

Registration Form

Black Hills Psychology, LLC

Date _____

DX Code _____

Therapist _____

Primary Care
Physician _____

Patient Information

Patient Name (Print) _____
Last Name First Name Initial Date of Birth _____

Street Address _____ Home Phone _____

City _____ State _____ ZIP _____ Work Phone _____

Soc. Sec. # _____ Emergency Contact _____ Emerg Phone _____

Sex: ☐ Female ☐ Male Age _____ Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed ☐ Other

Employer _____ Occupation _____

E-mail Address: _____ Referred by: _____

Primary Insurance

Primary Insurance Company _____ Phone _____

Ins Claims Address _____ City _____ State _____ Zip _____

Policy/ID # _____ Group/Plan # _____

Policy Holder Information: (if the patient is not the employee/policy holder)

Name _____
Last name First Name Initial Relationship _____

Address _____ City _____ State _____ Zip _____ Date of Birth _____

Soc. Sec# _____ Employer _____

Secondary Insurance

Secondary Insurance Company _____ Phone _____

Ins Claims Address _____ City _____ State _____ Zip _____

Policy/ID # _____ Group/Plan # _____

Policy Holder Information: (if the patient is not the employee/policy holder)

Name _____
Last name First Name Initial Relationship _____

Address _____ City _____ State _____ Zip _____ Date of Birth _____

Soc. Sec# _____ Employer _____

Responsible Party (Where should the patient's portion of the bill be sent, if not to the patient?)

Name _____ Relationship _____

Address _____ Phone _____

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Relationship To Patient _____

Date _____



NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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

Our Duty to Safeguard Your Protected Health Information

Protected Health Information (PHI) refers to information in your health record that could identify you. It is individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care. Examples of PHI include your name, address, birth date, age, phone number, diagnosis, medical records, and billing records.

-We are required by applicable federal and state law to maintain the privacy of your protected health information, and to give you this Notice of Privacy Practices that describes our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notification takes effect August 11, 2014 and will remain in effect until replaced.

-We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

-You may request a copy of our Notice of Privacy Practices at any time. For more information about our privacy practices or additional copies of this Notice, contact our office.

How We May Use and Disclose Your Protected Health Information

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its HIPAA Privacy Rule (Rule), we are permitted to use and/or disclose your PHI for a variety of reasons. Except in specified circumstances, we are required to use and/or disclose only that minimum amount of your PHI necessary to accomplish the purpose for the use and/or disclosure. Generally, we are permitted to use and/or disclose your PHI for the purposes of treatment, the payment for services you receive, and for my normal health care operations. For most other uses and/or disclosures of your PHI, you will be asked to grant your permission via a signed Authorization. However, the Rule provides that we are permitted to make certain other specified uses and/or disclosures of your PHI without your Authorization. The following information offers more descriptive examples of our potential use and/or disclosure of your PHI:

1. Uses and/or Disclosures of PHI for Treatment, Payment, and Health Care Operations That Do Not Require Authorization

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you or for the management of healthcare and related services. This also includes, but is not limited to, consultations and referrals between one or more providers. For example, an insurance company may contact a provider on your behalf to facilitate your access to mental health treatment.

Appointment Scheduling/Reminders: Unless you request that we contact you by other means, the Privacy Rule permits us to contact you by phone/ voice mail to schedule appointments and to leave appointment reminders.

Payment: We may use or disclose your health information to obtain reimbursement for your healthcare. For example we may disclose your PHI to your health insurer to determine eligibility or coverage for psychotherapy. Or, we may disclose PHI when we obtain reimbursement from your health insurer for your health care.

Healthcare Operations: We may use or disclose your health information in healthcare operations. For example, we may disclose your PHI to your health insurer for care coordination or case management.

