PCA
Psychiatric and Counseling Associates

Brent Menninger, M.D.
Nancy Pierce, APRN
Andrea Gerry, LMFT
Marissa Lahey, APRN
Diane Gaunt, APRN
Darcy Lane, LMFT-t

AUTHORIZATION FOR MEDIA RELEASE

The marriage and family therapy offered is being delivered by therapist under the clinical supervision of **Janet Byars, Licensed Clinical Marriage and Family Therapist, Kansas – License #284**. In order to meet professional and ethical standards of marriage and family therapists in the state of Kansas clients may accept the following and indicate your agreement to these procedures by signing this authorization form. It is the therapist belief that these practices contribute to the high quality of professional service to you, my valued client please read the following items carefully and discuss them with the therapist.

By signing this form, I/we am/are giving the therapist:

1. Permission to allow your therapist to make video or audio tape recordings of sessions. Portions of these tapes may be viewed by the therapist supervisor as part of case management and training. Portions may also be viewed in session by the therapist and the client. After supervisory cues, the tapes are erased. Though not part of the clinical record, all tapes are treated with the same ethical concern as confidential records.
2. Permission for your therapist to present your case and segments of video or audio tapes during supervision with a supervisor and members of this Therapist supervision group for the purpose of case management and training. The supervision group is made up of 1 to 6 therapist.

These arrangements are not a requirement. Agreement is optional. However, your consideration of these arrangements is appreciated. Thank you for your consideration.

Print Client Name	Client Signature	Date

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I understand under the provisions of KSA 65-6404 my therapist is required to consult with my primary care physician or Psychiatrist to determine if there may be a medical condition or medication that may be causing or contributing to any signs of a mental disorder that he or she may have observed while working with me or my minor child(ren) listed below. In the event that I or my minor child(ren) do not have a primary care physician or psychiatrist, I acknowledge that my therapist has/have recommended that I seek medical consultation.

Name(s) Of Minor Child	Name(s) Of Minor Child

By signing I am indication that I waive my right to such consultation and I am aware that this waiver will become part of my client record.

Client Signature(s)	Therapist Signature(s)

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Name:	Date:

Check any of the following terms that apply to you (Self =S)
Check any of the following terms that you have noticed in a family member (family = F)

S	F		S	F		S	F	
		Depressed mood			Significant on going physical pain			Drug usage
		Lost interest or pleasure			Stomach problems			Marital problems
		Lack of energy/fatigue			Headaches			Divorce
		Weight gain or loss			Bowel problems			Separation
		Unable to concentrate			Balance problems			Affair
		Excessive sleeping			Seizure problems			Problems with ex/spouse
		Difficulty sleeping			Learning/academic problems			Relational problems
		Decreased need for sleep			Stuttering problems			Parenting problems
		Pressure to keep talking			Frequent “on the go” behavior			Problems with friends
		Racing thoughts			Impulsive behavior			Problems with children
		Excessive risk taking behavior			Temper			Legal problems
		Panic attacks			Aggressive behavior toward others			Financial problems
		Excessive fear of situation/object			Destructive behaviors			School problems
		Reoccurring thoughts or impulses			Frequent lying/deceitfulness			Shyness
		Repetitive behaviors to reduce stress			Problems following rules			Anger
		Witness/experience event threatening life or serious injury			Sexual problems			Loneliness
		Excessive anxiety or worry			Eating problems			Insecurity
		Hear/see things others do not			Nightmares			Isolation
		Memory problems/memory loss			Gambling problems			Alcohol usage

If you have noticed any <u>recent changes</u> in the following areas **<u>please check those changes</u>**.

☐ Vision ☐ Hearing ☐ Coordination ☐ Balance ☐ Strength ☐ Speech ☐ Memory

☐ Energy ☐ Sleeping ☐ Menstrual Cycle ☐ Elimination ☐ Eating ☐ Sexual Activity ☐ Thinking

List any additional medical problems you may be experiencing.

8400 W 110TH ST STE 250 Overland Park, KS 66210-2331 ● 913-327-7505 phone ● 913-327-7054 fax ● w ww.pca4u.com

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List any counseling or therapy you, or a member of your family, are receiving or have received.

Therapist	Address	When	Family Member

Have you ever been physically, sexually, emotionally abused? ☐ No ☐ Yes

If yes, briefly describe:

Have you ever been hospitalized for mental or nervous problems? ☐ No ☐ Yes

If yes, when and where:

Have you ever attempted suicide? ☐ No ☐ Yes

If yes, where, when and how many attempts?

