

Birmingham Anxiety & Trauma Therapy

100 Centerview Drive, Suite 201, Vestavia Hills, Alabama 35216

Phone: 205-807-5372, Fax: 205-413-8789

<http://therapistsbirmingham.com>

AGREEMENT FOR PSYCHOLOGICAL SERVICES AND INFORMED CONSENT

Welcome to Birmingham Anxiety and Trauma Therapy (BATT)! This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions that you might have so that we can discuss them. Once you sign this, it will constitute a binding agreement between us.

ABOUT YOUR THERAPIST

Our therapists have extensive training in their areas of expertise. They know what the latest research says about the most successful approaches to your challenges. We pride ourselves on being readily available to you while you are in therapy, but we want to create a relationship that lasts longer than simply making your symptoms go away. We want to help you navigate toward a greater quality of life. We don't want to "fix" then "free you" – we want to remain a resource to you in the future as well. Research shows that up to 68% of the success in therapy is due to the fit between therapist and patient. It is important for us to give you the right therapist to fit your therapeutic needs. We want to make it as comfortable and easy as possible to engage in therapy. Your therapist will thoroughly review your intake form with you in order to get the most complete picture of 'what it is like to be you.' If additional info is needed, they may recommend some diagnostic testing and will be happy to arrange that for you. We want to build a warm, trusting, and collaborative relationship with each of our patients. We appreciate and value your uniqueness, so we design a treatment plan with your stated goals in mind.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personality of both the therapist and the patient and the particular problems that the patient brings. There are a number of different approaches which can be utilized to address the problems you hope to address. In order to be most successful, you will have to work both during our sessions and at home.

Psychotherapy has both benefits and risks. Risks sometimes include experiencing uncomfortable levels of feelings like sadness, guilt, anxiety, anger, frustration, loneliness or helplessness. This may also include recalling unpleasant aspects of your history. Psychotherapy has also been shown to have benefits for people who undertake it. It often leads to a significant reduction of feelings of distress, better relationships, and resolutions of specific problems. However, there are no guarantees about what will happen. If you have any questions about any of the procedures used at BATT, please discuss them with your therapist as soon as they arise: if your doubts persist, we will be happy to refer you to another therapist.

From time to time, our office sends correspondence to patients or families about developments in the practice, upcoming programs and information about the fields of psychology and education that we believe may be of value to you. If you do not wish to receive this information, please let us know. Also, at any time you can ask to be excluded from our mailing list by informing us by telephone or email.

MEETINGS

Our normal practice is to begin by gathering information (often called "intake"), which lasts from one to three sessions. During this time, you and your therapist can decide whether there is a good patient-therapist fit in order to meet your treatment goals. After that, you and your therapist will usually schedule a 53 to 55-minute session per week or every other week at a mutually agreed upon time, although sometimes sessions will be longer or more frequent.

PROFESSIONAL FEES

Fees depend on the amount of time each session lasts. There is a \$150 fee for a session that lasts 40 to 50 minutes. There is a \$200 fee for a session that lasts more than 53 minutes. In addition to appointments, it is our practice to charge this amount on a prorated basis for other professional services you may require, such as report writing, attendance at meetings or consultations with other professionals that you have authorized, preparation of records, or the time required to perform any other service which you may request of your therapist (including phone calls lasting more than 15 minutes and frequent texting). Please note that insurance may not pay for phone calls or texting, and you will be sent a bill for these fees.

Reports, referral letters, and recommendation letters will be billed in 15-minute increments at \$25 per 15 minutes, unless such documents are related to an ongoing or upcoming court case.

Legal related services are either those ordered by a court or those for which reporting on progress to a court or court officer is expected, or cases in which a subpoena is likely. For legal related services such as documents, depositions and court appearances, our fees are \$200.00 per hour plus a \$250.00 preparation fee. If services are provided any place other than our office, travel time is charged as part of our fee.

