HEITT CLINICAL & CORPORATE CONSULTING, LLC
MICHAEL HEITT, PSYD, LICENSED PSYCHOLOGIST
EXECUTIVE CENTRE AT HOOKS LANE
8 RESERVOIR CIRCLE, SUITE 105
BALTIMORE, MARYLAND 21208
PHONE 410-580-9047
FAX 410-580-9046
WWW.HEITTC3.COM
MICHAEL@HEITTC3.COM

Patient Registration Form

CLIENT INFORMATION				
Name		Referred by		
Street				
City		State	Zip	
Phone (Home)	(Work)		(Cell)	
Date of Birth	Gender Male Female		SSN	
Marital Status	Single	Married	Divorced	Other
Relationship to Policyholder	Self	Spouse	Child	Other
Employment Status	Full-Time	Part-Time	Unemployed	
School Status	Full-Time	Part-Time	Does not Attend School	N/A
Is treatment related to	Employment	Auto Accident	Other Accident	N/A

POLICYHOLDER/INSURANCE INFORMATION ***If secondary coverage is available, please request additional insurance form***			
Name	SSN #	Group #	
Street	Member ID #		
City	State	Zip	
Phone (Home)	(Work)	(Cell)	
Date of Birth	Gender Male Female		
Insurance Company	Phone		
Street	City	State	Zip
Employer	Authorization #		

FOR OFFICE USE ONLY		
Intake Date	Primary Dx	
R&C 90801 90806	Authorization #	
Copay Sessions ___ - ___ @ ___/___	From _____ To _____ # _____	
Copay Sessions ___ - ___ @ ___/___	Deductible	Amount Met
Copay Sessions ___ - ___ @ ___/___	Max $/yr	Max #/yr

In order for us to bill your insurance company we must have complete information about your insurance. If there is some information that you do not have available at this time, please call it in to the office as soon as possible. If we are lacking information, we are unable to bill your insurance company. You will be held financially responsible for all charges incurred.

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Adult Health Questionnaire

Patient Name:	Date of Birth:	
Physician's Name:	Physician's Phone:	
Physician's Address:		
Family Members' Names	Relationship	Date of Birth
Emergency Contact:		
Name:	Relationship:	Phone:
Please complete this section if you have ever received any other therapy or special treatments (including psychological counseling, psychiatric treatment, speech therapy, occupational therapy, medication, special diets, etc).		
Type of Treatment	Date of Treatment	Treatment Provider Name
Hospitalizations	Date of Hospitalization	Facility Name
Allergies:		
Medical Conditions:		
Current Medications (and Dosage):		
Other Health Information:		

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SUMMARY OF AGREEMENT

Please initial each section

_____ I understand that Dr Heitt requires *48 hours advance notice* of cancellations and that I - not my insurance company - will be responsible for the full fee of missed sessions.

_____ I understand payment of professional fees and/or co-insurance or co-payment is required *at the time of service*. Unless otherwise arranged, Dr Heitt will not directly bill my insurance company; however, if requested, he will provide me with a receipt of payment for professional services or a monthly statement with the necessary insurance information I may submit to my insurance company to attempt to be reimbursed for his services as a non-participating provider. If requested, Dr Heitt will complete any treatment plans necessary in order for me to potentially receive my maximum reimbursement from my insurance company.

☐ *Please check here if you have received outpatient mental health treatment in the past as your previous use of mental health benefits may affect your lifetime maximum benefits.*

_____ I understand that if I am required to obtain authorization for mental health services *it is my responsibility to do so*; I should do so *prior to the initial session* by contacting my insurance company.

_____ I understand that if I am unable to reach Dr Heitt directly in case of emergency, I should follow the emergency contact instructions on his voicemail and/or I should contact the nearest emergency room or crisis service.

_____ I understand that services provided by Dr Heitt are confidential with the exceptions listed in the Psychologist-Patient Services Agreement.

My signature below indicates that I have received, read and understood this Summary Agreement, the Psychologist-Patient Agreement, and the HIPAA notice form.