2. Uses and/or Disclosures of PHI Requiring Authorization

You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocations will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Psychotherapy Notes: We will also need to obtain an authorization before releasing your psychotherapy notes. Psychotherapy notes are notes we have made about our conversation during an individual, group, conjoint, or family counseling session, which we have

kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

3. Uses and/or Disclosures Not Requiring Your Authorization or Consent

The HIPAA Privacy Rule provides that we may use and/or disclose your PHI without your Authorization in the following circumstances:

When required by law: We may use and/or disclose your PHI when existing law requires that we report information including each of the following areas:

- **Reporting abuse, neglect or domestic violence:** We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of domestic violence or the possible victim of other crimes.
- **Child abuse:** Whenever we, in our professional capacity, have knowledge of or observe a child we know or reasonably suspect, has been the victim of child abuse or neglect, we must immediately report such to a police department or sheriff's department, county probation department, or county welfare department. Also, if we have knowledge of, or reasonably suspect that, mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way, we may report such to the above agencies.
- **Adult and domestic abuse:** If we, in our professional capacity, have observed or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if we are told by an elder or dependent adult that he or she has experienced these, or if we reasonably suspect such, we must report the known or suspected abuse immediately to the local ombudsman or the local law enforcement agency. We do not have to report such an incident told to us by an elder or dependent adult if (a) we are not aware of any independent evidence that corroborates the statement that the abuse has occurred; (b) the elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia; and (c) in the exercise of clinical judgment, we reasonably believe that the abuse did not occur.
- **To avert a serious threat to health or safety:** We may use and/or disclose your PHI in order to avert a serious threat to health or safety. If you communicate to us a serious threat of physical violence against an identifiable victim, we must make reasonable efforts to communicate that information to the potential victim and the police. If we have reasonable cause to believe that you are in such a condition as to be dangerous to yourself or others, we may release relevant information as necessary to prevent the threatened danger.
- **Public health activities:** We may use and/or disclose your PHI to prevent or control the spread of disease or other injury, public health surveillance or investigations, reporting adverse events with respect to food, dietary supplements, product defects and other related problems to the Food and Drug Administration, medical surveillance of the workplace or to evaluate whether or not you have a work-related illness or injury, in order to comply with Federal or state law.
- **Health oversight activities:** We may use and/or disclose your PHI to designated activities and functions including audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary actions, or civil, administrative, or criminal proceedings or actions, or other activities necessary for appropriate oversight of government benefit programs.
- **Judicial and administrative proceedings:** We may use and/or disclose your PHI in response to an order of a court or administrative tribunal, a warrant, subpoena, discovery request, or other lawful process.
- **Law enforcement activities:** We may use and/or disclose your PHI for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person, or reporting crimes in emergencies, or reporting a death.
- **Relating to decedents:** We may use and/or disclose the PHI of an individual's death to coroners, medical examiners and funeral directors.
- **For specific government functions:** We may use and/or disclose the PHI of military personnel and veterans in certain situations. Similarly, we may disclose the PHI of inmates to correctional facilities in certain situations. We may also disclose your PHI to governmental programs responsible for providing public health benefits, and for workers' compensation. Additionally, we may disclose your PHI, if required, for national security reasons.

4. Uses and/or Disclosures Requiring You to Have an Opportunity to Object

We may disclose your PHI in the following circumstances if we inform you about the disclosure in advance and you do not object. We may use or disclose health information to notify or assist the notification of (including identifying or locating) a family member, your personal representative or another person responsible for our care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such use or disclosure. However, in the event of your incapacity or emergency circumstances and you cannot be given an opportunity to object,

disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests. We will disclose only health information that is directly relevant to the person's involvement in your healthcare. You must be informed and given an opportunity to object to further disclosure as soon as you are able to do so.

Your Rights Regarding Your Protected Health Information (PHI)

The HIPAA Privacy Rule grants you each of the following individual rights:

Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of your 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.