CANCELLATIONS AND MISSED APPOINTMENTS

We never purposely double-book our therapy schedules. Instead, we reserve a specific time for you to receive services. Because this time has been reserved specifically for you, we expect you to provide at least 48 hours' notice if you need to cancel or reschedule the session. Sessions without 48 hours' notice will be charged a \$100 no-show fee. If you miss 3 sessions without giving us 48 hours' notice, we will assume that you no longer wish to receive any services. Your regular standing appointment may be given to someone else at that time. As explained at the time you scheduled your first appointment, a credit card on file was required in order to reserve your first appointment. It is our policy to charge a \$100 no-show fee if the first session is missed. If the first appointment was attended as planned, regular insurance or self-pay fees apply. (The reservation fee is not charged if you show up for the first session.)

BILLING AND PAYMENTS

We deeply value our relationship with you! To best provide services for you and our community, BATT recognizes the following patient payment agreement. As we get started, please read each item below to ensure your understanding. For further clarification, please call our office @ 205-807-5372 or email us at info@batthelp.com

- A credit/debit card is required to be on file to secure payment for services. FOR YOUR PROTECTION AND PEACE OF MIND, YOUR CREDIT CARD INFORMATION WILL BE SECURED IN OUR ENCRYPTED SYSTEM.
- Copayment, Coinsurance, Deductible, and Self-Pay Patient Fees can be paid by cash, check or credit card. If paying by cash or check (made to "BATT"), please give that to your therapist at the beginning of each session. If paying by credit card, your fee will be processed to your card at the end of your session.
- Missed Appointment fees will be automatically charged to your credit/debit card in accordance with the BATT Cancellation and Missed Appointment Policy.
- We appreciate your commitment to stay current on your account while we focus on serving YOU! If you run a balance of greater than \$100, services will be suspended until the balance is paid in full.

If your account is more than sixty days in arrears and suitable arrangements for payment have not been agreed to, I have the option of using legal means to secure payment, including collection agencies or small claims court. If such legal action is necessary, the costs of bringing that proceeding will be included in the claim. In most cases, the only information I release about a patient's treatment is the patient's name and address, the nature of the services provided, and the amount due. Please Note: There will be a \$35.00 service charge for all returned checks.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources are available to pay for your treatment. If you have a health benefits policy, it will usually provide some coverage for mental health treatment. You are responsible for any portion of the fees not covered by your insurance company. The general process is as follows: You pay your co-pay at time of session, your services are submitted to your insurance company, and you are then billed by BATT for any costs not covered by your insurance company. Please remember that insurance is considered a method of reimbursing the patient for the fee paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. Testing services are not always reimbursed. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance. Please remember that we try to work with insurance companies as a courtesy to you. We will follow up on claims for services rejected by your insurance company only three times. After three rejections, you will be responsible for payment in full. At that time, we will provide you with a superbill if you choose to continue to pursue reimbursement by your insurance company.

In many instances, we are able to look up your eligibility and benefits on websites provided by the insurance companies. However, the insurance companies clearly state that the information on the website is not a contractual agreement and that the information is subject to change without notice. Therefore, while we can give you a good idea of eligibility and benefits, we cannot be held accountable for differences between what we quote to you as your eligibility and benefits (based on the website information) and what the insurance companies actually pay on your behalf. YOU are responsible for reviewing your insurance policy statements and Explanation of Benefits.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions, you should call your plan and inquire. The number for this inquiry is usually noted on the back of your insurance card at the bottom. Of course, we will provide you with whatever information we can, based on our experience and will be happy to try to assist you in deciphering the information you receive from your carrier.

Managed health care plans such as HMOs and PPOs sometimes require advance authorization before they will provide reimbursement for mental health services. These plans are often oriented towards a short-term treatment approach, designed to resolve specific problems that are interfering with one's usual level of functioning. It may be necessary to seek additional approval after a certain number of sessions. In our experience, while quite a lot can be accomplished in short term therapy, many patients feel that more services are necessary after insurance benefits expire.

