charges for minor children will be billed to the parent with whom the child resides. We will bill appropriate insurance if all required information is provided. We will not bill or contact a non-custodial parent on behalf of the custodial parent.

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Retainer (if applicable)

Patients coming to Atlantic Psych Associates under forensic circumstances – i.e., by court order, agreed stipulation or on recommendation of their attorney -- will be required to pay a retainer. Atlantic Psych Associates does not accept insurance for forensic matters.

Payment Options

Atlantic Psych Associates accepts cash, check, VISA, MasterCard and Discover (however, no American Express). We understand that financial circumstances vary from patient to patient. If you are unable to pay your patient due balance in full, you must call our Practice Manager at 302-448-4266 to make payment arrangements. Accounts with a patient due balance outstanding over 90 days will be charged finance charges of 20%.

No Show Fees

Appointment reminders are done as a courtesy. Patients will be held responsible for missed appointments whether or not a reminder is delivered. For example, if a phone isn't answered, is repeatedly busy, voice mail/message machine is full, email goes to spam and/or text message is deleted or not read, no reminder can be delivered. A 24 hour notice is requested if you cannot make/keep an appointment and a no show fee of $50.00 will be assessed.

Non-Payment

Failure to pay will result in your account being referred to a collection agency, which may affect your credit. You must contact our collection analyst to discuss payment arrangements. Referral to a collection agency, or naming Atlantic Psych Associates, LLC in a bankruptcy filing, you will be charged a processing fee and any applicable legal fees. NSF checks will result in a $25 processing fee.

I have received this financial policy, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be referred to a collection service. If it becomes necessary to send my account to a collection service, I agree to pay for all costs and expenses, including reasonable attorney fees. I also acknowledge that I have received a copy of this financial agreement for my records.

_____	_____	_____
Patient Signature	Printed Name	Date
_____	_____	_____
Parent/Guardian Signature	Printed Name	Date

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I would like to keep a credit card on file. I understand that this car will be charged for the cost of my appointment or co-pay, if using insurance, AT THE TIME OF SERVICE. No charge will be made toward outstanding balances without my additional consent. We only accept: VISA, MASTERCARD, and DISCOVER.

Printed name:_____

Signature_____ Date:_____

Credit card number:_____

Expiration:_____ Security code:_____

Name as it appears on the card:_____

Zip Code where you receive the credit card bills: _____

_____ I do not request a receipt _____ I do want a receipt

PLEASE PRINT CLEARLY. Thank you.

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Telehealth Informed Consent

1. I, _____, understand that telehealth services are completely voluntary and I can end the session at any time.

2. I understand that none of the telehealth sessions will be recorded.

3. I understand that the laws that protect privacy and the confidentiality of client information also apply to telehealth, and that no information obtained in the use of telehealth that identifies me will be disclosed to other entities without my consent.

4. I understand that telehealth is performed over a secure communication system that is HIPPA compliant. I accept the risk that a technological breach could affect confidentiality.

5. My therapist has explained to me how video conferencing technology procedures will be used. I understand that any telehealth sessions will not be exactly the same as an in-person session due to the fact that I will not be in the same room as my therapist.

6. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that I or my therapist may discontinue the telehealth sessions if it is felt that the videoconferencing is not adequate for my situation.

7. I understand that I may experience benefits from the use of telehealth, but that no results can be guaranteed or assured.

8. I understand that if the video conferencing connection drops while I am in a session and I cannot reconnect, I should contact the office of Atlantic Psych Associates to establish a secondary method of contact or to reschedule my appointment.
9. I understand that this form is signed in addition to the Information, Authorization, and Consent to Treatment document and that all other policy and procedure documents I have completed apply to telehealth services.

10. I understand that I am still responsible for any co-pays or deductibles for my session, and that they will be charged to the credit card I have on file at the time of the appointment.

11. I understand that I am responsible to make sure that telehealth is a covered benefit under my insurance. I understand that I am responsible for payment if my insurance will not cover the session.

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12. I understand that Atlantic Psych Associates is not liable for any breaches in privacy or confidentiality that is due to problems based from the electronic device used by me or by my location. Some applications specifically interact via phone / tablet, device, etc. and have the capability to report activity, gps location, etc. This also includes others overhearing you at your location, others using your electronics, or by stolen or hacked electronics.

13. I understand that I am responsible for providing the necessary telecommunications equipment and internet access for my telehealth sessions, the security on my computer, and arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my telehealth session.

14. I understand I have the right to withhold or withdraw this consent at any time.

15. I understand the laws that protect the confidentiality of my personal health information also apply to telehealth, as do the limitations to that confidentiality discussed in the Information, Authorization, and Consent to Treatment documents that I have previously signed.

_____ _____

Signature of client or guardian Date

_____ _____

Printed name of client or guardian Name of client (if signed by guardian)

I would like my link to my telehealth session to be sent via (pick one):

-email: _____
E-mail address

-text message : _____
Phone number