



**KNOWLES-DUNCAN & ASSOCIATES, LLC**

**CHILD / ADOLESCENT - NEW PATIENT REGISTRATION**

This registration **MUST** be completed by the custodial parent / legal guardian of the minor patient.

Person completing paperwork: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **Nickname:** \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SEX: MALE / FEMALE

EMPLOYED:  FULL-TIME  PART-TIME  UNEMPLOYED  RETIRED  ON LEAVE

EMPLOYER NAME: \_\_\_\_\_

STUDENT:  NO  FULL TIME  PART TIME GRADE LEVEL: \_\_\_\_\_

SCHOOL: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_ PHONE #: ( ) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ FAX #: ( ) \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

HOME PHONE: ( ) \_\_\_\_\_ OTHER PHONE: ( ) \_\_\_\_\_

**FATHER:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

SSN: \_\_\_\_\_ or DRIVERS LICENSE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ HOME PHONE: ( ) \_\_\_\_\_

\_\_\_\_\_ OTHER PHONE: ( ) \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE: ( ) \_\_\_\_\_

**MOTHER:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

SSN: \_\_\_\_\_ or DRIVERS LICENSE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ HOME PHONE: ( ) \_\_\_\_\_

\_\_\_\_\_ OTHER PHONE: ( ) \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ WORK PHONE: ( ) \_\_\_\_\_

## **Patient Rights & Responsibilities**

- Be treated with respect and recognition of my dignity and right to privacy
- Receive care that is considerate and respects my personal values and belief system
- Personal privacy and confidentiality of information
- Receive information about my managed care company's services, practitioners, clinical guidelines, quality improvement program and patient rights and responsibilities
- Reasonable access to care, regardless of my race, religion, gender, sexual orientation, ethnicity, age or disability
- Participate in an informed way in the decision making process regarding my treatment planning
- Discuss with my treating professionals appropriate or medically necessary treatment options for my condition regardless of cost or benefit coverage
- Have family members participate in treatment planning and if I am over the age of 12 to participate in such planning
- Individualized treatment, including
  - Adequate and humane services regardless of the source(s) of financial support
  - Provision of services within the least restrictive environment possible
  - An individualized treatment or program plan
  - Periodic review of the treatment or program plan
  - An adequate number of competent, qualified and experienced professional clinical staff to supervise and carry out the treatment or program plan
- Participate in the consideration of ethical issues that arise in the provision of care and services, including
  - Resolving conflict
  - Designate a surrogate decision maker if I am incapable of understanding a proposed treatment or procedure or am unable to communicate my wishes regarding care
- Be informed, along with my family, of my rights in a language I/we understand
- Voice complaints or appeals about my managed care company, provider of care or privacy practices
- Make recommendations regarding my managed care company's rights and responsibilities policies
- Be informed of rules and regulations concerning my own conduct
- Be informed of the reason for any utilization management adverse determination including the specific utilization review criteria or benefits provision used in the determination
- Have utilization management decisions based on appropriateness of care
- Request access to my Protected Health Information (PHI) or other records that are in the possession of my managed care company
- Request to inspect and obtain a copy of my PHI, to amend my PHI or to restrict the use of my PHI, and to receive an accounting of disclosures of PHI

### **I understand that I am responsible for:**

- Providing (to the extent possible) my treating clinician and managed care company with information needed in order to receive appropriate care.
- Following plans and instructions for care that I have agreed on with my treating clinician.
- Understanding my health problems and participating, to the degree possible, in developing, with my treating clinician, mutually agreed upon treatment goals.
- Attendance at scheduled appointments and cancellations within 48 hours of scheduled appointments are necessary to meet and maintain treatment goals.

