PLEASE READ ALL INSTRUCTIONS BEFORE COMPLETEING PAPERWORK!

***ALL PAGES MUST BE COMPLETED AND SIGNED BEFORE APPOINTMENTS CAN BE SCHEDULED.**

***CHILDREN AGES 14 THROUGH 17 MUST SIGN ALL PAPERWORK ALONG WITH THE PARENT/GUARDIAN ON ALL SIGNATURE LINES.**

1. INFORMATION FORM – PLEASE COMPLETE ALL INFORMATION
2. PROBLEM LIST - PLEASE CIRCLE THE APPROPRIATE RESPONSE NUMBER AND BE SURE TO SIGN, DATE AND PRINT THE PATIENT'S NAME AT THE BOTTOM.
3. PHYSICAL HEALTH SCREENING – COMPLETE ALL SECTIONS AND SIGN, DATE, AND PRINT THE PATIENT'S NAME AT THE BOTTOM
4. PATIENT RIGHTS AND RESPONSIBILITIES – PLEASE READ CAREFULLY AND SIGN DATE AND PRINT THE PATIENT'S NAME AT THE BOTTOM
5. SIGNATURE ON FILE – PLEASE COMPLETE ALL INSURANCE INFORMATION. **PLEASE NOTE: THERE ARE 2 SIGNATURES AND DATES REQUIRED ON THIS FORM. MISSING A SIGNATURE WILL RESULT IN THE RETURN OF THE FORM TO YOU FOR COMPLETION.**
6. HIPPA PRIVACY LAWS (2 pages) – PLEASE KEEP FOR YOUR RECORDS – DO NOT RETURN TO RICHARDSON PSYCHIATRIC.
7. PCP RELEASE OF INFORMATION – CHECK THE APPROPRIATE BOXES; PRINT YOUR DOCTOR'S NAME AND ADDRESS; PRINT THE PATIENT NAME AFTER THE LETTER "I"; AT THE BOTTOM, PRINT THE PATIENT NAME, PATIENT DATE OF BIRTH, AND SIGN AND DATE THE FORM
8. FEE SCHEDULE AND POLICIES – PLEASE READ CAREFULLY AND PAY SPECIAL ATTENTION TO THE MISSED APPOINTMENT/ LATE CANCELLATION POLICY. SIGN AND DATE AT THE BOTTOM AND PRINT THE PATIENT NAME

FORMS CAN BE RETURNED 2 WAYS:

1. DIGITAL SCAN (NO PICTURES) AND EMAILED TO richardsonpsych@comcast.net *PLEASE NOTE -THIS EMAIL BOX IS SOLEY FOR THE USE OF RETURNING FORMS AND NOT INTENDED FOR PATIENT COMMUNICATION. IF THERE ARE ANY QUESTIONS, YOU MUST CALL THE OFFICE AT 724-657-1881.*
2. *OR* MAIL FORMS TO: 11 SHENANGO RD. STE 1 NEW CASTLE PA 16105

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

Item											
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 ____________ Date ________

PRINT PATIENT NAME → ____________

PATIENT'S NAME

Richardson Psychiatric Associates

PHYSICAL HEALTH SCREENING

Name ______________________________ Age ____ Sex _____ Weight ____ Height _____

Name of your primary care physician (PCP) ______________________________ □ NONE

Date of your last visit to the doctor? ____________ Last complete physical ____________ Bloodwork ____________

Please list any medication allergies: ______________________________ □ NONE

____

Please list all medications you are currently taking: □ NONE

MEDICATION	DOSE/TIME	REASON FOR MEDICATION

□ *Continued on reverse*

Please list any current OR PAST medical problems not listed above, including major surgeries (list the year), head injuries/concussions and seizure history □ NONE

____

□ *Continued on reverse*

Signature of Patient or Parent/Guardian ______________________________ Date ____________

PRINT PATIENT NAME → 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 ______________________________ Date ______________

OR Signature of Parent or Guardian ______________________________ Date ______________

PRINT PATIENT NAME → Name ______________________________

Richardson
Psychiatric Associates

SIGNATURE ON FILE FORM

INSURANCE INFORMATION

Patient's Name ______________________________

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 ______________________________ 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 ______________________________ 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. <u>Disclosure of Your PHI Without Your Authorization</u>

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. <u>Treatment</u> 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. <u>Payment</u> 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. <u>Health Care Operations</u> 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).

KEEP FOR YOUR RECORDS

- **Essential Government Functions** - Richardson Psychiatric may disclose your PHI for certain essential government functions, including assuring proper execution of a military mission, conducting intelligence and national security activities that are authorized by law, providing protective services to the President, making medical suitability determinations for U.S. State Department employees, protecting the health and safety of inmates or employees in a correctional institution, and determining eligibility for or conducting enrollment in certain government benefit programs.
- **Workers' Compensation** - Richardson Psychiatric may disclose your PHI as authorized by, and to comply with, workers' compensation laws and other similar programs providing benefits for work-related injuries or illnesses.
- **Limited Data Set** - A limited data set is PHI from which certain specified direct identifiers of individuals and their relatives, household members, and employers have been removed. Richardson Psychiatric may disclose for research , health care operations, and public health purposes, a limited data set, provided the recipient of the limited data set enters into a data use agreement promising specified safeguards for PHI within the limited data set.

