DAYSPRING
PSYCHOLOGICAL SERVICES
Therapy for individuals, couples, and families

13-15 East Deer Park Drive, Suite 103D
Gaithersburg, MD 20877
(240) 686-6885

PATIENT CONTACT INFORMATION AND INSURANCE FORM

First Name:_____Middle Name: _____ Last Name:_____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Voice Message okay? Yes No

Work:_____ Voice Message okay? Yes No

Cell Phone:_____ Voice Message okay? Yes No Text okay? Yes No

Email address: _____

Date of Birth:_____ Age:_____ Gender: _____

How did you hear about us? _____

EMERGENCY CONTACT INFORMATION

In case of emergency, who should I contact?_____

Home #:_____ Work #:_____ Cell #:_____

Is it okay to leave a voice message? Yes No Text message? Yes No

Contact person's relationship to patient:_____

By providing your signature below, you are giving Dr. Gordon permission to contact the person listed above in case of emergencies: _____ _____

(Signature of Client/Parent if Minor) (Date)

INSURANCE INFORMATION
(Please bring your insurance card so a copy can be made!)

Primary Insurance:

Name of Policy Holder (if different from patient): _____

Address of Policy Holder: _____

Work phone number:_____ Home: _____ Cell: _____

Occupation: _____ Date of birth: _____

Employer Name: _____

Employer Address: _____

Insurance Name: _____

Policy Number: _____

Address: _____

Phone Number: _____

Secondary Insurance (If applicable):

Name of Policy Holder (if different from patient): _____

Address of Policy Holder: _____

Work phone number:_____ Home: _____ Cell: _____

Occupation: _____ Date of birth: _____

Employer Name: _____

Employer Address: _____

Insurance Name: _____

Policy Number: _____

Address: _____

Phone Number: _____

PAYMENTS

You are responsible for your co-pays. We will take a payment at each session unless a special arrangement has been made. Credit card/debit card payments are accepted.

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NEW PATIENT INFORMATION FORM

Patient Name:_____ Date of First Session: _____

Primary Complaints (Check all that apply):

___ Alcohol/Substance Abuse
___ Adjustment to a new situation
___ Anxiety
___ Depression
___ Divorce
___ Domestic Violence
___ Eating Disorders
___ Grief and Loss
___ Job Dissatisfaction
___ Medical Issues
___ Obsessive thoughts/Behaviors
___ Panic Attacks
___ Post Traumatic Stress
___ Relationship Issues
___ Schizophrenia
___ Sexual Abuse
___ Sexual Dysfunction
___ Suicide/Homicidal Thoughts
___ Other: _____

Please feel free to share specific details as to what brings you to therapy: _____

_____

_____

_____

<u>Background Information</u>

Relationship Status (circle): Single Married Partnered Separated Divorced Widowed

If married/significant relationship, name of spouse/partner: _____

How long married/together? _____

Names and ages of children: _____

_____

Where were you born? _____ Where were you raised? _____

Names of parents and ages: Mother_____ Father_____

Sibling(s) names and ages: _____

_____

Is there anyone in the family who has been diagnosed with a mental health/psychiatric condition? Yes No

If yes, list name and condition: _____

_____

Occupation:_____How many years? _____

Employer:_____

Highest grade/degree attained _____ From what program/school?_____

If currently unemployed, when was the last day you worked? _____

If retired, when did you retire?_____

From what occupation?_____

If student, name of school:_____ Grade/Year:_____

If disabled, what caused it?_____ When? _____

Do you receive disability benefits? Yes No If yes, when did you start receiving benefits? _____

Have you been in therapy before? Yes No If yes, when?_____

For what issues/concerns/diagnoses?_____

Have you ever been evaluated by a psychiatrist for medication? Yes No If yes, when? _____

Do you have any medical/physical conditions or diagnoses? _____

_____

Please list any medications and dosages you are currently taking (including over-the-counter meds):

_____ _____

_____ _____

_____ _____

Have you ever been hospitalized for mental health issues? Yes No If yes, when? _____