Are you suicidal now? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes

If yes, what is your typical drink and how often do you drink alcohol? _____

Age of first alcohol use _____ Age of heaviest/most frequent use _____ Use in last three months _____

Have you ever been arrested for driving under the influence (DUI)? ☐ No ☐ Yes If yes, how many times? _____

Do you use drugs? ☐ No ☐ Yes

If yes, what drugs do you use and how often? _____

Age of first drug use _____ Age of heaviest/most frequent use _____ Use in last three months _____

Have you ever been arrested? ☐ No ☐ Yes If yes, how many times and what for? _____

Are you currently involved or do you expect to be involved in any court-related matters? ☐ No ☐ Yes

If yes, please describe: _____

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What is in your marriage, family or individual life that brings you to therapy?

What kinds of stressors are you experiencing right now?

What important things about your marriage or family would it be helpful for your therapist to know (i.e. illness, handicaps, deaths, divorce, school/job changes, suicide)?

Do you have any concerns about violence or abuse in your family? Alcohol or drug use? Please describe them.

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Patient Information Form

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Name: _____ **Date of Birth:**_____/_____/_____ **Sex:** M F

Preferred Name: _____ **Social Security #:**_____

Address:_____**City:**_____ **State:**____**Zip:**_____

Phone # (for reminder calls):_____**Cell:**_____

E-mail (for reminder appts only):_____

Emergency Contact: _____

Relationship: _____ **Phone:** _____

Employment Status: Full Time Part Time Not Working Student (Circle One)

Marital Status: Single Married Divorced Widowed Separated (Circle One)

Parent (s) Name (if minor)
Mother: _____ **Phone:** _____

Father: _____ **Phone:** _____

Guardian: _____ **Phone:** _____

Spouse (if married): _____ **Phone:** _____

Primary Insurance Carrier

Insurance Name:_____**Insurance Phone Number:**_____

Address for Medical Claims: _____

Member ID#:_____ **Group #:**_____

Name of Policy Holder (Subscriber): _____**Subscriber's SS#:**_____

Subscriber's DOB__/___/___**Subscriber's Employer:** _____ **Subscriber's Phone#**_____
Patient's Relationship to Subscriber: Self Spouse Dependent (Circle One)

How did you hear about our practice? _____

I authorize the release of any information necessary to process insurance claims and to obtain reimbursement. I request that payment of authorized benefits be made on my behalf to this practice. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges not paid by my insurance.

Some insurance companies pay a fixed amount; others pay a percentage of the charge. We will estimate your co-pay for services rendered at the time of service. It is your responsibility to pay any deductible, co-pay or balance not paid by your insurance company.

_____ _____
Patient's Signature (or Legal Guardian Signature) **Date**

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Web: www.pca4u.com

PCA FINANCIAL POLICY

The following is a statement of our Financial Policy which we require you to read, initial letters **A** through **H** and sign prior to receiving any treatment from our providers.

_____ **(A)** Thank you for choosing us as your behavior healthcare provider. Please understand that payment of your bill is considered a part of your treatment. Insurance is a contract between **you and your insurance company**. It is your responsibility to know your insurance policy benefits. We are not always informed of your specific contract. We will not become involved in disputes between you and your insurance regarding deductibles, co-payments, covered charges, secondary insurance or other matters regarding reimbursement.

Insurance and Fee Policy

_____ **(B)** As a courtesy, we will verify and submit your insurance claim to a primary insurance plan only. We do not bill to secondary or third party insurance. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under your insurance. Any amount that your insurance company will not be paying is due from you at the time services are rendered. We do not balance bill on insurance plans in which we are participating or contracted providers. **You are responsible for providing this office with copies of your insurance card or any changes with your insurance or coverage prior to being seen by one of our providers.** Failure to do so may result in a denial of your claim making you financially responsible for your sessions(s). If you do not have insurance, we offer a discounted rate due at the time of service.

24-Hour Cancellation Policy

_____ **(C)** You will be charged for every scheduled appointment unless you cancel at least **24 hours in advance.** Late cancellation or no shows will be billed at the rate of $50.00 for a medication check and $75.00 for a 30 minute or longer appointment. Insurance companies will not pay for no shows or late cancellation charges. Those are your responsibility before you can be rescheduled for another appointment.

