Maria Abercrombie, Ph.D.
Clinical Psychologist
104 East Park Drive, Suite 308 *Phone: 615-972-5333*
Brentwood, TN 37027 *dr.maria.abercrombie@gmail.com*

CONFIDENTIAL INFORMATION - ADULT

Name_____Date_____Email_____
last first m.i.
Home Address_____
number street apt# city state zip
Cell Phone_____ Work/Home Phone_____ SS#_____
Date of Birth_____ Age_____ Sex: M F Referred by_____
Marital Status: Sing. Mar. Sep. Div. Wid. Education_____Religion_____
Employer_____ Job Title/Occupation_____
Spouse's Name_____ Age_____ Spouse's Occupation_____
# of Years Married_____ # of Previous Marriages_____ Age First Married_____

Parents:	Name	Age	Occupation
Father			
Mother			

Is this the first marriage for your mother? Your father?

Siblings:	Name	Sex	Age	Occupation

Children:	Name	Sex	Age	Occupation

Medical Information:
Do you have any medical problems? Please explain_____
_____
Do you take regular medications? If so, what?

Name of medication	Dose	Prescribed by

Confidential Information - Adult
*Name*_____

Do you smoke? Yes No If so, how much?_____ How long?_____
Do you drink alcohol? Yes No If so, how much? _____ How often?_____
Have you seen a counselor before or been in a psychiatric hospital? If so, please list:

Type of Mental Health Service	Provider	Date

Current or expected legal involvement? Yes No If yes, please explain:

_____

_____

Person to notify in case of emergency_____ Relationship_____
Address_____
number street apt# city state zip
Home Phone_____ Work Phone_____
What are your leisure interests?_____

_____

What do you consider to be your strengths?_____

_____

Briefly describe the problems that bring you here_____

_____

What would do like to accomplish by coming here (goals)?_____

_____

Payment Information
Have you pre-authorized these visits through your insurance company? Yes No
If yes, authorization number: _____
If no, please check one of the following:
- ☐ I will pay my bill for services in full at each visit.
- ☐ I have checked with my insurance and no pre-authorization is required. I am aware of my co-payment amount and will pay my co-payment amount in full at each visit.

I authorize Maria Abercrombie, Ph.D. to provide treatment interventions as needed. I promise to pay all charges incurred for services rendered. I authorize the release of any information acquired in the course of treatment in order to process insurance claims. I understand that if my bill is not paid in a timely fashion, services of a collection agency may be used. I have received a copy of the Practice Policy Information and Patient Notification of Privacy Rights.

Signature:_____Date_____

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INSURANCE INFORMATION

****a copy of your insurance card will be needed****

TYPE OF INSURANCE: PRIMARY / SECONDARY / OTHER

PATIENT'S NAME first, middle initial, last

SEX: MALE / FEMALE / OTHER DATE OF BIRTH ____________________

PATIENT'S RELATIONSHIP TO INSURED: SELF / SPOUSE / CHILD / OTHER

INSURED'S NAME first, middle initial, last

SEX: MALE / FEMALE / OTHER DATE OF BIRTH ____________________

INSURED'S ADDRESS number street apt# city state zip

INSURED'S PHONE NUMBER cell work home

Do you have secondary Health Insurance Coverage? YES / NO

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I certify that the information completed by me is correct. I authorize the release of any information regarding my examination or treatment necessary to process the insurance claim. I authorize the release of pertinent information required by my Managed Care company for Treatment Plans and Summaries.

________________________________ ____________________

Signature Date

I authorize the payment of benefits to the provider for services provided.

________________________________ ____________________

Signature Date

Maria Abercrombie, Ph.D.
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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION
TO PRIMARY CARE PROVIDER

____ I do not want information released to my primary care provider
or
____ I do not have a primary care provider
or
I _____
full name of adult client or parent of minor child

AUTHORIZE Maria Abercrombie, Ph.D.to release protected health information concerning professional services received by myself or my minor child or legal charge:

_____
full name of minor or child

to _____
full name of primary care provider receiving information

for the purpose of _____
(if you are a current patient, "at patient request" is sufficient)

You may revoke this consent to release protected health information at any time by written request. Unless you revoke it, this authorization shall remain in effect for one year or until such time as specified herein:_____.

Psychologists do not generally make signing releases of authorization of protected health information a condition of treatment unless there are clinical indications to do so (e.g., if important to talk to your psychiatrist or personal physician to coordinate our treatment efforts). Your right to revoke authorizations does not apply if the authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest the claim.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your protected health information and no longer protected by the HIPAA Privacy Rule. I understand all of the aforementioned, and with the authorization consent and of my own free will, authorize this disclosure of protected health information.