You should also be aware that insurance agreements may require you to authorize us to provide a clinical diagnosis, and sometimes additional clinical information such as a treatment plan or summary, or in rare cases, a copy of the entire record. This information will become part of the insurance company files, and in all probability, some of it will be computerized. All insurance companies claim to keep such information confidential, but once it is in their hands, we have no control over what they do with it. In some cases, they may share the information with a national medical information data bank.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if the insurance benefits run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself and avoid the complexities that are described above. Please note: Insurance rarely covers forensic psychology services.

CONFIDENTIALITY

In general, the confidentiality of all communications between a patient and a psychologist is protected by law, and your therapist can only release information about your treatment to others with the written permission of the patient or his/her guardian. However, there are a number of exceptions: In most judicial proceedings, you have the right to prevent your therapist from providing any information about your treatment. However, in some circumstances, such as child custody proceedings and proceedings in which your emotional condition is an important element, a judge may require your therapist's testimony if s/he determines that resolution of the issues before him/her demands it.

When there is a court order for your therapist's services, generally the court will expect a report of attendance and progress.

There are some situations in which your therapist is legally required to take action to protect others from harm, even though that may require revealing some information about a patient's treatment. If your therapist believes a minor, an elderly person, or a disabled person is being abused, s/he must file a report with the appropriate state agency. If your therapist believes that a patient is threatening serious bodily harm to another, s/he required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a patient threatens to harm him/herself, the therapist may be required to seek hospitalization of the patient, or to contact family members or others who can help provide protection. Should such a situation occur, your therapist will make every effort to fully discuss it with you before taking any action.

Your therapist may occasionally find it helpful to consult about a case with other professionals. In these consultations, s/he will make every effort to avoid revealing the identity of any patient. The consultant is, of course, also legally bound to keep the information confidential. Unless you object, s/he will not tell you about these consultations unless s/he feels that it is important to your work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important to discuss any questions or concerns which you may have as soon as possible. As you might suspect, the laws governing these issues are quite complex and none of the therapists at BATT are attorneys. While we are happy to discuss these issues with you, should you need specific advice, formal legal consultation may be desirable.

PROFESSIONAL RECORDS

We are required to keep appropriate records of the professional services we provide, and you have the right to review your records. (For more information on this, refer to the HIPAA Privacy Statement.) However, because these records contain information that can be misinterpreted by someone who is not a mental health professional, it is our general policy to discourage patients from viewing their files. Instead, if you request, we will provide you with a treatment summary unless we believe that to do so would be emotionally damaging. If that is the case, we will be happy to forward the summary to another appropriate mental health professional who is working with you.

MINORS

If the patient is under eighteen years of age, please be aware that the law may provide the parents (in the case of divorces, the custodial parent/s) with the right to examine the patient's treatment records. I will usually provide parents only with general information on how the patient's treatment is proceeding, unless I feel that there is a high risk that the patient will seriously harm him/herself or another, in which case I will notify them of my concern. I will also provide them with updates of the patient's treatment. Before giving them any information, I will discuss the matter with the patient and will do the best I can to resolve any objections the patient may have about what I am prepared to discuss.

CONTACTING ME

The office contact number is 205-807-5372. Your therapist not always immediately available by telephone, especially when they are in a session with another patient. For non-emergencies, we will make every effort to return your call on the same day you make it, including calls I receive after office hours. Otherwise, it may be the next day before we can respond to a non-emergency call. If you are difficult to reach, please leave some times when you will be available. If it is an emergency and you feel that you cannot wait for me to return your call, you should call your family physician or the emergency room at the nearest hospital and ask for the psychologist or psychiatrist on call OR CALL 911.

It is important for you to understand that we cannot guarantee confidentiality of communication by email and text. While our electronic online files are encrypted, our emails and texts are not. We certainly do our best to keep any type of communication with you private and confidential, but while you are welcome to make use of these communication tools, you do so at your own risk.