Appointment Reminders

_____ **(D)** We will make a courtesy reminder call and/or send an e-mail 48 hours prior to your scheduled appointment. Ultimately, keeping scheduled appointments is your responsibility.

Returned Check Fee

_____ **(E)** There is a $45.00 fee for any check returned unpaid by your bank. You will have 10 days to clear up the outstanding check, otherwise it will be sent to our collection agency. Your account will be placed on a cash or credit card only basis, as we will no longer accept checks from you.

Payments and Collections

_____**(F)** We accept cash, checks, Visa, MasterCard, Discover and American Express and recommend keeping your credit card on file. Any outstanding balances are due within 30 days of the statement, after which a $5.00 fee will be added to your account. If you experience circumstances beyond your control, please speak with your clinician or the billing department for payment arrangements. All balances reaching 90 days past due may be sent to our collection agency. You will be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the delinquent balance. Please be aware if your past due status is reported to a collection agency and /or a credit reporting agency, the fact you received treatment at our office may be a matter of public record.

Medical Records/Paperwork/Prescription Refill Fees

_____ **(G)** There may be times when you may need medical records, paperwork or prescription refills completed by one of our providers. There is a fee for filling out these requests. The fees vary according to the document(s) needed. Medical Records may take up to 60 days, paperwork up to 10 days and prescription refills 3 days.

Divorce

_____ **(H)** If you have been or are now involved in a divorce, please understand that we are legally not part of the divorce and are not bound to any divorce decree issued by a court of law. The person that presents themselves or a minor child for treatment is responsible for payment of the medical bill. If your divorce decree states that your ex-spouse is to pay any portion of the medical bills, then you must pay us at the time of service and then seek payment from your ex-spouse per the terms of your divorce decree. We encourage all legal guardians to be present at all appointments for minor children.

Printed Name of Person Financially Responsible (Guarantor) _____

_____ _____

Signature of Guarantor Date

__ _____ _____

Address of Guarantor (where statements will be mailed) Social Security # of Guarantor

Date of Birth of Guarantor: _____/_____/_____ Guarantor's Phone #_____

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CREDIT CARD ON FILE AGREEMENT

Psychiatric & Counseling Associates recommends keeping your credit or debit card on-file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable. Your credit card information is kept confidential and secure. An example of your liability is a deductible amount that insurance applies to your responsibility after they process the claim. Payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account. Whenever a payment is processed you will receive a detailed receipt by email. If you choose not to keep your credit card on file, your first statement is mailed at no charge. If a second statement is required to settle the account, a billing fee of $5.00 will be added to your account.

I authorize Psychiatric & Counseling Associates to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

Amex Visa MasterCard Discover

Credit Card Number _____

Expiration Date _____ **/** _____ **/** _____ **Security Code (CVV)** _____

Cardholder Name _____

Signature _____

Email _____

Billing Address _____

City _____ **State**_____ **Zip** _____

I (we), the undersigned, authorize and request Psychiatric & Counseling Associates to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Psychiatric & Counseling Associates. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 30-day notification to Psychiatric & Counseling Associates in writing.

Patient Name (Print): _____

Patient or Parent Signature: _____**Date**: _____ / _____ / _____

I, (print name) _____ decline to keep my credit card on file, and understand that any balance over 30 days past due will incur an additional $5.00 charge for our office to continue collection efforts. Any balance over 90 days past due may be sent to collections.

Patient Name (Print): _____

Patient or Guarantor Signature: _____ **Date**: _____ / _____ / ___

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CONSENT FOR TREATMENT

I hereby voluntarily consent to receive services, which may include assessment, and referral recommendations deemed necessary and advisable in the judgment of Psychiatric & Counseling Associates, LLC. If the patient is a minor or otherwise incapable of providing consent, I hereby authorize and consent to the same services for him/her.

I understand that the information given to Psychiatric & Counseling Associates, LLC., will be kept confidential and will only be released when: a written consent is obtained, a medical emergency occurs, a court order or subpoena is received; information is required by the insurance company and/or managed care firm to process claims and manage treatment; or a patient represents a serious danger to himself/herself or others. I hereby hold harmless Psychiatric & Counseling Associates, LLC., for any loss, costs, and damages allegedly sustained by me or my ward because of the release of information under the circumstances listed above.

