Richardson
Psychiatric Associates

INFORMATION FORM

Name_____ Sex_____ Date_____

Date of Birth_____ Age _____ Race _____

Complete Address_____

Billing Address(if different from home)_____

Home Phone_____ Cell Phone _____

SS#_____ Occupation _____

Employer _____Work Phone #_____

If child, Name of School _____Grade _____

Marital Status _____ If child, marital status of parents _____

Spouse's Name(if applic)_____Occupation_____Age____

Spouse's Employer _____ Work Phone #_____

If child, Father_____ Date of Birth_____SS#_____

Address(if different)_____ Phone #_____

Cell #_____His employer_____ Work #_____

If child, Mother_____Date of Birth_____SS#_____

Address(if different)_____Phone#_____

Cell #_____Her employer_____Work #_____

If child, Legal Guardian(if applic) Phone#_____ Cell #_____

Names and Ages of Household Members_____

_____

Pending Legal Issues(arrest, probations, etc)_____

Emergency Contact(not in household)_____ Relationship_____

Address_____Phone#_____Cell#_____

Referred by _____

Please list current medical services, past and current psychological services of patient(incl names/dates):

_____

_____

_____

Richardson Psychiatric Associates

PROBLEM LIST

Main reason for seeking treatment: _____

This checklist includes common difficulties or concerns that individuals may have. Please read the list and rate the severity of each item by circling one number for each item. If the item is not a problem for you, circle "0". Periodically, you may be ask to complete this Problem Severity Rating as a measure of progress.

LEGEND: 0 = Not a Problem 2 = Mild Problem 5 = Moderate Problem 8 = Severe Problem 10 = Extreme Problem

1 Attention/Concentrating Problems	0	1	2	3	4	5	6	7	8	9	10
2 Memory Problems	0	1	2	3	4	5	6	7	8	9	10
3 Confusion or Disorganized Thoughts	0	1	2	3	4	5	6	7	8	9	10
4 Racing or Obsessive Thoughts	0	1	2	3	4	5	6	7	8	9	10
5 Disturbing Thoughts or Dreams	0	1	2	3	4	5	6	7	8	9	10
6 Seeing/Hearing Things Others Don't	0	1	2	3	4	5	6	7	8	9	10
7 Low Self-Esteem	0	1	2	3	4	5	6	7	8	9	10
8 Low Energy/Fatigue	0	1	2	3	4	5	6	7	8	9	10
9 Feelings of Sadness or Depression or Crying	0	1	2	3	4	5	6	7	8	9	10
10 Issues with Grief or Loss	0	1	2	3	4	5	6	7	8	9	10
11 Loneliness or Social Withdrawal	0	1	2	3	4	5	6	7	8	9	10
12 Feelings of Guilt	0	1	2	3	4	5	6	7	8	9	10
13 Mood Swings	0	1	2	3	4	5	6	7	8	9	10
14 Thoughts of Not Wanting to Live	0	1	2	3	4	5	6	7	8	9	10
15 Tension, Stress or Pressure	0	1	2	3	4	5	6	7	8	9	10
16 Feeling of Nervousness or Worry	0	1	2	3	4	5	6	7	8	9	10
17 Fears or Phobias/Panic Attacks	0	1	2	3	4	5	6	7	8	9	10
18 Trauma/Abuse Issues	0	1	2	3	4	5	6	7	8	9	10
19 Irritability/Anger/Temper Problems	0	1	2	3	4	5	6	7	8	9	10
20 Hyperactivity/Restlessness	0	1	2	3	4	5	6	7	8	9	10
21 Thoughts of Harming Others	0	1	2	3	4	5	6	7	8	9	10
22 Self Injurious/Self Defeating Behavior	0	1	2	3	4	5	6	7	8	9	10
23 Destructive Habits _____	0	1	2	3	4	5	6	7	8	9	10
24 Impulse Control Problems	0	1	2	3	4	5	6	7	8	9	10
25 Trouble Relating to Others	0	1	2	3	4	5	6	7	8	9	10
26 Argumentativeness/Problems with Authority	0	1	2	3	4	5	6	7	8	9	10
27 Marital and/or Family Problems	0	1	2	3	4	5	6	7	8	9	10
28 Sexual Concerns	0	1	2	3	4	5	6	7	8	9	10
29 Alcohol or Drug Use Problems	0	1	2	3	4	5	6	7	8	9	10
30 Nutritional, Appetite or Weight Problems	0	1	2	3	4	5	6	7	8	9	10
31 Sleep Disturbance	0	1	2	3	4	5	6	7	8	9	10
32 Pain	0	1	2	3	4	5	6	7	8	9	10
33 Physical Health Problems	0	1	2	3	4	5	6	7	8	9	10
34 Employment and/or School Problems	0	1	2	3	4	5	6	7	8	9	10
35 Financial Problems	0	1	2	3	4	5	6	7	8	9	10
36 Legal Problems	0	1	2	3	4	5	6	7	8	9	10
37 Other _____	0	1	2	3	4	5	6	7	8	9	10
FOR CHILDREN ONLY:											
38 Toilet Training Problems (ie. Bed Wetting/Soiling)	0	1	2	3	4	5	6	7	8	9	10
39 Difficulty Separating From Parental Figures	0	1	2	3	4	5	6	7	8	9	10
40 Physical Aggression or Stealing	0	1	2	3	4	5	6	7	8	9	10
41 Cruelty to Animals or Fire Setting	0	1	2	3	4	5	6	7	8	9	10