We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

Right to Request an Amendment: If you believe that your PHI is incorrect or incomplete, you may ask us to amend the information. This request must be made in writing, and it must explain why the information should be amended. You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. A request for a restriction must be put in writing. However, we are not required to agree to a restriction you request. You do not have the right to limit the uses and disclosures that we are legally required or permitted to make. If we do agree to your request, we will put these limits in writing and abide by them except in emergency situations.

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. Upon your request, we will send your bills to another address.) You must make your request in writing. It must specify how and/or where you wish to be contacted. We will accommodate all reasonable requests.

Right to an Accounting: You generally have the right to receive a list of disclosures of PHI for which you have neither authorization nor consent (see above for this section). This accounting will begin on 8/11/2014 and disclosure records will be held for six years. On your request, we will discuss with you the details of the accounting process.

Limits of privacy when treating persons under the age of 18

All references to parents include legal guardian in the absence of parent.

- The provider maintains a record that contains dates of evaluation, goals of evaluation, diagnostic impressions, and recommendations.
- The parents of a client who is younger than the age of 18 have the right to read their child's/adolescent's record, which includes all information generated from Black Hills Psychology.
- The provider will inform parents if he/she assessed the child/adolescent to be in immediate danger or to be a danger to someone else.
- The provider will also communicate to the parent a summary of the evaluation as needed or as requested.
- The provider requests that parents otherwise respect their child's/adolescent's privacy regarding the content of the evaluation and treatment. A provider's evaluation may be more beneficial when parents do not ask to read the evaluation or ask the provider to reveal the content of the evaluation.
- The provider can refuse to give information to the parents about their child/adolescent if the provider predicts that disclosing such information may be harmful to the child/adolescent.

Questions and Complaints

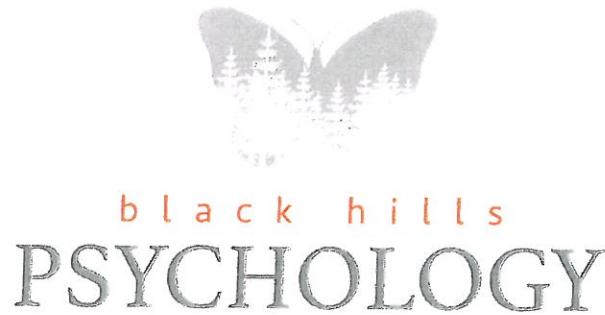
-If you want more information about our privacy practices or have questions or concerns, please contact us.

-If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about your access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the Secretary of the U.S. Department of Health and Human Services. Upon request we will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. Any complaint you file must be received by us, or filed with the Secretary, within 180 days of when you know, or should have known, the act or omission occurred.

-We support your right to the privacy of your health information. We will not retaliate in any way if you make a complaint.

Effective Date: This Notice of Privacy Practices is effective August 11, 2014.

Contact Information: For further information, please contact Black Hills Psychology in person at 115 N 7th Street, Suite 6, Spearfish, SD, 57783 or by telephone at 605-645-0100.



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Provider's Notice of Privacy Practices with the effective date of August 11, 2014.

Signature of Patient/Patient Representative

Date

Relationship to Patient

For Office Use Only

Black Hills Psychology attempted to obtain written acknowledgment of receipt of his/her Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
☐ An emergency situation prevented him/her from obtaining the acknowledgment
☐ Other (specify)



black hills
PSYCHOLOGY

115 N 7th Street Spearfish, SD 57783
(605) 645-0100 Fax (605) 717-1009

Adam J. Opbroek, MD

Policies & Treatment Consent

EXPLANATION OF TREATMENT

I have found that the collaborative effort of doctor and patient benefits by clear policies articulated at the initiation of treatment and by open communication throughout treatment. Psychiatric treatment can have many benefits, such as significant relief from uncomfortable or distressing symptoms, the development of more adaptive coping skills to deal with life's challenges, improvement in the quality of relationships, clarification of goals and priorities, and the resolution of conflicts that may interfere with one's ability to function effectively. For treatment to be most successful, you must be an active participant in your care. Initially, treatment may sometimes lead to an emergence of unpleasant thoughts and feelings as you reveal and face some of your past history and current difficulties, but these feelings are most often temporary. If medication is indicated, I will explain in detail the indications, risks, benefits, and possible alternatives to the medication I am recommending. You may experience medication side effects, which we will promptly address. After I complete your initial evaluation, I will offer you a preliminary assessment and a treatment plan, which also takes into consideration what your personal goals are regarding treatment.