## **KNOWLES–DUNCAN & ASSOCIATES, LLC FINANCIAL POLICY Updated 4/1/11**

All fees are due at the time of service. Acceptable forms of payment include cash, check, credit card (Visa/MC) and health savings accounts. As a courtesy, Knowles-Duncan Associates, LLC (KDA) can file claims upon your behalf with your primary insurance company upon submission of proof of insurance, however, the patient is ultimately responsible for all charges incurred with KDA. Unless your primary insurance is Medicare or Medicaid we will be unable to file secondary insurance claims. It is the patient responsibility to verify that any/all providers with whom they are scheduled participate in their provider network. Patients will be responsible for all charges incurred as a result of services rendered with an out-of-network provider. At the time of service if the patient is unable to provide proof of insurance, payment will be due in full. Patients will be unable to schedule future appointments with outstanding or past due balances. KDA will not provide services to any patient with accounts in violation of the financial policy. Patient is responsible for all charges deemed non-covered by your insurance company. i.e. forensic time, prescription refill charges, patient assistance, medical record charges, report/paperwork fees, telephone consultations, etc.

***In an effort to provide the best patient care and to maximize appointment time physicians and counselors will not discuss financial matters, all questions and inquiries must be directed to the office staff or Practice Administrator, they will be happy to help.***

**Fee Schedule is as follows:**

**M.D. Charges:**

New Patient Evaluation \$325  
Brief Therapy/Extended Medication Follow Up (20-30 minutes) \$145  
Therapy/Extended Medication Follow Up (30-45 minutes) \$225  
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Medication Follow Up \$100

**Counselor Charges:**

New Patient Evaluation \$175  
Therapy Session \$125.00

**New Patients:** New patients are required to pay a \$125 deposit in advance. The deposit will be applied to the patient's account following your 1<sup>st</sup> appointment to be used for future services. In the situation where KDA is submitting claims on the patient's behalf deposits will be applied to the patients account after receipt of the 1<sup>st</sup> explanation of benefits is received detailing patient responsibility. This process can take up to 90 days. All deductibles, co-pays/co-insurances are due at the time of service. We require a 48 hour (2 business days) notice for all cancellations. Failure to attend your initial appointment (or if you cancel for any reason without proper notice) will result in the patient being responsible for full amount due of scheduled appointment.

The deposit is usually paid by credit card unless otherwise arranged. By providing KDA with your credit card account information for your deposit grants KDA permission to charge this said account for any initial appointments that are missed or cancelled appointments without proper notice.

- ❖ **All checks returned to KDA for non-sufficient funds will result in a \$35 processing fee. The original check amount plus the processing fee must be paid immediately.**
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- ❖ **A \$10.00 statement fee will be assessed to any balance not paid in full at the time of service.**
- ❖ **2% interest will be assessed monthly on all outstanding patient balances.**
- ❖ **KDA requires a 48-HOUR (2 business days) ADVANCE NOTICE FOR CANCELLATIONS. If a patient arrives late for their appointment they may need to reschedule as well as be responsible to pay for the entire appointment. In the situation when the patient misses an appointment without proper notice they will be responsible for full amount due for set appointment. If KDA is able to fill that appointment no charges will be assessed to the patient. If severe weather permits our office to close or if our office closes for any reason the patient will NOT be charged for a missed/late-cancelled appointment. Multiple late arrivals, missed or late-cancelled appointments will result in an inability to continue to provide services to you.**
- ❖ **Accounts in violation of our financial policy are subject to placement with a third party collection agency. The patient will then be responsible for reasonable attorney and collection fees.**
- ❖ **If you are detained or incarcerated we will not be able to provide services to you. We will attempt to help you locate an establishment who can provide services.**

BY MY SIGNATURE BELOW:

- I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF KNOWLES-DUNCAN & ASSOCIATES, LLC.
- I HAVE READ AND UNDERSTAND THE PATIENT RIGHTS & RESPONSIBILITIES.
- I AUTHORIZE MY PROVIDER TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIM TO MY INSURANCE COMPANY AND TO RECEIVE PAYMENT FROM MY INSURANCE COMPANY FOR SERVICES RENDERED BY KNOWLES-DUNCAN & ASSOCIATES, LLC.
- I AGREE AND CONSENT TO PARTICIPATE IN THE MENTAL HEALTH SERVICES OFFERED AND PROVIDED BY KNOWLES-DUNCAN & ASSOCIATES, LLC., A MENTAL HEALTH PROVIDER AS DEFINED IN INDIANA LAW. I UNDERSTAND THAT I AM CONSENTING AND AGREEING ONLY TO THOSE SERVICES THAT THE ABOVE NAME PROVIDER IS QUALIFIED TO PROVIDE WITHIN: (1) THE SCOPE OF THE PROVIDER'S LICENSE, CERTIFICATION, AND TRAINING; OR (2) THE SCOPE OF THE LICENSE, CERTIFICATION, AND TRAINING OF THESE MENTAL HEALTH PROVIDERS DIRECTLY SUPERVISING THE SERVICES RECEIVED BY THE PATIENT.
- I HAVE RECEIVED THE PRACTICE'S NOTICE OF PRIVACY PRACTICES AND UNDERSTAND THAT MY PROTECTED HEALTH INFORMATION MAY BE USED BY THE PRACTICE AS DESCRIBED IN THE NOTICE.
- BY PROVIDING KDA THE CREDIT CARD ENDING IN (last 4 digits) \_\_ \_\_ \_\_ \_\_ EXP. DATE \_\_\_\_/\_\_\_\_ NAME ON CARD \_\_\_\_\_ YOU EXPRESSLY GRANT KDA PERMISSION TO CHARGE THIS ACCOUNT FOR ANY AND ALL CHARGES RELATED TO YOUR INITIAL APPOINTMENT.

\_\_\_\_\_  
**Patient Signature or Personal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Description of Personal Representative's Authority**

\_\_\_\_\_  
**Office Staff Initials / Date**

Office Arrival

\_\_\_\_\_  
(Patient Initials)

\_\_\_\_\_  
Office Staff Initials

**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO  
PRIMARY CARE PHYSICIAN**

PATIENT NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

\*\*\*\*\*PLEASE CHOOSE ONE OF THE FOLLOWING OPTIONS\*\*\*\*\*

I **do not** want any information released to my Primary Care Physician

I **authorize** Knowles-Duncan & Associates, LLC to release my protected health information to my PCP

**PLEASE NOTE:** *Without complete information below we will be unable to process your request.*

Dr: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I understand that this request will be valid for one hundred eighty (180) days from the date written below. At that time the request will be void and no further information will be furnished pursuant to it.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Knowles-Duncan & Associates, LLC. I understand that a revocation is not effective to the extent that Knowles-Duncan & Associates, LLC has relied on the use or disclosure of the protected health information.

This release prohibits re-disclosure except in accordance with 42 C.F.R., 21 et seq., which is a federal regulation governing release and use of patient record information pertaining to treatment for alcohol and drug abuse.

Knowles-Duncan & Associates, LLC. will not condition my treatment whether I provide authorization for the requested use or disclosure.

I agree to pay, KNOWLES-DUNCAN ASSOCIATES, LLC. an actual cost incurred in preparing and delivering the information requested herein.

A copy of this authorization shall be as valid as the original.

I understand that I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).
- Refuse to sign this authorization.
- Receive a signed copy of this authorization.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority

\_\_\_\_\_  
**WITNESS - Office Staff Signature & Date**

\*\*\*\*\* For Internal Use Only \*\*\*\*\*

MAILED  FAXED records to PCP on \_\_\_\_\_ by \_\_\_\_\_

# 2010 INSURANCE FORM

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**\*\*\*\* Are you utilizing EAP benefits? YES / NO \*\*\*\***

EAP Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

AUTH# \_\_\_\_\_ START DATE: \_\_\_\_\_ # OF VISITS \_\_\_\_\_

## **PRIMARY:**

Insurance: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insured: \_\_\_\_\_ DOB: \_\_\_\_\_

ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Relationship: \_\_\_\_\_ Insured SSN: \_\_\_\_\_

Employer: \_\_\_\_\_

## **SECONDARY:** \*We will only file claims if provider is IN NETWORK\*

Insurance: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insured: \_\_\_\_\_ DOB: \_\_\_\_\_

ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Relationship: \_\_\_\_\_ Insured SSN: \_\_\_\_\_

Employer: \_\_\_\_\_

Please be aware that mental health benefits may be separate from medical insurance benefits. If you are not familiar with your mental health benefits we would strongly suggest that you call your insurance company. You will be responsible for all charges that are not paid by your insurance.