Patient Signature / Under 14 y.o. Parent or Guardian Signature X _____ Date _____

PRINT →

PATIENT'S NAME

Richardson Psychiatric Associates

PHYSICAL HEALTH SCREENING

NOTE: All patients need to complete this form.

Name _____ Age _____ Sex _____ Weight _____ Height _____

Name of your personal/family physician or medical clinic: _____

When was your last visit to the doctor? _____

When was your last complete physical examination? _____

Please list any current physical symptoms, past and current medical problems including infectious and communicable diseases: (if you do not have any symptoms or problems place a checkmark in the box to the right) None ☐

_____

_____

_____

_____

Please list any allergies: None ☐

_____

_____

Please list any medications you are currently taking: None ☐

_____

_____

_____

_____

Have you developed any physical symptoms since your last visit to your doctor or that you have not previously discussed with your doctor? None ☐

_____

_____

If patient is a child please answer the following question: Are immunizations up to date? Yes _____ No _____

I attest that the above information is accurate to the best of my knowledge.

Signature of Patient or Parent/Guardian X _____ Date _____

PRINT → Name _____

Richardson
Psychiatric Associates

PATIENT RIGHTS AND RESPONSIBILITIES

Below is a list of your rights and responsibilities as a Richardson Psychiatric Associates Patient. This list represents current Richardson Psychiatric Associates policies that are in compliance with federal, state and local statutes and regulations. Please read this list and then sign on the appropriate line at the bottom. You may discuss any questions with your therapist.

1. You have the right to be treated with consideration and respect for personal dignity, autonomy and privacy.

2. You have the right to treatment. These rights include, but are not limited to:

   A. The right to a humane psychological and physical environment that is the least restrictive environment appropriate to your needs.
   B. The right to a current, written, individualized treatment plan, which you have participated in establishing, and to review and sign that plan.
   C. The right to be informed of alternative and additional treatment resources and the right to request and receive aid in referral to another agency.
   D. The right to be informed of any potential negative consequences to treatment.
   E. The right to be protected from abuse and neglect.
   F. The right to refuse medication and/or treatment.

3. You have the right to have equitable access to treatment regardless of age, race, ethnicity, religious orientation, sex, sexual orientation, disability, or source of payment for services.

4. You have the right to confidentiality in accordance with federal and state laws.

5. You have the right to full disclosure of all costs and fees.

6. You have the right to know that under the following five conditions, you have no right to confidentiality. Richardson Psychiatric Associates clinicians have the legal responsibility to:

   A. Report suspected abuse or neglect of minors to the County Children Services Board.
   B. Report suspected elder abuse to the appropriate county agency.
   C. Report homicidal intentions to the identified victim(s) and appropriate legal authority.
   D. Report suicidal intentions to your family and/or the appropriate legal authority if you fail to follow treatment recommendations.
   E. Comply with requests for records if court ordered.