II. Disclosure of PHI With Your Authorization

In all instances (including most uses or disclosures of PHI consisting of psychotherapy notes.) Richardson Psychiatric may use or disclose your PHI only with your authorization. "Authorization" is written permission that allows Richardson Psychiatric to disclosure specific PHI. 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) we have relied on that authorization or (2) if the authorization was obtained as a condition of obtaining insurance coverage and the law provides the insurer the right to contest the claim under the policy.

We will obtain a written authorization for any use or disclosure of psychotherapy notes, except: (1) to carry out the following treatment, payment, or health care operations: use by us for treatment; use or disclosure by us for our own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling; or use or disclosure by us to defend ourselves in a legal action or other proceeding brought by you; and (2) a use or disclosure that is: required by the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule; permitted by law; for health oversight with respect to the oversight of our operations; to a coroner or medical examiner for the purpose of identifying a decedent; or to avert a serious threat to health or safety.

III. Disclosures That Will Not Be Made

Please note that we do not use your PHI for marketing or fund-raising efforts. We do not sell your PHI. We also do not use or disclose your genetic information PHI for underwriting purposes, which is prohibited by the Genetic Information Nondiscrimination Act (GINA) of 2008.

IV. Your Rights Under HIPAA

- **Rights to Request Restrictions** - You have the right to request restrictions on certain uses and disclosures of your PHI; however, we are not required to agree to a restriction at your request except for restrictions for any disclosures to be made to a health plan for payment or health care operations functions (but not for treatment purposes) involving a health care item or service for which you have paid us out of pocket in full.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations** - You have the right to request and receive confidential communication of PHI by alternative means and

at alternative locations. For example, you may not want a family member to know that you are receiving services at Richardson Psychiatric. Upon your request, we will send your statements to another address.
- **Rights to Inspect and Copy** - You have the right to inspect or obtain a copy (or both) of PHI records used to make decisions about you for as long as the PHI is maintained in the record. If we maintain your PHI in an electronic format (including in an electronic health record), you have the right to obtain a copy of such information in an electronic format and, if you so choose, direct us to transmit such copy directly to another entity or person. We may deny your request to inspect or copy your PHI in certain limited circumstances. In some circumstances, you may request that the denial be reviewed.
- **Right to Amend** - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. On your request we will discuss with you the details of the amendment process. We may accept or deny your request.
- **Right to an Accounting** - Generally, you have the right to receive an accounting of disclosures of PHI for which you have not provided either contest or authorization (as described in Section III of this Notice). You also have the right to request an accounting of disclosures of your PHI through an electronic health record made by us to carry out our payment activities or health care operations within the past three years from the date of your request. On your request, we will discuss with you the details of the accounting process.
- **Right to Receive Notification** - You are entitled to receive notification from us if the confidentiality of any of your PHI maintained in an unsecured form is compromised.

V. Richardson Psychiatric's Duties Under HIPAA

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. We are required to abide by the terms currently in effect, unless we notify you of such changes.
- We reserve the right to change the terms of this notice and to make the provisions of the new notice effective for all PHI that we maintain. If we revise our policies and procedures that will affect your PHI, we will send a notice of these changes to you by regular mail to your last known address that we have on file for you.

VI. Questions and Complaints

- If you have questions about this notice, disagree with our decision about access to your records, or have other concerns about your privacy rights, you may contact the Privacy Office for Richardson Psychiatric Associates in writing, at Richardson Psychiatric Associates, 11 Shenango Road, Suite 1, New Castle, PA 16105, or by phone at 724-657-1881.
- If you believe that your privacy rights have been violated and wish to file a complaint, you may send your written complaint to the Privacy Officer for Richardson Psychiatric Associates in writing, at Richardson Psychiatric Associates, 11 Shenango Road, Suite 1, New Castle, PA 16105, or by phone at 724-657-1881.
- You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, SW, in Washington, D.C., 20201.
- We will not retaliate against you for exercising your right to file a complaint.

Richardson Psychiatric Associates

PCP RELEASE OF INFORMATION

Richardson Psychiatric Associates, 11 Shenango Rd., Suite 1, New Castle, PA 16105
Phone: 724-657-1881 Fax: 724-657-9178

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) ____________________

Phone: ____________ Fax: ____________

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.**
- ☐ **Please file in patient's chart for future communication.**
- ☐ **Other instruction/limitations to this authorization.** ____________________

____

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

____________________ ____________
Signature of Patient or Guardian Date

FEE SCHEDULE AND POLICIES

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 $135.00. 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 $300.00 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 $200.00 An extended psychiatric follow-up session (45 minutes) will cost $150. The fee for a brief psychiatric or med/somatic session (15 minutes) is $105.00.

MISSED APPOINTMENTS OR LATE CANCELLATIONS: There will be no charge for appointments cancelled by 12:00 noon 1 business day before the scheduled appointment time. However, due to the nature of psychiatric services, payment is necessary for late cancellations, (less than 1 business day prior to the scheduled appointment) and missed appointments. Unlike many professional practices 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 $45 charge for late cancellations. $85 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 ______________________ Date ______________

Witness's Signature ______________________ Date ______________

PRINT PATIENT'S NAME →

Name ______________________