SOCIAL MEDIA

Contact between therapists and a patient via social media (Facebook, Twitter, LinkedIn, Instagram, Pinterest, etc.) has the potential to produce unnecessary complications that may interfere with progress in therapy. Therefore, none of the therapists or employees at BATT will respond to personal friend requests or other social media contact requests. BATT currently has a Facebook page and a Twitter page. You are welcome to view and participate on those pages.

MULTIPLE RELATIONSHIPS

We make all attempts to avoid multiple relationships in regard to our patients engaged in counseling services. A multiple relationship occurs when a psychologist/counselor is in a professional role with a person and (1) at the same time is in another role with the same person, (2) at the same time is in a relationship with a person closely associated with or related to the person with whom the psychologist has a professional relationship, or (3) promises to enter into another relationship in the future with the person or a person closely associated with or related to the person. Although some multiple relationships are unavoidable, multiple relationships have the potential to impair our objectivity and effectiveness in our role as a therapist. Therefore, we usually refrain from providing individual services to more than one member of a family. If we are providing couples therapy, please understand that the union itself is the patient, and therefore, we will not keep secrets from either member of the couple.

(PLEASE PROCEED TO THE NEXT PAGE OF THIS DOCUMENT TO PROVIDE SIGNATURES INDICATING UNDERSTANDING AND AGREEMENT WITH THE CONTENTS OF THIS DOCUMENT...)

Thank you for choosing B'ham Anxiety & Trauma Therapy!

PLEASE INITIAL THE FOLLOWING STATEMENTS TO VERIFY YOUR UNDERSTANDING AND AGREEMENT:

- _____ I (the patient/patient's representative) understand that I am required to provide BATT a minimum of 48 hours advanced notice of any need to cancel or reschedule a session. Missed sessions without 48 hours' notice will be charged a \$100 no-show fee.
- _____ I understand that I am responsible for any portion of the fees not covered by my insurance company.
- _____ I understand that I am responsible for any professional fees associated with my care.
- _____ I understand that BATT will only pursue rejected claims a maximum of three times and after that I am responsible for paying the entire bill.
- _____ I understand that BATT provides eligibility and benefit information as a courtesy only, and that BATT cannot be held accountable for differences between what they tell me about my benefits (based on good faith understanding of the insurance website information) and what the insurance companies actually pay on my behalf.
- _____ I understand the limits to my confidentiality information as described in the CONFIDENTIALITY section above.
- _____ I understand that should I choose to contact my therapist via email or text, that these devices are not encrypted and thus pose a potential privacy breach.
- _____ I understand that the social media rules described above were established for my welfare and to foster therapeutic success.
- _____ I have read and understood the BATT Billing and Payments section of this document. Please process my credit card on file for my copays or self-pay fees (not otherwise paid by cash or check at the time of service), coinsurance, insurance deductibles (as noted on insurance EOB's), and/or missed appointment fees.
- _____ I understand that all copays are due at time of service or the credit card on file will be used to clear the balance.
- _____ I understand that therapy visits will be postponed if for any reason my balance is over \$100.

PLEASE NOTE: Your signature below indicates that you have read all the information in this document, and agree to abide by its terms during our professional relationship. Your signature below also signifies that you have received a copy of the Birmingham Anxiety and Trauma Therapy HIPAA Privacy Notice.

Date: ____/____/____

Printed Name:

Signature:

Patient's Name (print)

Patient's signature

Parent/Guardian (if patient is under 18 years of age)

Parent/Guardian (if patient is under 18 years of age)

Therapist Signature

Therapist Credentials

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CONFIDENTIAL ADULT INTAKE FORM

VITAL INFORMATION

Name: _____ Date: _____ DOB: _____ Gender: M F Other

Ethnic Identity: _____ Contact Phone #: _____ Email Address: _____

Home Address: _____ (Street) _____ (City, State) _____ (Zip Code) May we place you on our mailing list? Yes No

Emergency Contact: _____ Contact's Phone #: _____ Contact's relation to you: _____

Referred By: Internet Doctor School Individual Other: _____

If employed, who is your employer? _____ What is your position? _____

Longest job you've worked since high school? _____ Highest Degree of Education: _____

