Birmingham Anxiety & Trauma Therapy

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

CHILD INTAKE FORM

Today's Date: __________**Name of Child**: ______________________________Date of Birth: __________ Male ____Female ____

Phone number: ___________________________________ Address: ____

Biological parents together? Yes __ No __ If separated, for how long? _______ Child adopted? Yes __ No __
Custodial Parent/Guardian: ____
Frequency of contact with noncustodial parents: ____

BIOLOGICAL MOTHER: ________________________
Age: _____ Involved in child's life? Yes __ No __
Marital Status: __ never married __divorced __married
Education (circle): HS some college college degree
Address: ______________________________________
Employer: _____________________________________
Home phone: ___________________________________

BIOLOGICAL FATHER: __________________________
Age: _____ Involved in child's life? Yes __ No __
Marital Status: __ never married __divorced __married
Education (circle): HS some college college degree
Address: ____
Employer: ____
Home phone: _______________________________________

List all who live in the home:	Age:	Gender:	Relationship to client:
_____________________________	______	______	____
_____________________________	______	______	____
_____________________________	______	______	____
_____________________________	______	______	____
_____________________________	______	______	____
_____________________________	______	______	____

CHILD'S DEVELOPMENTAL

Milestones met on time? Yes __ No __

Pregnancy, labor or delivery problems? Yes __ No __ Explain: ____

List any alcohol, drugs, or medications child's mother used during pregnancy: ____
____
____

Any physical problems? (illness, surgery, and serious falls, etc.) ____
____

All previous diagnoses: ____
____

What other professionals have been involved in your child's treatment? ____
Who referred you to Birmingham Anxiety and Trauma Therapy? ____

List the age the child:

_____	Smiled	_____	Head up	_____	Rolled over
_____	Reached for objects	_____	Sat without support	_____	Crawled
_____	Stood w/support	_____	Walked	_____	First word

Name of child's medical doctor: ____ **Date of last medical exam:** ______________
Current medications: ____
Allergies: ____

Bedtime on **school** nights? ____________________ Bedtime on **weekend** nights? __________________

Has your child ever made statements of wanting to hurt him/her self or seriously hurt someone else? Has s/he ever purposely hurt himself or another? If yes, explain:____

What are some of the things that are currently stressful to the child and his/her family?

____

Previous psychotherapy or counseling (list dates and name of therapist or counselor):

____

SCHOOL: ______________________ Grade level: ______ Current grades: ________________

Recent change in grades Yes __ No __
Repeated a grade? Yes __ No __
Fights in past year? Yes __ No __
Child been formally assessed? Yes __ No __
Absences in past year? Yes __ No __
Suspensions in past year? Yes __ No __
Summer school? Yes __ No __
Special Education? Yes __ No __

Does child have an IEP? ______________________
Last time IEP was reviewed? ______________________
At what school and grade level was your child tested? ______________________
What services were provided to him/her at that time? ______________________
What services are provided to him/her currently? ______________________
What does your child do after school most days? ______________________
When and where does your child do homework? ______________________

Please describe your child's friendships

____

Describe any anger problems your child has ______________________

Briefly describe your child's current problems at school: ______________________

How have you dealt with the problems at school thus far? ______________________

Briefly describe your child's current problems at home: ______________________

How have you dealt with the problems at home thus far? ______________________

When was the last time you moved? ______________________

Other major events that may have upset your child? ____
____
____

When your child does something wrong, what kinds of consequences does s/he receive? _________________________________
____
____

When not at school, what types of things does s/he like to do? How does s/he spend his /her time? _________________________
____
____

Please list any other problems/concerns:
____
____
____

TRAUMA

Please answer the following regarding your child's history:

No___ Yes ___ Did a parent or other adult in the household often or very often… Swear at your child, insult your child, put your child down, or humiliate your child? or Act in a way that made your child afraid that s/he 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 your child? or Ever hit your child so hard that your child had marks or was injured?

No___ Yes ___ Did an adult or person at least 5 years older than your child ever… Touch or fondle your child or have your child touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with your child?

No___ Yes ___ Did your child often or very often feel that … No one in the family loved your child or thought s/he was important or special? or The family didn't look out for each other, feel close to each other, or support each other?

No___ Yes ___ Did your child often or very often feel that … Your child didn't have enough to eat, had to wear dirty clothes, and had no one to protect him/her? or Your child's parents were too drunk or high to take care of or take him/her to the doctor needed?

No___ Yes ___ Were your child's parents ever separated or divorced?

No___ Yes ___ Was your child's mother/stepmother 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 your child ever 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?

Child & Family Medical Histories: (Check all that apply**)**

Condition	Child Current	Child Past	Mother	Father	Sibling	Other
Abuse/Neglect						
ADD/ADHD						
Alcoholism						
Anxiety/Excessive Worry						
Asthma						
Attempted Suicide						
Bipolar						
Depression/Sadness						
Eating Disorder(s)						
Gang Influence						
Headaches						
Hearing Problems						
High Fever						
History of Physical Abuse						
History of Sexual Abuse						
History of Verbal Abuse						
Hospitalization						
Learning Disabilities						
Meningitis						
Mental Illness						
Mental Retardation						
Miscarriage						
Nervous Breakdown						
Obsessions/Compulsions						
Oppositional/Defiance						
Other:						
Panic Attacks						
Premature Birth						
Problems with Anger						
Problems with Assertiveness						
Problems with the Law						
Schizophrenia/Psychosis						
Seizures						
Serious Accident(s)						
Sleep problems						
Substance Abuse						
Suicidal Thoughts						
Surgery						
Tics: Verbal or Visual						
Vision Problems						

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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 will provide all custody paperwork for my child (if applicable). COPIES OF CUSTODY PAPERWORK MUST BE PROVIDED BEFORE THERAPY CAN BEGIN.

______ 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. The first session without 48 hours' notice will results in a $100 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 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 child's benefits (based on good faith understanding of the insurance website information) and what the insurance companies actually pay on my child's behalf.

______ I understand the limits to my child's confidentiality information as described in the CONFIDENTIALITY section above.

______ I understand that should I choose to contact my child's 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 for my child.

______ I have read and understood the BATT Billing and Payments section of this document. Please process my credit card on file for my child's 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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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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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:

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

If I revise our policies and procedures, I 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 I have violated your privacy rights or you disagree with a decision I 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 June 11, 2007. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice at your request, and I 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

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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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