Where?_____ How long?_____

Do you smoke cigarettes? Yes No If yes, how much per day? _____

Do you drink alcohol? Yes No If yes, how much per day or week or month? _____

Have you ever been in treatment for alcohol-related problems? Yes No

If yes, when, where and for how long? _____

Have you ever used illicit drugs? Yes No If yes, which one(s)? _____

And when did you last use? _____

Any legal history or history of arrests? Yes No If yes, please describe briefly the circumstances: _____

_____

Experiences of Trauma: Without going into too much detail, please list dates and significant events in your life which you may consider traumatic or outside the norm of your regular experience (e.g., accidents, natural events, abuse, difficult transitions, loss). _____

_____

_____

_____

What are your hobbies or interests?_____

_____

_____

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Health Insurance Portability Accountability Act (HIPAA)
Client Rights and Therapists Duties

This document contains important information about federal law, the Health Insurance Portability and Accountability Act (HIPAA), that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations.

HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, explains HIPAA and its application to your PHI in greater detail.

The law requires that I obtain your signature acknowledging that I have provided you with this. If you have any questions, it is your right and obligation to ask so I can have a further discussion prior to signing this document. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding unless I have taken action in reliance on it.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a therapist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are some situations where I am permitted or required to disclose information without either your consent or authorization. If such a situation arises, I will limit my disclosure to what is necessary. Reasons I may have to release your information without authorization:

1. If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.
2. If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
3. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
4. If a patient files a worker's compensation claim, and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.
5. I may disclose the minimum necessary health information to my business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. My business associates sign agreements to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

There are some situations in which I am legally obligated to take actions, which I believe are necessary to attempt to protect others from harm, and I may have to reveal some information about a patient's treatment:

1. If I know, or have reason to suspect, that a child under 18 has been abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires

that I file a report with the Child Protective Services or Maryland Department of Human Services. Once such a report is filed, I may be required to provide additional information.

2. If I know or have reasonable cause to suspect, that a vulnerable adult has been abused, neglected, or exploited, the law requires that I file a report with the Adult Protective Services or Maryland Department of Human Services. Once such a report is filed, I may be required to provide additional information.
3. If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or to seek hospitalization of the patient.

CLIENT RIGHTS AND THERAPIST DUTIES

Use and Disclosure of Protected Health Information:

- ***For Treatment –*** I use and disclose your health information internally in the course of your treatment. If I wish to provide information outside of our practice for your treatment by another health care provider, I will have you sign an authorization for release of information. Furthermore, an authorization is required for most uses and disclosures of psychotherapy notes.
- ***For Payment*** – I may use and disclose your health information to obtain payment for services provided to you as delineated in the Therapy Agreement.
- ***For Operations*** – I may use and disclose your health information as part of our internal operations. For example, this could mean a review of records to assure quality. I may also use your information to tell you about services, educational activities, and programs that I feel might be of interest to you.

Patient's Rights:

- ***Right to Treatment*** – You have the right to ethical treatment without discrimination regarding race, ethnicity, gender identity, sexual orientation, religion, disability status, age, or any other protected category.
- ***Right to Confidentiality*** – You have the right to have your health care information protected. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will agree to such unless a law requires us to share that information.
- ***Right to Request Restrictions*** – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- ***Right to Receive Confidential Communications by Alternative Means and at Alternative Locations*** – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations.
- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI. Records must be requested in writing and release of information must be completed. Furthermore, there is a copying fee charge of $1.00 per page. Please make your request well in advanced and allow 2 weeks to receive the copies. If I refuse your request for access to your records, you have a right of review, which I will discuss with you upon request.
- ***Right to Amend*** – If you believe the information in your records is incorrect and/or missing important information, you can ask us to make certain changes, also known as amending, to your health information. You have to make this request in writing. You must tell us the reasons you want to make these changes, and I will decide if it is and if I refuse to do so, I will tell you why within 60 days.
- ***Right to a Copy of This Notice*** – If you received the paperwork electronically, you have a copy in your email. If you completed this paperwork in the office at your first session a copy will be provided to you per your request or at any time.
- ***Right to an Accounting*** – You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- ***Right to Choose Someone to Act for You*** – If someone is your legal guardian, that person can exercise your rights and make choices about your health information; I will make sure the person has this authority and can act for you before I take any action.
- ***Right to Choose*** – You have the right to decide not to receive services with me. If you wish, I will provide you with names of other qualified professionals.
- ***Right to Terminate*** – You have the right to terminate therapeutic services with me at any time without any legal or financial obligations other than those already accrued. I ask that you discuss your decision with me in session before terminating or at least contact me by phone letting me know you are terminating services.