Spouse/Partner's Employer? _____ Highest Degree of Education: _____

If in school, what school do you attend and what is your focus? _____

Primary Care Physician (PCP): _____ PCP Practice Name: _____

Primary Care Physician Phone: _____ PCP Email: _____

PCP Address: : _____ (Street) _____ (City, State) _____ (Zip Code) PCP FAX Number: _____

Any previous outpatient therapy? Yes No Dates and length of treatment: _____

Any previous inpatient therapy? Yes No Dates and length of treatment: _____

Was the therapy helpful? Yes No Why or why not? _____

Have you ever been previously diagnosed with a psychological disorder? Yes No Please describe: _____

REASON FOR COMING TO THERAPY

What brings you to therapy at this time? _____

What do you hope to get out of therapy? _____

HOW YOU'VE BEEN FEELING LATELY

What has your mood been like lately? (Up? Down? Both?) _____

Have you ever felt suicidal? Have you ever attempted suicide? Please describe: _____

STRESSFUL EVENTS

Please rate the level of stress you are currently experiencing on a daily basis (1=no stress, 10= constant, severe stress): _____

What do you think is responsible for the stress in your life at this time? _____

Have you ever experienced a life event that was especially difficult to overcome or get through? ___ Yes ___ No

Please describe: _____

Have you ever experienced any type of abuse? ___ Verbal ___ Emotional ___ Physical ___ Sexual

If so, please describe: _____

MEDICATION

Are you currently prescribed any medications? ___ Yes ___ No Please describe: _____

Prescribing Physician: _____

Have you previously been prescribed psychiatric medication/s? ___ Yes ___ No Please list all previous psychiatric medications: _____

USE OF SUBSTANCES

Have you smoked cigarettes in the past? ___ Yes ___ No Are you currently smoking? ___ Yes ___ No If so, how many packs a day? _____

When was the last time you drank any alcohol? _____ How much did you drink at that time? _____

How often do you drink alcohol? _____ How much alcohol do you usually drink when you do drink? _____

Has anyone ever expressed a concern about your drinking? ___ Yes ___ No What was their concern? _____

Please complete the following information about your use of various substances, if applicable:

Substance (please circle): _____ **First Use:** _____ **Last Use:** _____ **Highest Use:** _____

Crack/Cocaine..... _____

PCP..... _____

Heroin..... _____

MJ..... _____

Hallucinogens..... _____

Pain Killers..... _____

Other: _____

PHYSICAL

Significant medical events (including seizures or epilepsy): _____

Chronic diseases in family (including mental illness): _____

All known allergies: _____

How has your appetite for food been lately? _____

Have your eating patterns or your body weight ever been a concern for you? _____ If so, please describe: _____

Describe the amount and type of physical activity or exercise that you engage in on a regular basis: _____

Describe your quality of sleep at night (Please circle): Can't get to sleep Wake up in the middle of sleep Can't wake up Other:

How many significant relationships have you had? _____ How many friends outside of family you can depend on for support? _____

Have you noticed any concentration difficulties or attention problems recently? Describe: _____

SOCIAL

Relationship Status: _____ Separated _____ Widowed _____ Never Married _____ Living Together _____ Dating _____ Not Dating At This Time

Currently married to: _____ How long have you been married to this person? _____

If divorced: How many times have you been married? _____ What was the date of your most recent divorce? _____

What are your favorite leisure activities? _____

Have you had a sense of losing time recently? Feeling distant from friends/family? _____

Have you been getting criticized by your family? Please describe: _____

Have you ever had intelligence testing? Do you recall the results? _____

What is your current living situation? _____ Alone _____ With spouse _____ With spouse and children _____ With significant other _____ With roommate

Other (please explain): _____

Please list your spouse/significant other, your children, and their ages:

Name: _____ Relationship: _____ Age: _____

What one word best describes your childhood? _____ Who were you closest to during childhood? _____

Are you currently experiencing any family conflicts? ___ Yes ___ No If so, please describe: _____