Initial here: _____

HIPAA

Our office complies with the Health Information Portability and Accountability Act of 1996 (HIPAA). Please review the Notice of Privacy Practices provided in the front office or on the Black Hills Psychology website. You may request a copy of this notice if you wish. I have had the opportunity to review the Notice of Privacy Practices.

Initial here: _____

I authorize the release of information to my health plan pertaining to claims, certification, case management, quality improvement, benefit administration and other related purposes. I consent to benefits being assigned to my clinician for services rendered.

Initial here: _____

CONFIDENTIALITY:

Confidentiality is essential in mental health treatment. It is crucial that you feel free to discuss whatever you want in treatment without fear that information will leak out. No information revealed during our sessions will be disclosed to third parties without your explicit written permission. Please be aware, though, that if you choose to utilize your insurance benefits, and thus we are filing insurance claims, obtaining treatment authorizations, and undergoing insurance audits, we must share the required details of your treatment with your insurance carrier.

Exceptions to confidentiality in which the law mandates disclosure without your consent:

1. The most important exception is if I believe your safety is in jeopardy or you are unable to meet your basic needs, I will take whatever measures are necessary to protect you. I may seek hospitalization for you, and/or contact family members or others who can help provide assistance and protection.
2. If someone else is in danger due to your actions, I am obligated to warn them or appropriate authorities, without your consent. This may include notifying the potential victim, notifying law enforcement, or seeking hospitalization for you.
3. If there is suspected abuse to a child, an elderly or disabled person (even if it is about a party other than yourself), I must report it to the authorities.
4. If I am ordered by the court to release your records due to your emotional condition being considered relevant in a judicial proceeding you are involved in, I am mandated to comply with the order. These are rare and unusual circumstances, but even then, I will try to inform you of exactly what steps I will be taking.

Initial here: _____

PRACTICE LIMITATIONS:

I do not offer the following services:

- Forensic evaluations for legal purposes or for use in courts
- Custody evaluations or parental assessments for use in determining custody or visitation
- Disability evaluations
- Opiate medication prescriptions
- Suboxone prescriptions
- Fitness for Duty Evaluations
- Gastric Bypass Evaluations

LEGAL TESTIMONY:

Occasionally, the testimony of a mental health professional is required in certain legal matters. Legal testimony has the potential to be damaging to the relationship between a patient and their psychiatrist. Due to this, I require that you hire an independent forensic psychiatrist, should forensic evaluation or testimony be required. If, for any reason, I am deposed or subpoenaed on your behalf and I am required to testify or appear in court, you will be responsible for my court fees, which are \$450 per hour, including travel time.

Initial here: _____

PAYMENT POLICY:

Please understand that payment of your bill is considered part of your treatment. We will bill your insurance; however, you are responsible for co-payment amounts and deductibles as set by your benefit plan. If we are not a contracted provider with your carrier, you are responsible for full payment. If you have a calendar year deductible, you are responsible for paying each visit in full until you have met that obligation with the insurance carrier. Co-payments are to be paid in full each visit. You are responsible for notifying the office before services are rendered if you have a change in coverage. If, for whatever reason, your insurance coverage was not current at the time of service, you are responsible for 100% of the bill. If your account is referred to a collection agency for non-payment, a service charge equal to 30% of the account balance will be added to cover agency fees.