_____ _____
Signature of Patient or Parent of Minor or Legal Charge **Date**

If legal charge, provide description of such representative authority:

_____

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Informed Consent Checklist for Tele-Psychological Services

There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions. To minimize risks to your confidentiality, I use a telehealth platform called Simple Practice that is fully HIPAA compliant, encrypts all of our data before passing it over the Internet, and that does not store any information from our confidential psychotherapy session.

Confidentiality still applies for telepsychology services, and your session will not be recorded without your permission.

By signing this agreement, you consent to using the Simple Practice video- conferencing platform selected for our virtual sessions, and Dr. Abercrombie will explain how to use it.

You need to use a either a smartphone, a tablet, a computer with a built-in webcam, or a computer with a separate webcam during the session.

It is important to be in a quiet, private space that is free of distractions (including additional cell phones or other devices) during the session.

It is important to use a secure internet connection rather than public/free Wi- Fi.

It is important to be on time. If you need to cancel or change your tele- appointment, you must notify the psychologist in advance by phone or text message.

We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.

We need a safety plan that includes at least one emergency contact and the closest emergency room to your location, in the event of a crisis situation.

If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.

You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.

As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

_____

Client Signature

_____

Maria Abercrombie, Ph.D

_____

Date

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PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law," HIPAA provides patient protections related to the electronic transmission of data ("the transaction rules"), the keeping and use of patient records ("privacy rules"), and storage and access to health care records ("the security rules"). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide patients with a notification of their privacy rights as it relates to their health care records. You may have already received similar notices, such as this one, from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. My Patient Notification of Privacy Rights is my attempt to inform you of your rights in a simple, yet comprehensive fashion. Please read this document as it is important you know what patient protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship, and as such, you will find I will do all I can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received this Patient Notification of Privacy Rights document. Thank you for your thoughtful consideration of these matters.

Maria Abercrombie, Ph.D.
Clinical Psychologist

I, _____, understand and have been provided a copy of Dr. Maria Abercrombie's Patient Notification of Privacy Rights document, which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

_____ _____
Patient Signature or Parent (if Minor) or Legal Charge Date

If Legal Charge, describe representative authority: _____

PATIENT NOTIFICATION OF PRIVACY RIGHTS :
THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

I. Preamble

The Psychology Licensing law provides extremely strong privileged communication protections for conversations between your Psychologist and you in the context of your established professional relationship with your Psychologist. There is a difference between privileged conversations and documentation in your mental health records. Records are kept that document your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "designated medical record" as well as some material, known as "Psychotherapy Notes," which is not accessible to insurance companies and other third-party reviewers, and in some cases, not even to the patient.

HIPAA provides privacy protections about your personal health information, which is called "protected health information (PHI)" that could personally identify you. PHI consists of three components: *treatment, payment, and health care operations*.

Treatment refers to activities whereby I provide, coordinate or manage your mental health care, or other services related to your mental health care. Examples include a psychotherapy session, psychological testing, or talking to your primary care physician about your medication or overall medical condition.

Payment is when I obtain reimbursement for your mental health care. The clearest example of this is filing insurance on your behalf to help pay for some of the costs of the mental health services provided to you.

Health care operations are activities related to the performance of my practice, such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process where your insurance company reviews our work together to see if your care is "really medically necessary."

The *use* of your protected health information refers to activities my office conducts, such as filing your claims, scheduling appointments, keeping records, and other tasks occurring *within* my office that are related to your care. *Disclosures* refer to activities you authorize that occur *outside* my office, such as the sending of your protected health information to other parties (i.e., your primary care physician, the school your child attends).

II. Uses and Disclosures of Protected Health Information (PHI) Requiring Authorization

Tennessee requires authorization and consent for treatment, payment and health care operations. HIPAA does nothing to change this requirement by law in Tennessee. I may disclose PHI for the purposes of treatment, payment, and health care operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and conduct the administrative steps associated with your care (e.g., file insurance for you).

Additionally, if you ever want me to send any part of your protected health information to anyone outside my office, you will always first sign a specific authorization to release information to this outside party. A copy of that

authorization form is available upon request. The requirement that you sign an addition authorization form is an added protection to help ensure that your protected health information is kept strictly confidential. An example of this type of release of information might be your request that I talk to your child's school teacher about his/her ADHD condition and what this teacher might do to help your child. Before I talk to that teacher, you will have to sign the proper authorization for me to do so.