_____	_____
Patient Signature	Psychologist's Signature
_____	_____
Date	Date

PSYCHOLOGIST-PATIENT SERVICES AGREEMENT

Welcome to the office of Heitt Clinical & Corporate Consulting, LLC. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that went into effect in April 2003 and provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI). HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which accompanies this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information by the end of your initial consultation session. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

THERAPY SERVICES

Therapy can vary depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods I may use to deal with the problems that you hope to address. In order for therapy to be most successful you will have to make an active effort to work on things talked about both during your sessions and at home.

Therapy can have benefits and risks. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, sometimes to achieve these goals, therapy may involve discussing unpleasant aspects of your life and you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness.

The initial consultation session(s) will involve an evaluation of your needs. By the end of this meeting, I will be able to offer you some initial impressions of what your therapy work will include and a treatment plan to follow, if we mutually decide to continue with therapy. Therapy involves a large commitment of time, money, and energy, so you should feel comfortable with the psychologist you select and with the plan presented to you. If you have questions about my procedures, we should discuss them whenever they arise. If doubts arise and persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

After your initial consultation, if psychotherapy is indicated, I will usually schedule one 45-minute session (one appointment hour of 45 minutes duration) per week at a time we agree on, although this can vary in duration and frequency. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide *48 hours advance notice* of cancellation. It is important to note that insurance companies do not provide reimbursement for late cancellations or missed scheduled appointments.

PROFESSIONAL FEES

My fee schedule is as follows:

- Initial Consultation/Evaluation $200
- Individual Sessions $180
- Family/Couples Sessions $180
- Group Therapy Sessions $75
- Psychological Testing (per hour) from $200
- Psychological Testing Materials Fee $75
- Other_____

In addition to weekly appointments, I charge from $200 per hour for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. If you become involved in legal proceedings that require my participation, *you will be expected to pay* for all of my professional time, including preparation and transportation costs, *even if I am called to testify by another party*. Because of the intricacies of legal/forensic work, my fees begin at $250 per hour for preparation, travel and attendance at any legal proceeding.

CONTACTING ME

Due to my work schedule and the fact that I generally do not interrupt sessions with patients to take phone calls, I am often not immediately available by telephone. When I am unavailable, my telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. My colleagues/office-mates, Drs Sandra Hawkins-Heitt, Sheryl Jacobs, Andrew Burns and Barry Hurwitz and I often share on-call coverage for our practices. If you are unable to reach me and feel that you cannot wait for a return call, you can contact one of us by following the instructions on my voicemail and/or you can contact the nearest emergency room or crisis service.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of communications between a patient and a psychologist.

In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA and/or Maryland law. However, in the following situations, no authorization is required:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing your identity. The other professionals are also legally bound to keep the information confidential.
- You should be aware that I may employ administrative staff. In most cases, I may need to share protected information with these individuals for administrative purposes, such as scheduling, billing and quality assurance. Any staff I use will received training about protecting your privacy.
- I may utilize a clearinghouse which submits electronic claims to insurance companies. As required by HIPAA, I will have a formal business associate contract with this business, in which the clearinghouse promises to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.
- If you are involved in a court proceeding, I cannot provide any information without your written authorization, a valid subpoena or court order.
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice:

- If I have reason to believe that a child or vulnerable adult has been subjected to abuse or neglect, or that a vulnerable adult has been subjected to self-neglect, or exploitation, the law requires that I file a report with the appropriate government agency, usually the local office of the Department of Social Services.
- If I know that a patient has a propensity for violence and the patient indicates that he/she has the intention to inflict imminent physical injury upon a specified victim(s), I may be required to take protective actions. These actions may include establishing and undertaking a treatment plan that is calculated to eliminate the possibility that the patient will carry out the threat, seeking hospitalization of the patient and/or informing the potential victim(s) or the police about the threat.
- If I believe that there is an imminent risk that a patient will inflict serious physical harm or death on him/herself, or that immediate disclosure is required to provide for the patient's emergency health care needs, I may be required to take appropriate protective actions, including initiating hospitalization and/or notifying family members or others who can protect the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. You may examine and/or receive a copy of your Clinical Record, if you request it in writing. If I feel that disclosure of your Clinical Record is likely to endanger the life or physical safety of you or another person, you have a right to a summary and to have your record sent to another mental health provider. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge a copying fee of $0.76 per page (and certain other expenses). If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures.