7. The attending clinician reserves the right to terminate treatment due to a patient's failure to comply with treatment recommendations, failure to keep scheduled appointments, and/or failure to keep contractual obligations regarding payment of fees. In that event, the patient will be provided with the names of other appropriate treatment providers.

8. You have the responsibility to report to the Clinic Director or another staff member any inappropriate sexual advances, overtures, behaviors or efforts to establish a personal relationship outside of treatment by your therapist. Under no circumstances is this behavior ethical or acceptable in a professional treatment relationship, and is entirely outside of the scope of Richardson Psychiatric Associates services. Given the privacy of the treatment relationship, Richardson Psychiatric Associates can offer protection only if we are advised regarding the behavior as soon as it first occurs.

I have read or had this form read to me, and fully understand its contents.

Signature of Patient X _____ Date _____

OR Signature of Parent or Guardian X _____ Date _____

PRINT → Name _____

Richardson
Psychiatric Associates

SIGNATURE ON FILE FORM

INSURANCE INFORMATION

Patient's Name _____

PRINT

Insurance Carrier # 1 _____

Subscriber's Name _____ SS # _____ DOB _____

Subscriber's Employer _____

Subscriber's ID # _____ Group # _____ Plan Code _____

Insurance Carrier # 2 _____

Subscriber's Name _____ SS # _____ DOB _____

Subscriber's Employer _____

Subscriber's ID # _____ Group # _____ Plan Code _____

I hereby authorize Richardson Psychiatric Associates to furnish information to insurance carriers concerning diagnosis and treatment, and I authorize the insurance carriers to forward all payments to the doctor for services rendered to my dependents or myself. I understand that I am responsible for any charges not covered by insurance.

The information provided above is complete and there are no other insurance policies covering services.

I understand that it is my responsibility to notify Richardson Psychiatric Associates of an changes in my insurance coverage; otherwise I will be responsible for payment in full.

This authorization will be effective as of the date entered below. A photocopy of this authorization shall be considered as valid as the original.

Patient/Guardian's Signature X _____ Date _____

HANDBOOK AND HIPAA NOTICE OF PRIVACY PRACTICES INFORMATION/CONSENT TO SERVICES:

My signature below verifies that I have received and have had an opportunity to read the Richardson Psychiatric Associates Handbook and HIPAA Notice of Privacy Practices. I understand that if I have questions or need clarification, I can ask any member of the Richardson Psychiatric Associates staff for assistance.

I consent to Richardson Psychiatric Associates providing me with assessment and treatment services.

Patient/Guardian's Signature X _____ Date _____

KEEP FOR YOUR RECORDS

RICHARDSON PSYCHIATRIC ASSOCIATES P.C.
HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: September 23, 2013

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

The mission of Richardson Psychiatric is to enhance and promote the mental and emotional will being and optimal social functioning of all persons. This mission is accomplished by providing a comprehensive and integrated continuum of outpatient mental health and related services. In conjunction with the provision of such services, at times it may be necessary for us to use and to disclose your protected health information (PHI). PHI refers to information in your health records that could identify you. It includes information about your symptoms, test results, diagnosis, treatment, and related medical information.

Richardson Psychiatric is required by law to maintain the privacy of your PHI and to provide you with notice of the legal duties and privacy practices regarding PHI and to notify you following a breach of unsecured PHI. We understand that your health information is highly personal, and we are committed to safeguarding your privacy.

I. Disclosure of Your PHI Without Your Authorization

This Notice sets forth different reasons for which we may use and disclose your PHI. The Notice does not list every possible use and disclosure; however, all the reasons for which we are permitted to use and disclose your PHI are listed. The amount of health information used or disclosed will be limited to information that excludes most direct identifiers, such as name, address, and Social Security Number, unless more information is needed. If additional information is needed, it will be limited to the "minimum necessary" to accomplish the purpose of the use or disclosure.