Briefly describe your relationship with your mother: While growing up: _____

Now: _____

Briefly describe your relationship with your father: While growing up: _____

Now: _____

List your brothers and sisters, their ages and current state of residence:

Name: _____ Relationship: _____ Age: _____ State Lives In: _____

TRAUMA

Prior to your 18th birthday:

- No__ Yes __ Did a parent or other adult in the household often or very often... Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
- No__ Yes __ Did a parent or other adult in the household often or very often... Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
- No__ Yes __ Did an adult or person at least 5 years older than you ever... Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?
- No__ Yes __ Did you often or very often feel that ... No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
- No__ Yes __ Did you often or very often feel that ... You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
- No__ Yes __ Were your parents ever separated or divorced?

Was your mother or stepmother:

- No__ Yes __ Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
- No__ Yes __ Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?
- No__ Yes __ Was a household member depressed or mentally ill, or did a household member attempt suicide?
- No__ Yes __ Did a household member go to prison?

STRENGTHS

Have you ever had significant personal growth experiences in the form of special trainings, workshops, or related experiences? __ Yes __ No

If so, please describe: _____

Are there any spiritual, religious, philosophical tradition/s that have had a significant effect on your life, now or in the past? __ Yes __ No

If so, please describe: _____

What are your greatest strengths, talents and resources? _____

Have any aspects of your sexuality ever been a cause of concern for you? __ Yes __ No If yes, please describe: _____

Have you ever been arrested? Convictions? Time served? Please explain: _____

Thank you for providing this information

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Notice of Policies and Practices Regarding Privacy of Health Information

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

OUR PLEDGE REGARDING HEALTH INFORMATION: This notice applies to all personal health information about you created, maintained, or gathered by Birmingham Anxiety and Trauma Therapy. We understand that psychological and medical information about you is personal. We are committed to protecting your personal health information (PHI). We create and maintain a record of services provided to you and this record may contain information from other agencies, departments, companies or entities that have referred you to the practice for services. This record is to provide you with quality services. This notice will tell you about the ways we may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- “PHI” refers to information in your health record that could identify you.
- “Treatment, Payment and Health Care Operations”
 - Treatment is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another doctor or therapist.
 - Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer or payment provider to obtain reimbursement for your health care or to determine eligibility, coverage, or to provide documentation of current services.
 - Health Care Operations are activities that relate to the performance and operation of the practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- “Disclosure” applies to activities outside of the office, such as releasing, transferring, or providing access to information about you to other parties.
- “Use” applies only to activities within the office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An “authorization” is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. “Psychotherapy Notes” are notes I have made about your conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse – If I know or suspect that a child is abused, abandoned, or neglected by a parent, legal guardian, caregiver, or other person, the law requires that I report such knowledge or suspicion to a duly constituted authority.
- Adult and Domestic Abuse – If I have reasonable cause to believe an adult, who is unable to take care of himself or herself, has been or is being subjected to physical abuse, neglect, exploitation, sexual abuse, or emotional abuse, I must report this belief to the appropriate authorities.
- Health Oversight Activities – If the Alabama Board of Examiners in Psychology is conducting an investigation into my practice, then I am required to disclose PHI upon receipt of a subpoena from the Board.
- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information

without the written authorization of you or your legally appointed representative or a court order. ***The privilege does not apply when you are being provided services at the request of a third party or where services are court ordered.*** You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety* – I may disclose PHI to the appropriate individuals if I believe in good faith that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of you or another identifiable person(s).
- *Worker's Compensation* – I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of PHI. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, we will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You may inspect and copy Psychotherapy Notes unless I make a clinical determination that access would be detrimental to your health. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting of Disclosures* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- We are required by law to maintain the privacy of protected health information regarding you and to provide you with notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

If we revise our policies and procedures, we will discuss changes with you. If you are no longer in active treatment, you may request a current copy of this Notice by either calling the office or by mail.