MINORS & PARENTS

Patients under 16 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. While privacy in psychotherapy is very important, particularly with teenagers, parental involvement is also essential to successful treatment. Therefore, it is usually my policy to request an agreement from any patient between 16 and 18 and his/her parents allowing me to share general information about the progress of treatment and their teen's attendance at scheduled sessions. Any other communication will require the teen's authorization, unless I feel that the teen is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the teen, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session *at the time it is held*, unless we agree otherwise. I charge interest of 1.5 % per month on accounts that are 30 days past due.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon and initiated, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, address, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, *you (not your insurance company) are responsible for full payment of my fees*. It is very important that you find out exactly what mental health services your insurance policy covers.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before you are seen by a psychologist in order to provide reimbursement for mental health services. *You are required to obtain the initial authorization* by calling the appropriate number on your insurance card. Failure to do this may result in your insurance company rejecting your claim, making you responsible for the entire charge.

You should also be aware that your contract with your health insurance company may require that I provide it with information relevant to the services that I provide to you. Maryland law permits me to send some information without your consent in order to file appropriate claims. I am required to provide them with a clinical diagnosis, dates of service, and the type of service rendered. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. If I believe that your health insurance company is requesting an unreasonable amount of information, I will call it to your attention and we can discuss what to do. You can instruct me not to send requested information, but this could result in claims not being paid and an additional financial burden being placed on you. Once the insurance company has this information, it will become part of the insurance company files and will probably be stored by them indefinitely. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. I will provide you with a copy of any report I submit, if you request it. By signing the attached Summary of Agreement and Maryland Notice Form, you agree that I can provide requested information to your carrier.

Once I 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 they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for services yourself to avoid the need to release information to your insurance company.

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MARYLAND NOTICE FORM / NOTICE OF PRIVACY PRACTICES
Notice of Policies and Practices to Protect the Privacy of Patients' 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.

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

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your written authorization. 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 psychologist.
- Payment is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- Health Care Operations are activities that relate to the performance and operation of my 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.
- "Use" applies only to activities within my practice group such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my practice group, such as releasing, transferring, or providing access to information about you to other parties.
- "Authorization" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other 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. In those instances when I am asked for information for purposes out-side of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information.

You may revoke all such authorizations 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 without Authorization

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

- Child Abuse/Neglect – If I have reason to believe that a child has been subjected to abuse or neglect, I must report this belief to the appropriate authorities.
- Vulnerable Adult Abuse/Neglect – If I have reason to believe that a dependent adult has been subjected to abuse or neglect, I must report this belief to the appropriate authorities.
- Health Oversight Activities – If I receive a subpoena from the Maryland Board of Examiners of Psychologists because they are investigating my practice, I must disclose any PHI requested by 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 or the records thereof, such information is privileged under state law,

and I will not release information without your written authorization, a valid subpoena or a court order. The privilege does not apply when you are being evaluated by a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

• Serious Threat to Health or Safety – If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

• Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. 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, I 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. On your request, I will discuss with you the details of the request and denial process for PHI.

• 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 – 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.

Psychologist's Duties:

• I am required by law to maintain the privacy of PHI and to provide you with a 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 my policies and procedures, I will provide notice to you of the changes at your first appointment following the change or by mail. A copy of the most current Policies and Practices to Protect the Privacy of Patient's Heath Information will also be posted on my Website at www.HeittC3.com.

V. Questions and Complaints

• If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Dr Heitt, 8 Reservoir Circle, Suite 105, Baltimore, MD 21208.

• If you believe that your privacy rights have been violated and wish to file a complaint with Dr Heitt, you may send your written complaint to Dr Heitt, 8 Reservoir Circle, Suite 105, Baltimore, MD 21208. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

• You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

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

• This notice went into effect on April 14, 2003 and the revision date is below.

• 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 by giving you a copy of the revised notice at a session with you or by mailing you a copy of the revision should a revision be made.