- ***Right to Release Information with Written Consent*** – With your written consent, any part of your record can be released to any person or agency you designate. Together, we will discuss whether or not I think releasing the information in question to that person or agency might be harmful to you.

Therapist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect. If I revise my policies and procedures, I will provide you with a revised notice in office during our session.

COMPLAINTS

If you are concerned that I have violated your privacy rights, or you disagree with a decision I made about access to your records, you may contact me, Maryland Department of Human Services, or the Secretary of the U.S. Department of Health and Human Services.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____

Client/Legal Guardian Signature Date

_____

Printed Name

_____ _____

Client/Legal Guardian Signature Date

_____

Printed Name

_____ _____

Signature of Therapist Date

_____

Printed Name

POLICIES OF THE PRACTICE

Benefits and Emotional Risks:

Psychotherapy or talk therapy is a type of mental health treatment that is known to be beneficial. It can help individuals with a range of mental illnesses and emotional as well as behavioral difficulties. Problems addressed in psychotherapy include depression, anxiety, death of a loved one, impact of trauma, or changes in life situation such as divorce, loss of a job, and medical illness/physical injury. While psychotherapy is generally known to be helpful, there are risks involved. In talk therapy, difficult and uncomfortable feelings may emerge such as sadness, anger, guilt, or frustration. It also often involves discussing aspects of your life that may be unpleasant or you would rather not acknowledge. However, many individuals find that psychotherapy ultimately leads to a significant reduction in feelings of distress, improved relationships, and resolutions of specific problems.

Accepted Insurance:

The following insurances are accepted: **CareFirst BlueCross BlueShield (BCBS), CareFirst BlueChoice, Cigna, and Medicare.** I comply with the policies outlined by the insurance companies in terms of payments and fees. The patient is fully responsible for payment of services rendered should there be a gap in insurance coverage.

Payment for Services:

Payment is expected at the time services are provided unless other billing arrangements have been made. I accept personal checks, debit/credit cards, and/or cash. If you pay in cash, please have the exact amount as I do not typically make change. There is a $30.00 fee assessed for checks returned due to insufficient funds. If your account is more than 60 days past due, I have the option of using legal means to obtain payment, including collection agencies or small claims court. Please know that the State of Maryland allows me to charge you for any fees incurred through use of collection agencies, and fees can vary from 30 to 50% of the debt. Before this action is taken, several attempts will have been made by me or the collection agency to contact you.

Cancellations:

If you must cancel an appointment please give a minimum of 24-hour advanced notice. If you cancel an appointment without giving at least 24-hour notice, you will be charged $50.00 for the missed session. In cases of inclement weather, an attempt will be made to contact patients who have scheduled appointments to decide jointly whether the appointment still stands. The 24-hour notice policy does not apply to cancellations due to inclement weather.

Contacting Me:

Because of the nature of my profession, I am often not immediately available by telephone. When I am unavailable, the following line will be answered by voice mail: **(240) 686-6885 (**main office), with the option number specific to me.

In cases of life-threatening or psychiatric emergency, please call 911 or go to the nearest hospital emergency room.

Authorization/Agreement:

By signing this document, you agree that you have reviewed this information and agree to these conditions.

_____ _____

Signature of Patient or Guardian if Minor Date

_____ _____

Signature of Patient or Guardian if Minor Date

_____ _____

Signature of Therapist Date