V. Complaints

If you are concerned that we have violated your privacy rights or you disagree with a decision we made about access to your records, you may contact the Secretary of Health and Human Services, 200 Independence Avenue, SW, Washington DC, 20201. No individual will be retaliated against for filing a complaint.

The Alabama Board of Examiners in Psychology may be contacted via 660 Adams Avenue, Suite 360; Montgomery, Alabama 36104. No individual will be retaliated against for filing a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on January 1, 2019. We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. We will provide you with a revised notice at your request, and we will advise you of changes directly if you are in treatment at the time they occur (you may request in writing that notices be sent by mail at any time during the course of therapy, and all subsequent notices will be sent to you).

Birmingham Anxiety & Trauma Therapy

100 Centerview Drive, Suite 201, Vestavia Hills, Alabama 35216
 Phone: 205-807-5372, Fax: 205-413-8789
<http://therapistsbirmingham.com>

PATIENT REGISTRATION FORM

Patient Name: _____ **Therapist Name:** _____

Patient DOB: _____	Age: _____	Gender: Male ___ Female ___ Identify As: ___
Address: _____		
City _____ State _____ Zip _____		
Home phone: _____	Work phone: _____	Cell phone: _____
Preferred phone for appointment reminders: _____ Email: _____		
Referred by _____		

Responsible Party: _____

Name: _____	Relationship to Patient: _____
Address: _____	Date of Birth: _____
City/State/Zip _____	SSN: _____
Employer and address: _____	Home phone: _____ Cell phone: _____
	Work phone: _____

Insurance Information (Primary)

Carrier: _____	Subscriber's Name: _____
Contract or Member Number: _____	Group Number: _____
Subscriber DOB: _____	Subscriber SSN: _____
Subscriber relationship to patient: (circle)	Parent ___ Guardian ___ Spouse ___ Self ___

If you have a secondary insurance, we are happy to provide you with the paperwork you need to file your visits to your secondary insurance provider.

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AUTHORIZATION FOR DISCLOSURE/RELEASE OF INFORMATION

In order to best serve you, we would like to make contact periodically with your primary care physician. This is to insure that you receive quality coordination of care among all the professionals who are providing services to you. This usually consists of a fax and a brief phone call to let your physician know the general goals on which we are working. We are also willing to send a letter of introduction to physicians should we refer you for a medication consultation. To assist us in this, please provide the following information:

Patient Name: _____

Therapist Name: _____

Parent/Guardian Name: _____

Patient Address: _____

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

Patient Date of Birth: _____

Patient Social Security #: _____

Your Doctor's Name: _____

Doctor's Practice: _____

Doctor's Address: _____

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

Doctor's Telephone: _____

Doctor's Fax: _____

- I give my permission for the individual or agency listed above to obtain and/or release the protected information checked below about me or my child for use in my therapeutic treatment efforts.
- I understand this information will be private and that my permission is voluntary. At any time, I can revoke this permission by notifying Birmingham Anxiety and Trauma Therapy in writing.
- I understand that a revocation will not be retroactive and will not affect disclosures prior to revocation.
- I understand that this information may include medically sensitive material, and I authorize its release for the purposes stated. I understand that information used or disclosed related to this authorization may be subject to disclosure by the recipient for therapeutic purposes and may no longer be protected by federal or state law.
- I understand my right to request Birmingham Anxiety and Trauma Therapy to restrict the release of the requested information.
- I understand this information is being obtained for purposes of therapeutic benefit and/or planning.

Your Signature

Date

The agency allowed to release/obtain information is:

Name: Birmingham Anxiety and Trauma Therapy

Address: 100 Centerview Drive, Suite 201
Vestavia Hills, AL 35216

Telephone: (205) 807-5372

Fax: (205) 413-8789

Insurance FAQ

Do you file insurance?

Birmingham Anxiety and Trauma Therapy is happy to file your primary insurance, which is why we request your insurance information when you call to schedule your first appointment. As a courtesy, we check your insurance eligibility and benefits and then provide the insurance company's quote to you. Please note that insurance companies do not guarantee their quotes, and actual amounts may differ upon processing your billing.