Initial here: _____

PRACTICE STATUS:

Black Hills Psychology is an office with other independent mental health professionals. While we share an office space, we are independent in providing clinical services, and each clinician alone is responsible for those services. I frequently refer patients to other clinicians and specialists, with specific consideration given toward who might be most helpful to you; however, I take no responsibility for the treatment they provide. Ultimately, it is up to you to decide whether a particular clinician is the right fit for you.

Initial here: _____

NOTICE TO PATIENTS:

You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, this physician, or any office policy, please inform us immediately and discuss the situation. Medical doctors are licensed and regulated by the South Dakota Board of Medical and Osteopathic Examiners. For more information, call 605-367-7781. **Initial here:** _____

PROFESSIONAL FEES:

My fee schedule is available by contacting the office. These fees include the charge for office visits, reasonable time for phone calls, record keeping and treatment plan completion. It does not include additional miscellaneous fees described below that are not covered by insurance. These fees are payable at the time you request these services. Fees are as follows:

- Completion of forms - \$10 per page
- Letters written on your behalf - \$25
- Copy of records - \$25 per set
- Returned check - \$25

Initial here: _____

CANCELLATIONS & MISSED APPOINTMENTS:

Your appointment time is reserved exclusively for you. If you miss your scheduled appointment without sufficient advance notice, you will be billed \$60. You may cancel without incurring a charge on the day prior to your scheduled appointment by 4 p.m. Monday through Friday. You must cancel Monday appointments by 4 p.m. on Friday. Our policy is to charge you the normal office visit rates, not your co-pay, for no-shows and late cancellations, as your insurance will not pay for missed appointments. We do try to contact you two days prior to confirm your appointment, but please realize that this is only a courtesy call. Ultimately, you are responsible for remembering your appointment date and time. Repeated no show appointments may result in referring you back to your insurance company for reassignment to another provider.

Initial here: _____

MEDICATION REFILLS:

Regular visits are crucial to good medical care and it is impossible to properly prescribe psychiatric medications without adhering to a regular, mutually agreed upon schedule. Please make sure that when you schedule appointments you consider your available medication supply. I will refill a prescription between visits only if you have an upcoming appointment scheduled. If you require this repeatedly, I will give you a one-time prescription with the amount of medication to last only until the day of your next appointment. Medication refill request should be faxed to the office by your pharmacist, which I will review and authorize as appropriate.

Initial here: _____

AVAILABILITY:

During business hours you may call the office and relay messages through staff or leave them on my voicemail. Please keep in mind that often I may not be able to check voicemail messages during the day while I am working with patients. On days when evening appointments are scheduled it may not be possible for me to respond the same day. I will make every effort to return your call on the same day you make contact, with the exception of weekends and holidays. I am available after hours by cell phone in case of emergency. If I will be unavailable for an extended period of time, I will provide you with the name

NON-DISCRIMINATION PRACTICES:

Our practice strictly abides by our policies ensuring that patients are not discriminated against in the delivery of health care services based on race, ethnicity, national origin, religion, sex, age, sexual orientation, mental or physical disability, medical condition, genetic information, or claims experience.

CONSENT TO TREATMENT:

My signature below indicates that I have read the above treatment consent form and I agree to abide by its terms during our professional relationship. I authorize and request my practitioner to carry out psychiatric exams, diagnostic and treatment procedures, which now or during the course of my treatment become advisable.

Name of Patient (Print) _____

Signature of Patient _____

CONSENT TO TREATMENT OF CHILD OR DEPENDENT:

My signature below indicates that I have read the treatment consent form, and I agree to abide by its terms during our professional relationship.

As the parent or legal guardian of the patient named _____, I authorize and request his/her practitioner to carry out psychiatric exams, diagnostic and treatment procedures, which now or during the course of his/her treatment become advisable.

Name of Parent/Guardian (Print) _____

Relationship to Patient (Print) _____

Signature of Parent/Guardian _____ Date _____