There is a third, special authorization provision potentially relevant to the privacy of your records: my psychotherapy notes. In recognition of the importance of the confidentiality of conversations between psychologist-patient in treatment settings, HIPAA permits keeping separate "psychotherapy notes," which are not part of the overall "designated medical record." "Psychotherapy notes" cannot be secured by insurance companies, nor can they insist upon their release for payment of services, as has unfortunately occurred over the past two decades of managed mental health care. "Psychotherapy notes" are *my* notes, "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group, or joint family counseling session and separated from the rest of the individual's medical record." "Psychotherapy notes" are necessarily more private and contain much more personal information about you; hence, the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes," which provide the following information about your care each time you have an appointment at my office, including medication prescriptions and monitoring, assessment/treatment start and stop times, the modalities of care, frequency of treatment, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

Certain payers of care, such as Medicare and Workers Compensation, require the release of both your progress notes and my psychotherapy notes in order to pay for your care. If I am forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release my psychotherapy notes. Most of the time, I will be able to limit reviews of your protected health information to only your "designated record set," which includes the following: all identifying paperwork you completed when you first started your care here, all billing information, a summary of our first appointment, your mental status examination, your individualized, comprehensive treatment plan, your discharge summary, progress notes, reviews of your care by managed care companies, results of psychological testing, and any authorization letters or summaries of care you have authorized me to release on your behalf. Please note that the actual test questions or raw data of psychological tests are protected by copyright laws as well as the need to protect patients from unintended, potentially harmful use, and are not part of your "designated mental health record."

You may, in writing, revoke all authorizations to disclose protected health information at any time. You cannot revoke an authorization for an activity already done that you instructed me to do. You also cannot revoke an authorization if it was obtained as a condition for obtaining insurance and Tennessee law provides the insurer the right to contest the claim under the policy.

III. Business Associates Disclosures

HIPAA requires that I train and monitor the conduct of those people (called "Business Associates") who perform ancillary administrative services for my practice. In my practice, "business associates" include our office staff who provide services, such as typing, making phone calls, and filing insurance claims—all activities that bring them into some type of contact with your protected health information. The only other "business associate" in my office is the cleaning crew. In compliance with HIPAA, I have signed a formal contract with all of my business associates that

very clearly spells out to them the crucial importance of protecting your mental health information as an absolute and mandatory condition for employment. I train them in my privacy practices, monitor their compliance, and correct any errors if they should occur.

IV. Uses and Disclosures Not Requiring Consent or Authorization

By law, protected health information *may* be released without your consent or authorization in the following instances.

- Child abuse
- Suspected sexual abuse of a child
- Adult and domestic abuse
- Health oversight activities (e.g., Tennessee Psychology Licensing Board)
- Judicial or administrative proceeding (i.e., if you are ordered by the Court to see me for an independent child custody evaluation in a divorce)
- Serious threat to health or safety (i.e., our "Duty to Warn" law, national security threats)
- Workers Compensation claims (i.e., if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s))

I never release any information of any sort for marketing purposes.

V. Patient's Rights and My Duties

You have a right to the following:

- *The right to request restrictions* on certain uses and disclosures of your protected health information which I may or may not agree to, but if I do, such restrictions shall apply unless our agreement is changed in writing;
- *The right to receive confidential communications by alternative means and at alternative locations*. For example, you may not want your bills sent to your home address, so I will send them to another location of your choosing;
- *The right to inspect and copy* your protected health information in my designated mental health record set and any billing records for as long as the protected health information is maintained in the record;
- *The right to amend* material in your protected health information, although I may deny an improper request and/or respond to any amendment(s) you make to your record of care;
- *The right to an accounting of nonauthorized disclosures* of your protected health information;
- *The right to a paper copy* of notices/information from me, even if you have previously requested electronic transmission of notices/information; and
- *The right to revoke your authorization* of your protected health information except to the extent that action has already been taken.

For more information on how to exercise each of these rights mentioned above, please do not hesitate to ask me for further assistance. I am required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and my duties regarding your PHI. I reserve the right to change my privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of my policies when you come for future appointments. My duties as a Psychologist on these matters include maintaining the privacy of your protected health information, providing you with this notice of your rights and my privacy practices with respect to your PHI, and abiding by the terms of this notice unless it is changed and you

are so notified. If, for some reason, you want a copy of my internal policies for executing privacy practices, please tell me, and I will get you a copy of these documents I keep on file for auditing purposes.

VI. Complaints

Maria Abercrombie, Ph.D. is the appointed "Privacy Officer" for my practice per HIPAA regulations. If you have any concerns that my office may have compromised your privacy rights, please do not hesitate to speak to me immediately about this matter. You will always find me willing to talk to you about preserving the privacy of your protected mental health information. You may also send a written complaint to the Secretary of the U. S. Department of Health and Human Services.

VI. This notice shall go into effect April 14, 2003 and remain so, unless new notice provisions effective for all protected health information are enacted.