- It is your responsibility to:**
- 1) **Verify your coverage and benefit information**
  - 2) **Verify that you are scheduled to see a provider in your network**
  - 3) **Obtain authorization for services if required by your insurance**

Our office will not contact your insurance company to verify, benefit information until after the provider has seen you.

Do you understand this disclaimer? [ ] YES [ ] NO

\_\_\_\_\_  
Patient Signature or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Personal Representative's Authority

\_\_\_\_\_  
Witness- Office Staff Signature & Date

## **CHILD / ADOLESCENT QUESTIONNAIRE**

Briefly describe the problems your child is having & when they began:

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**MENTAL HEALTH HISTORY**

Has your child ever been abused (emotionally, physically, or sexually)?       YES     NO

Explain: \_\_\_\_\_

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Has your child ever experienced any other emotional or physical trauma?       YES     NO

Explain: \_\_\_\_\_

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|                     |   |                              |                             |
|---------------------|---|------------------------------|-----------------------------|
| Has your child ever | a) been in counseling                                       | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|                     | b) been hospitalized for emotional or alcohol/drug problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|                     | c) been professionally evaluated                            | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
|                     | d) received special education services                      | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

If yes to any of the above, please provide dates, names of agencies, reason for service, & outcome:

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Please list any medications your child currently takes for emotional or behavioral problems:       NONE

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Please list any medications your child has taken in the past for emotional/behavioral problems:  NONE

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---

Please list any family history of mental health/substance abuse problems: \_\_\_\_\_

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**GENERAL MEDICAL HISTORY**

Height:\_\_\_\_\_ Weight:\_\_\_\_\_ Are immunizations up to date: [ ] YES [ ] NO

Please list all allergies, childhood illnesses (including chronic illnesses and infectious diseases), accidents, injuries, hospitalizations, and surgeries:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all prescription and over-the-counter medications your child takes for any medical reason (include any vitamins & herbal supplements):

\_\_\_\_\_  
\_\_\_\_\_

Please list any family history of medical problems: \_\_\_\_\_

\_\_\_\_\_

**FAMILY STATUS**

Are the child's biological parents currently married? [ ] YES [ ] NO

If no, custody is with [ ] Mother primary [ ] Father primary [ ] Joint [ ] Other \_\_\_\_\_

Please describe living arrangements, visitations, etc: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List all people currently residing in your home, and the relationship of each to your child: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Are there any traditions/events that are important to your child? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Is there any additional information you feel would be helpful to the treatment of your child? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**DEVELOPMENTAL HISTORY**Pregnancy

Was the pregnancy planned?  YES  NO

Please check any of the following experienced during mother's pregnancy with the child being evaluated.

|  |  |                                   |
|--|--|-----------------------------------|
| <input type="checkbox"/> Excessive vomiting            | <input type="checkbox"/> Smoking                               | <input type="checkbox"/> Drug use |
| <input type="checkbox"/> Excessive spotting/blood loss | <input type="checkbox"/> Alcohol consumption                   | <input type="checkbox"/> Illness  |
| <input type="checkbox"/> Threatened miscarriage        | <input type="checkbox"/> Prescription medications              | <input type="checkbox"/> X-rays   |
| <input type="checkbox"/> Toxemia/Infection             | <input type="checkbox"/> Hospitalization (other than delivery) |                                   |

Were there any problems with the pregnancy? \_\_\_\_\_

Was Pregnancy:  Full Term  Premature—how much? \_\_\_\_\_  Late—how much? \_\_\_\_\_

Were there any problems with the delivery? \_\_\_\_\_

Early Childhood

Milestones ~ Please report the ages or if you cannot remember check one of the following