- **To You** - Richardson Psychiatric may disclose your PHI to you, the individual who is the subject of the information.
- **Treatment, Payment, & Heath Care Operations** - Richardson Psychiatric may use or disclose your PHI for treatment, payment, and health care operations purposes. Treatment is when we provide, coordinate, or manage your health care and other services related to your care. An example would be when we consult with another health care provider, such as your family physician or specialist. Payment is when we obtain reimbursement for your health care. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for our services to you or to determine eligibility or coverage. Health Care Operations are activities that relate to the performance and operation of our practice. Examples of this are quality improvement activities, business-related matters (such as audits and administrative services), case management, and care coordination. Use applies only to activities within our practice, such as sharing, applying, utilizing, examining, and analyzing information that identifies you. Disclosure applies to activities outside Richardson Psychiatric practice, such as releasing, transferring, or providing access to information about you to other parties.
- **Incidental Use and Disclosure** - Richardson Psychiatric may use of disclosure your PHI as a result of, or as "incident to", an otherwise permitted use or disclosure, as long as it has adopted reasonable safeguards as required by HIPAA and the information being shares is limited to the "minimum necessary".
- **Where Required by Law** - Richardson Psychiatric may use and disclose your PHI as required by law, including, but not limited to, statute, regulation, or court order.

- **Public Health Activities** - Richardson Psychiatric may disclose your PHI to: (1) public health authorities authorized by law to collect or receive such information for preventing or controlling disease, injury, or disability and to public health or other government authorities authorized to receive reports of child abuse and neglect; (2) entities subject to FDA regulations regarding FDA regulated products or activities for purposes such as adverse event reporting, tracking of products, product recalls, and post-marketing surveillance; (3) individuals who may have contracted or been exposed to a communicable disease when notification is authorized by law; and (4) employers, regarding employees, hen requested by employers, for information concerning a work-related illness or injury or workplace related medical surveillance, because such information is needed by the employer to comply with the Occupational Safety and Health Administration (OHSA), the Mine Safety and Health Administration (MHSA), or similar state law.
- **Victims of Abuse, Neglect or Domestic Violence** - In situation involving abuse, neglect, or domestic violence, Richardson Psychiatric may disclose your PHI to appropriate government authorities.
- **Health Oversight Activities** - Richardson Psychiatric may disclose your PHI to health oversight agencies for purposes of legal-authorized health oversight activities, such as audits and investigations necessary for oversight of the health care system and government benefit programs.
- **Judicial and Administrative Proceedings** - Richardson Psychiatric may disclose your PHI in a judicial or administrative proceeding if the request for the information is through an order from the court or administrative tribunal. Such information may also be disclosed in response to a subpoena or other lawful process if certain assurances regarding notice to the individual or a protective order are provided.
- **Law Enforcement Purposes** - Richardson Psychiatric may disclose your PHI to law enforcement officials for law enforcement purposes under the following six circumstances, and subject to specified conditions: (1) as required by law (including court orders, court-ordered warrants, subpoenas) and administrative requests; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) in response to a law enforcement official's request for information about a victim or suspected victim of a crime; (4) to alert law enforcement of a person's death, if Richardson Psychiatric suspects that criminal activity caused the death; (5) when Richardson Psychiatric believes that PHI is evidence of a crime that occurred on its premises; and (6) by Richardson Psychiatric in a medical emergency not occurring on its premises, when necessary to inform law enforcement about the commission and nature of a crime, the location of the crime or crime victims, and the perpetrator of the crime.
- **Decedents** - Richardson Psychiatric may disclose your PHI to funeral directors as needed, and to coroners or medical examiners to identify a deceased person, determine the cause of death, and perform other functions authorized by law.
- **Cadaveric Organ, Eye, or Tissue Donation** - Richardson Psychiatric may use or disclose PHI to facilitate the donation and transplantation of cadaveric organs, eyes, and tissue.
- **Research** - "Research" is any systematic investigation designed to develop or contribute to generalized knowledge. Richardson Psychiatric may use and disclose your PHI for research purposes, provided that it obtains either: (1) documentation that an alteration or waiver of individuals' authorization for the use or disclosure of PHI about them for research purposes has been approved by an Institutional Review Board or Privacy Board; (2) representations from the researcher that the use or disclosure of PHI is solely to prepare a research protocol or for similar purpose preparatory to research, that the researcher will not remove any PHI from Richardson Psychiatric, and that PHI for which access is sought is necessary for the research; or (3) representations from the researcher that the use or disclosure sought is solely for research on PHI of decedents, that the PHI sought is necessary for the research, and, at the request of Richardson Psychiatric documentation of the death of the individuals about whom information is sought.
- **Serious Threat to Health or Safety** - Richardson Psychiatric may disclose your PHI if it believes such disclosure is necessary to prevent or lessen a serious and imminent threat to a person or the public, when such disclosure is made to someone they believe can prevent or lessen the threat (including the target of the threat).