I give my consent for PCA clinicians and staff to leave a message regarding scheduling, treatment, lab results or other information as necessary. (Check all that apply):

____ On an answering machine or voicemail at
____ home or cell. On an answering machine or
voicemail at work.
____ With a specific individual: _____
____ I do not consent to messages left at home, work or with any other person. I wish to be contacted directly.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Signature of Parent/Responsible Party Date
Who is NOT living with the minor

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

To Our Patients:
Our office holds all your health information confidential. We are required, by law, to keep your health information private and provide you with this Notice of Privacy Practices. This Notice of Privacy Practice explains how Psychiatric and Counseling Associates, LLC (PCA) and its clinical staff and employees may share your Protected Health Information (PHI) with others for treatment, payment, health care operations, and other purposes allowed or required by law. This Notice of Privacy Practices is posted on our web site (www.pca4u.com) and is also available at the front check-in location.

Protected Health Information (PHI) is information about a patient's age, race, sex, and other personal health information that may identify the patient. The information relates to the patient's physical or mental health in the past, present, or future, and to the care, treatment, and services needed by a patient because of his or her health.

Healthcare Operations include activities such as discussions between PCA staff and other health care providers, training clinic staff, interacting with insurance companies, carrying out medical reviews to measure quality, and managing business functions.

PCA uses medical records to record health information, to plan care and treatment, and to carry out routine health care functions. Examples of which are listed below:

- Provide PHI to referring providers to create and carry out a plan for your treatment.
- Provide PHI to your insurance company to file claims for payment.
- May use PHI to review the quality of services you receive.
- May send you reminders for appointments.
- May share PHI with public health agencies as permitted by law.
- Will use and disclose PHI when required by federal or state law, or by court order. For example, to investigate reports of abuse.
- May use and disclose PHI for public benefits under other government programs.
- May disclose PHI to law enforcement in order to avoid serious threat to the health safety of a person or the public.
- May disclose PHI to your family or other persons who are officially involved in your medical care. You have the right to object to the sharing of this information.

To release patient PHI to other people for any reason other than treatment, payment, and health care operations (described above) or as required or permitted by law, we must have a permission form known as an Authorization Form signed by the patient or the patient's parent or legal guardian. This form clearly authorizes how you (the patient) wish the information to be used and disclosed.

Your Rights Regarding Your Health Information

Right to see and get copies of your records. In most cases, you have the right to review or get copies of your records. You must make the request in writing. You may be charged a fee for the cost of copying your records.

Right to request a correction or update to your records. You may ask PCA to change (amend) or add missing information to your records if you think there is as mistake. Your request must be made in writing to the Office Manager. In certain cases, we may deny your request for change.

Right to get a list of disclosures. You have a right to ask PCA for a list of disclosure(s) made after April 14, 2003. This is a list of the disclosures we made of medical information about you, other than for treatment, payment or healthcare operations as described in the Privacy Notice. We are not required to account for information releases: that you requested, that you agreed to by signing an Authorization Form, that are given to family or friends involved in your care or certain releases we are allowed to make without your permission. The request for a record must be made in writing to the Office Manager. The request should state the time period for the list. Requests for records about PCA disclosures of your PHI are limited to time frames of six years or less as require by law.

Right to request limits on uses or disclosures of PHI. You have the right to ask that PCA limit how your information is used or disclosed for the purposes of treatment, payment, and healthcare operations. You must make the request in writing telling PCA what information you want to limit and to whom you want the limits to apply. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. If you have paid for your treatment completely out of pocket, you can request for PCA not to provide information about your treatment to your insurance company.

Right to revoke permission. If you are asked to sign an authorization to use or disclose information, you can cancel that authorization at any time. You must make the request in writing. This will not affect information that has already been shared.

Right to choose how we communicate with you. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must request in writing to the Office Manager. Your request must specify how or where you wish to be contacted. We will not ask you the reason for the request. We will attempt to accommodate all reasonable requests.

Right to get a paper copy of this notice. You have the right to ask for a paper copy of this notice at any time.

Complaints: You may submit any complaints with respect to violations of your privacy rights to the PCA Office Manager. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services if you feel that your rights have been violated. There will be no retaliation from PCA for making a complaint.

Change to this Notice: If we make a material change to this Notice, we will provide a revised Notice available at www.pca4u.com.

Contact Information: Unless otherwise specified, to exercise any of the rights described in this Notice, for more information, or to file a complaint, please contact the Office Manager at 913-327-7505.