|                   |       |                                |                                  |                               |
|-------------------|-------|--------------------------------|----------------------------------|-------------------------------|
| Smiled            | _____ | <input type="checkbox"/> Early | <input type="checkbox"/> Average | <input type="checkbox"/> Late |
| Crawled           | _____ | <input type="checkbox"/> Early | <input type="checkbox"/> Average | <input type="checkbox"/> Late |
| Sat up on own     | _____ | <input type="checkbox"/> Early | <input type="checkbox"/> Average | <input type="checkbox"/> Late |
| Stood unassisted  | _____ | <input type="checkbox"/> Early | <input type="checkbox"/> Average | <input type="checkbox"/> Late |
| Walked unassisted | _____ | <input type="checkbox"/> Early | <input type="checkbox"/> Average | <input type="checkbox"/> Late |
| Spoke first words | _____ | <input type="checkbox"/> Early | <input type="checkbox"/> Average | <input type="checkbox"/> Late |
| Said sentences    | _____ | <input type="checkbox"/> Early | <input type="checkbox"/> Average | <input type="checkbox"/> Late |
| Toilet Trained    | _____ | <input type="checkbox"/> Early | <input type="checkbox"/> Average | <input type="checkbox"/> Late |
| Ran               | _____ | <input type="checkbox"/> Early | <input type="checkbox"/> Average | <input type="checkbox"/> Late |
| Fed self          | _____ | <input type="checkbox"/> Early | <input type="checkbox"/> Average | <input type="checkbox"/> Late |
| Dressed self      | _____ | <input type="checkbox"/> Early | <input type="checkbox"/> Average | <input type="checkbox"/> Late |

Where there any illnesses, behavioral difficulties, or discipline problems during early childhood? \_\_\_\_\_

Did your child have temper tantrums?  YES  NO Describe: \_\_\_\_\_

What discipline techniques were used? \_\_\_\_\_

Did the parents use consistent discipline?  YES  NO

**EDUCATIONAL HISTORY**

School: \_\_\_\_\_ Grade: \_\_\_\_\_

How many different schools has your child attended? \_\_\_\_\_

Has she/he ever repeated or skipped a grade? YES / NO Which one? \_\_\_\_\_

What is her/his attendance like at school? \_\_\_\_\_

Has she/he had any discipline problems at school and/or been suspended or expelled? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What are her/his grades like? \_\_\_\_\_ Have they changed recently? YES / NO

With which subject does she/he experience difficulty? \_\_\_\_\_

Does she/he have any learning disabilities or attend special education services? YES / NO

Briefly describe services: \_\_\_\_\_

\_\_\_\_\_

**SOCIAL HISTORY**

Does your child make friends easily? [ ] YES [ ] NO

Does your child have difficulty keeping friends? [ ] YES [ ] NO

Briefly describe any peer interaction problems experienced by your child: \_\_\_\_\_

\_\_\_\_\_

Have there been any losses, changes, or transitions in your child's life? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does the family have any spiritual, cultural, or religious beliefs that influence the child? \_\_\_\_\_

\_\_\_\_\_

Please describe your child's strengths, weaknesses, accomplishments, talents, and areas of interest:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CHILD/ADOLESCENT PROBLEM CHECKLIST**

Below are some common problems of children and teenagers. Please read each item carefully. If an item applies to the child please mark appropriately. Any comments will be especially helpful.

**BEHAVIOR PROBLEMS**

- ]Violates curfew
- ]Destroys property
- ]Steals
- ]Lies often
- ]Has been in trouble with police/probation
- ]Has runaway from home
- ]Has attempted or talked about suicide
- ]Argues when told to do something
- ]Is cruel to animals
- ]Rarely sits still
- ]Has to have everything his/her own way
- ]Acts like a younger child
- ]Has problems with anger
- ]Sets fire
- ]Prefers to be alone

**ACEDMIC PROBLEMS**

- ]Is truant from school
- ]Does not complete assignments in the classroom
- ]Does not do homework
- ]Is in special education classes
- ]Feels unfairly treated by teachers/administrators
- ]Has a short attention span
- ]Often clowns in class
- ]Cheats
- ]Is too often out of seat in school
- ]Misses school for a variety of reasons
- ]Makes below average grades

**PROBLEMS WITH FEELINGS**

- ]Is upset by any changes in routines/schedules
- ]Has a lot of fears
- ]Lacks self confidence
- ]Feels sad a lot
- ]Does not seem to feel guilt
- ]Is extremely critical
- ]Cries easily or often
- ]Does not like to be touched
- ]Resents even gentle criticism
- ]Has an "I don't care" attitude
- ]Feels bored a lot
- ]Has frequent nightmares