Richardson
Psychiatric Associates

PCP RELEASE OF INFORMATION

Richardson Psychiatric Associates, 11 Shenango Rd., Suite 1, New Castle, PA 16105

Richardson Psychiatric strongly recommends that the patient authorize the exchange of information between Richardson Psychiatric and the patient's Primary Care Physician (PCP) for the purpose of appropriate coordination of care. The PCP may have important medical information that will assist with assessment and treatment planning. Likewise, your PCP can best serve you by being fully informed regarding the care you receive at our practice. Please review your options below, and initial your choice.

☐ I have no Primary Care Physician.

☒ My Primary Care Physician is: (Name) _____

(Address) _____

I _____, authorize Richardson Psychiatric and my PCP to exchange clinical information regarding my health and psychological/psychiatric assessment and treatment for purposes of coordination of care. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. If I do not revoke this authorization, it will expire one year after I have terminated treatment at Richardson Psychiatric.

☐ I prefer that no information be released by Richardson Psychiatric to my PCP at this time.

☐ Other instruction/limitations to this authorization: _____

_____

_____

_____ _____

Printed Name of Patient or Guardian Patient's Date of Birth

X

_____ _____

Signature of Patient or Guardian Date

FEE SCHEDULE AND POLICIES

Please read, sign and date.

The following information is provided to acquaint you with our fee policy. All charges are based upon the current usual and customary rate for psychological /psychiatric services. If you have any questions, please don't hesitate to ask.

FEES: The charge for each standard 60 minute session or diagnostic interview is $125. The fee for a half-session (25 minutes) is $60. Fee for group therapy shall be established prior to the first session. The fees for psychological testing and for required reports are based upon the time requirements for testing, document review, report writing, and other related services with a $300.°° charge for each hour utilized. Costs for court appearances must be agreed upon with the Clinic Director and paid in full prior to the court appearance. The initial psychiatric evaluation is $175.^{00} An extended psychiatric follow-up session (45 minutes) will cost $150. The fee for a brief psychiatric or med/somatic session (15 minutes) is $95.

MISSED APPOINTMENTS OR LATE CANCELLATIONS: There will be no charge for appointments cancelled at least 24 hours before the scheduled appointment time. However, due to the nature of psychiatric services, payment is necessary for late cancellations, (less than 24 hours prior to the scheduled appointment) and missed appointments. Unlike many professional practice which allow "overbooking" ,brief visits and crowded waiting rooms, your appointment means you have reserved a session of professional time. This is time that, for practical purposes, is lost and cannot be made up if the appointment is cancelled late. It also is time that may have been utilized for the benefit of another person with proper advanced cancellation. Therefore, there will be a $30 charge for late cancellations. Seventy ($70.) will be charged for missed appointments with no prior notification. These are charges not covered by health insurance.

PAYMENT: Cash, Checks and Credit cards are accepted.

A. Full payment following each session.

B. Alternate payment plan to include required co-payment and/or deductible (payable at the time the service is delivered):

_____

_____

INSURANCE COVERAGE: Richardson Psychiatric Associates has agreed to contractual arrangements with many insurance or managed care companies which may supersede the policies described herein. Otherwise, Richardson Psychiatric Associates has established a policy of payment of the total fee by the patient. If you have insurance which covers a percentage of the total fee for psychiatric services, we will be happy to submit claims to your insurance company. You will need to provide us with the appropriate claim forms and any necessary information describing your coverage, as well as, your signature for authorization for us to provide information required by your insurance company. If there are difficulties with your insurance company, we will be pleased to assist, but payment in full is still the responsibility of the patient or guardian.

INTEREST CHARGES: There is no interest charge for accounts in good standing. However, overdue accounts will be charged an $8. re-billing fee and payment in full of the account balance may be required. If collection efforts become necessary, court costs will be added to the account balance.

I have read and agree to the financial arrangements documented above. I have been provided with a copy of this Fee Schedule and Policies form.

Patient/Guardian's Signature X _____ Date _____

Witness's Signature _____ Date _____

PRINT Name _____