Do you file secondary insurance?

We do not file secondary insurance claims, but we will provide information you request so you can file your secondary claims with your insurance after the primary payments come in. If you have any questions about this, please feel free to give the office a call (205-807-5372).

What is the difference between a copay and coinsurance?

A copay is a flat fee set by your insurance for each service you receive from us, and usually only changes when your policy renews. Coinsurance is similar to a copay but is a percentage of each service you receive from us. Coinsurance usually is required after you have met your deductible. You are usually required to pay the full fee for your visits until you meet your deductible each year. If you have any questions on your deductible or coinsurance, please feel free to give the office a call.

Why am I charged each time I come in?

Copays and coinsurance are due at the time of service for each visit. This is required by your insurance provider.

Why am I being sent a bill?

You could receive a bill from us for several reasons:

- We may have not received a copay or coinsurance payment from you.
- Your insurance may have refused to pay for some or all of your sessions.
- Your insurance company may have applied your deductible for some of our services, requiring you to pay out of pocket.
- We may be billing you for paperwork or court fees provided outside of your regular sessions.
- Your credit card on file may have failed to process.
- You may have failed to pay a no show fee for missed sessions in which you did not give us 48 hours advanced notice.

If you have any questions about your bill, please feel free to give the office a call.

Who do I talk to about past due balances?

You may talk to your therapist or the front office regarding any owed amounts. Feel free to reach us through email (info@batthelp.com or admin@batthelp.com) or phone (205-807-5372) Monday-Friday 8AM-5PM.

How can I handle a past due balance?

Past due balances are due immediately. Please contact us regarding the method you wish to take care of any past due balances.

Do you accept HRA or HSA?

We accept HSA credit or debit card payments. We can provide you with the necessary paperwork to provide for HRAs or any other savings accounts where you receive reimbursement for your copays. We do not accept accounts that pay directly to Birmingham Anxiety and Trauma Therapy. If you have any questions about how your savings account applies, please give the office a call (205-807-5372).

Birmingham Anxiety & Trauma Therapy

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<http://therapistsbirmingham.com>

Location and Directions

We are located in Vestavia Hills, just north of interstate 65. Please Note: Google and other apps still have our old address at times (3499 Independence Drive) and we are no longer at that location.

From North Birmingham:

- Get on Interstate 65 South
- Take Exit #252 for US Highway 31 North (Montgomery Highway)
- Turn right onto Vestavia Parkway (at Bruster's Ice Cream)
- Turn right onto Centerview Drive
- Turn left into Chambers Building parking lot
- We are on the second floor in Suite #201

From West Birmingham:

- Get on I-459 North toward Birmingham
- Take I-65 North toward Birmingham
- Take Exit #252 for US Highway 31 North (Montgomery Highway)
- Turn right onto Vestavia Parkway (at Bruster's Ice Cream)
- Turn right onto Centerview Drive
- Turn left into Chambers Building parking lot
- We are on the second floor in Suite #201

From Northeast Birmingham:

- Get on Interstate 20 West/I-59 South
- Take Exit 126A to merge onto US 280 East/US 31 South
- Continue South for approximately 9 miles
- Turn left onto Vestavia Parkway (at Bruster's Ice Cream)
- Turn right onto Centerview Drive
- Turn left into Chambers Building parking lot
- We are on the second floor in Suite #201

From South Birmingham:

- Get on Take I-65, Highway 280, or I-459 to US-31 North
- Turn right onto Vestavia Parkway (at Bruster's Ice Cream)
- Turn right onto Centerview Drive
- Turn left into Chambers Building parking lot
- We are on the second floor in Suite #201

From Southeast Birmingham:

- Take I-459 South to Highway 31 North going toward Birmingham
- After passing under Interstate 65, turn right onto Vestavia Parkway (at Bruster's Ice Cream)
- Turn right onto Centerview Drive
- Turn left into Chambers Building parking lot
- We are on the second floor in Suite #201