**FAMILY PROBLEMS**

- ]Avoids contact with family members
- ]Gets along poorly with mother
- ]Gets along poorly with father
- ]Gets along poorly with siblings
- ]Parents get along poorly with each other
- ]Clings to mother
- ]Clings to father

**PROBLEMS WITH THINKING**

- ]Says and does things over and over
- ]Hears or sees things that aren't there
- ]Has trouble concentrating
- ]Has ideas that don't make sense

**SOCIAL PROBLEMS**

- ]Hangs around with a bad crowd
- ]Is too easily led by others
- ]Chooses friends a lot younger
- ]Chooses friends a lot older
- ]Is often teased by others
- ]Teases younger children
- ]Doesn't like being alone
- ]Has few friends
- ]Tattles on other children
- ]Seems shy
- ]Often boasts
- ]Often interrupts others
- ]Won't argue/fight back when most would
- ]Fights

**DRUG/ALCOHOL USE**

- ]Uses alcoholic beverages
- ]Uses drugs
- ]Sells drugs
- ]Smokes cigarettes

**PHYSICAL COMPLAINTS**

- ]Has a lot of physical complaints
- ]Has trouble sleeping
- ]Sleeps a lot
- ]Is seriously overweight
- ]Is seriously underweight
- ]Has lost a lot of weight recently
- ]Has gained a lot of weight recently
- ]Has poor bladder control at night
- ]Has poor bladder control during the day
- ]Has poor bowel control at night
- ]Has poor bowel control during the day
- ]Is clumsy or awkward

# PATIENT COPY

Please retain the following documents for your records.

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- I AUTHORIZE MY PROVIDER TO RELEASE ANY INFORMATION REQUIRED TO PROCESS MY CLAIM TO MY INSURANCE COMPANY AND TO RECEIVE PAYMENT FROM MY INSURANCE COMPANY FOR SERVICES RENDERED BY KNOWLES-DUNCAN & ASSOCIATES, LLC.
- I AGREE AND CONSENT TO PARTICIPATE IN THE MENTAL HEALTH SERVICES OFFERED AND PROVIDED BY KNOWLES-DUNCAN & ASSOCIATES, LLC., A MENTAL HEALTH PROVIDER AS DEFINED IN INDIANA LAW. I UNDERSTAND THAT I AM CONSENTING AND AGREEING ONLY TO THOSE SERVICES THAT THE ABOVE NAME PROVIDER IS QUALIFIED TO PROVIDE WITHIN: (1) THE SCOPE OF THE PROVIDER'S LICENSE, CERTIFICATION, AND TRAINING; OR (2) THE SCOPE OF THE LICENSE, CERTIFICATION, AND TRAINING OF THESE MENTAL HEALTH PROVIDERS DIRECTLY SUPERVISING THE SERVICES RECEIVED BY THE PATIENT.
- I HAVE RECEIVED THE PRACTICE'S NOTICE OF PRIVACY PRACTICES AND UNDERSTAND THAT MY PROTECTED HEALTH INFORMATION MAY BE USED BY THE PRACTICE AS DESCRIBED IN THE NOTICE.
- BY PROVIDING KDA THE CREDIT CARD ENDING IN (last 4 digits) \_\_\_ \_\_\_ \_\_\_ \_\_\_ EXP. DATE \_\_\_/\_\_\_/\_\_\_ NAME ON CARD \_\_\_\_\_ YOU EXPRESSLY GRANT KDA PERMISSION TO CHARGE THIS ACCOUNT FOR ANY AND ALL CHARGES RELATED TO YOUR INITIAL APPOINTMENT.

\_\_\_\_\_  
**Patient Signature or Personal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Description of Personal Representative's Authority**

\_\_\_\_\_  
**Office Staff Initials / Date**

**PATIENT COPY - SIGNATURE ON FILE ON OFFICE COPY****KNOWLES-DUNCAN & ASSOCIATES, LLC - PATIENT INFORMATION**  
**EFFECTIVE JANUARY 1, 2006**

**EMERGENCIES** – Knowles-Duncan & Associates, LLC is not a crisis office. In the event that you feel you are in crisis DIAL 911 or go directly to the nearest emergency room. We do not accept walk-ins.