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Patient Acknowledgement of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy will be posted in the practice's office, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

_____
Patient's Signature

_____
Printed Name

_____
Date

If not signed by the patient, please indicate relationship:

_____ Parent of guardian of minor patient

_____ Guardian or conservator of incompetent

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law, requires that we provide you with this notice that explains our privacy procedures with regard to your medical information and how we may use and disclose your Protected Health Information (PHI) for treatment, payment, and for care operations, as well as purposes that are permitted or required by law. You have certain rights regarding the privacy of your PHI, and we also describe them in this notice.

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Medical Information Sheet

Patient Name:_____ Date of Birth: _____

Reason for Visit:_____

Occupation:_____ Employer/School:_____

Family Members in Household:_____

_____

Medication Allergies:_____

What is the date of your last physical examination?_____

What is the name of your Primary Care Physician (PCP)?_____

Do you have or have you had any of the following:

Condition	Y	N	Please Explain
Heart Problems			
Neurological Problems (Numbness, weakness, headaches, paralysis)			
Seizures			

Have you had previous outpatient mental health treatment? If yes, please let us know when and where._____

_____

Have you been an inpatient at a hospital/institution for psychiatric treatment? If yes, please let us know the reason for admission, location and the date(s) of your treatment._____

_____

_____

Continued on Back of Page

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Current Medications (include prescriptive, herbal and over-the-counter medications)

Name	Dosage & Frequency	Dates of Use	Prescribing Physician

Past Psychiatric Medications

Please review the following list of commonly prescribed psychotropics. Both the trade names and generic names are provided in an effort to aid in your recall. Please **check** all that you have been on in the past. Also, **circle** the ones that you feel were particularly helpful and **underline** any that caused you side effects.

	Viibryd / vilazodone		Saphris / asenapine		Campral / acamprosate
	Prozac / fluoxetine		Fanapt /iloperidone		Antabuse / disulfram
	Paxil / paroxetine		Thorazine / chlorpromazine		Revia / naltrexone
	Zoloft / sertraline		Mellaril / thioridazine		Ambien / zolpidem
	Celexa / citalopram		Prolixen / fluphenazine		Sonata / zaleplon
	Lexapro / escitalopram		Trilafon / perphenazine		Lunesta / eszopiclone
	Luvox / fluvoxamine		Stelazine / trifluoperazine		Somnote / chloral hydrate
	Wellbutrin / bupropion		Haldol / haloperidol		Restoril / temazepam
	Serzone / nefazodone		Navane / thiothixene		Halcion / triazolam
	Effexor / venlafaxine		Loxitane / loxapine		Prosom / estazolam
	Remeron / mirtazapine		Moban / molindone		Dalmane / flurazepam
	Desyrel / trazadone		Eskalith / Lithobid / lithium		Rozerem / ramelteon
	Elavil / amitriptyline		Depakote / divalproex		Xanex / alprazolam
	Anafranil / clomipramine		Tegretol / Carbatrol / carbamazepine		Klonopin / clonazepam
	Sinequan / doxapine		Lamictal / lamotrigine		Valium / diazepam
	Tofranil / imipramine		Trileptal / oxcarbazepine		Tranxene / clorazepate
	Cymbalta / duloxetine		Keppra / levetiracetam		Librium / chlordiazepoxide
	Norpramin / desipramine		Topamax / topiramate		Ativan / lorazepam
	Pamelor / nortriptyline		Gabitril / tiagabine		Serax / oxazepam
	Nardil / phenelzine		Neurontin / gabapentin		Ritalin / Concerta / Metadate / Daytrana / Focalin / Focalin XR / Methylphenidate
	Parnate / tranylcypromine		Buspar / buspirone		Adderall / Adderall XR / Vyvanse
	Eldepryl / selegiline		Inderal / propranolol		Dexedrine / dextroamphetamine / Amphetamine
	Risperdal / risperidone		Catapres / clonidine		Cylert / pemoline
	Zyprexa / olanzapine		Atarax / Vistoril / hydroxyzine		Strattera / atomoxetine
	Seroquel / quetiapine		Equinil / Miltown / meprobamate		Provigil / modafinil
	Geodon / ziprasidone		Tenormin / atenolol		Nuvigil / armodafinil
	Abilify / aripiprazole		Tenex / Intuniv / guanfacine		Exelon / rivastigmine
	Clozaril / clozapine				Reminyl / galantamine
	Latuda / luvasidone				Aricept / donepezil

Patient's/Guardian's Signature: _____ Date: _____