**MEDICATION REFILLS** - Medication refills should be addressed at the time of your appointment and will be provided until your next scheduled appointment. If due to unforeseen circumstances you will run out before your next scheduled appointment you must contact the office by calling 317-776-3310. .

**Again, Walk-in requests will not be honored due to the nature of our practice.**

***MEDICATION QUESTIONS, LAB RESULTS, AND OTHER MEDICAL CONCERNS SHOULD BE HANDLED DURING APPOINTMENTS.***

**SCHEDULE/CANCEL APPOINTMENTS** – You can schedule or cancel an appointment by calling our office at 317-776-3310. Please remember that we require a 48-Hour advance notice for all cancellations.

**MEDICAL RECORDS** - All requests for medical records will be charged according to Indiana State Law Code 16-39-9-3. Payment is due prior to the processing of your request. There is no charge for records released to another healthcare professional for treatment purposes. A current written release of information is required for all requests.

**COMPLETION OF FORMS** - A fee of **\$50** per every 15 minutes of time required to complete paperwork will be charged for all forms (including but not limited to return to work, disability, FMLA, life insurance, etc). Payment in full is required prior to the release of the completed paperwork.

**BILLING AND INSURANCE** – Please refer to Knowles-Duncan & Associates, LLC financial policy for details associated with billing and insurance. Acceptable methods of payment include cash, check, and credit/debit cards including VISA and MasterCard. If at any time you have a question on your account, please feel free to contact our billing department at 317-776-3310.

**Knowles-Duncan & Associates, LLC**

341 Logan Street

Suite 120

Noblesville, IN 46060

Phone: 317-776-3310

Fax: 317-776-3577

Office Hours:

Monday thru Friday: 8:30am – 4:30pm

# KNOWLES-DUNCAN & ASSOCIATES, LLC

## 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain both before and after the change. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

### 1. Uses and Disclosures of Protected Health Information

You will be asked by your physician to sign this Notice of Privacy Practices. We will make a good faith effort to obtain a written acknowledgement that you received this Notice of Privacy Practices for Protected Health Information the first time we provide services to you after April 14, 2003 or as soon as reasonably practicable under the circumstances. Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to obtain payment for your health care bills and to support the operation of the physician's practice.

Following are examples of the types of uses and disclosures of your protected health care information that the physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

- **Treatment.** We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with a third party that may need access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.
- **Payment.** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.
- **Healthcare Operations.** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities.

For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Contact and request that these fundraising materials not be sent to you.

### Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

### Other Permitted and Required Uses and Disclosures that may be made without Your Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person

you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

**Emergencies.** We may use or disclose your protected health information in an emergency treatment situation. If this happens, your physician shall try to obtain your acknowledgement of our Privacy Practices as soon as reasonably practicable after the delivery of treatment. If your physician or another physician in the practice is required by law to treat you and the physician has attempted to obtain your acknowledgement, but is unable, he or she may still use or disclose your protected health information for treatment, payment, and health care operations.

**Communication Barriers.** We may use and disclose your protected health information if your physician or another physician in the practice attempts to obtain an acknowledgement of our Privacy Practices from you, but is unable to do so due to substantial communication barriers.

**Other Permitted and Required Uses and Disclosures that may be made without Your Consent, Authorization or Opportunity to Object**

We may use or disclose your protected health information in the following situations without your acknowledgement or authorization. These situations include:

Required by Law - Legal Proceedings - Military Activity and National Security - Public Health - Communicable Diseases - Food and Drug Administration - Law Enforcement - Coroners & Funeral Directors - Organ Donation - Workers' Compensation - Health Oversight - Required Uses and Disclosures - Criminal Activity - Inmates - Abuse or Neglect

## 2. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. Under federal law, however; you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Contact if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by submitting a written request to our Privacy Contact.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Contact.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Contact if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations and valid authorizations or incidental disclosures as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

## 3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Contact of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Contact at 317-776-3310 for further information about the complaint process.

**This notice was published and becomes effective on April 14, 2003**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_