

Dynamic Behavioral Consulting

1975 E. Sunrise Blvd., Suite 533, Ft. Lauderdale, Florida, 33304
Phone: 954-232-7092; FAX: 954-208-3400; eMail: admin@dynamicbeh.com
Web: www.DynamicBeh.com

Please pardon the paperwork prior to the first meeting with your practitioner. We request that you complete, read, and sign the attached forms as appropriate and bring them to your first session. Filling them out before your meeting will insure that the time you spend with your practitioner will get to the heart of your needs more directly.

Your practitioner will be happy to discuss any questions you have about the forms at your first session.

The forms needing your attention are as follows:

- ✘ The Psychological Services Agreement & Policies is required by law when you begin your professional relationship with your practitioner.
- ✘ The Client Information & History form provides your practitioner with basic information about you and will assist your practitioner in attending to your needs.
- ✘ If you wish to use insurance to pay for your behavior healthcare services, then please fill out the Health Insurance Information & Consent form. Please fill out as much information as possible, sign it, and fax it to 954-208-3400 so that we may verify your benefits prior to your first session.
- ✘ The Payment Contract for Services may be filled-out at the time of your first session with your practitioner indicating the rate of each session (if you intend to pay out-of-pocket for services) or your portion of out-of-pocket payment in the even that you are using insurance.
- ✘ The Florida Notice Form: Notice of Mental Health Practitioner's Policies & Privacy Practices to Protect the Privacy of Your Health Information ("HIPAA Leaflet") is standard for any health care provider and is required by HIPAA law. It is yours to have as a future reference of your privacy rights. Directly following the *HIPAA Leaflet* is an acknowledgement form for you to sign indicating that you received it ("HIPAA Leaflet Acknowledgement").
- ✘ The Release of Information Authorization Form is only necessary should you wish for your practitioner to communicate with others about your treatment or other aspects of your protected health information. You may receive a copy of this form at your first session.

Thank you and welcome,

Dynamic Behavioral Consulting Staff

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PSYCHOLOGICAL SERVICES AGREEMENT & POLICIES: PAGE 1 OF 2

This form provides you with information that is in addition to that detailed in the *Florida Notice Form: Notice of Mental Health Practitioner's Policies & Privacy Practices (HIPAA Leaflet)*.

CONSENT FOR PRACTITIONER

I am choosing to enter into psychological services with _____ at Dynamic Behavioral Consulting. I am, therefore, consenting to the treatment with the above practitioner. I understand that at any time, I have the authority to exercise my right and terminate behavioral health services with this practitioner. I also, understand that the office is comprised of independent practitioners who are each solely responsible for their own practice and that the practitioners should not be considered liable for the practice of the others at the office.

Patient's Signature: _____

Date: _____

Parent / Guardian's Signature: _____

Date: _____

PAYMENTS

It is usual and customary for the provider and the client to agree upon Fees by the first session. Clients are expected to pay at the beginning of each session unless agreed otherwise. Initial consultations are 50-60 minutes long, subsequent Individual sessions are 45-50 minutes long; double-sessions are 1-½ hours in length. Telephone conversations, report writing, consultation with other professionals, releases, longer sessions, travel time, etc. will be charged at the same rate, unless other arrangements are made. Please notify your practitioner if any problem arises regarding your ability to make timely payments.

Payments From Clients Using Insurance: Not all issues that are the focus of psychotherapy are reimbursed by insurance companies. It is your responsibility to verify the specifics of your coverage. As indicated above in Health Insurance & Confidentiality of Records, you must be aware that submitting a mental health invoice for reimbursement carries some risk.

Clients utilizing insurance (in-network): Co-payments and deductible amounts are due at the time of service unless special arrangements have been made. The billing department of Dynamic Behavioral Consulting will gladly file insurance claims on your behalf; however, payments cannot be guaranteed. You will need to understand that the billing department will make every effort and several attempts to obtain payments and/or clarify your insurance carrier's decision regarding your outstanding balance. In the event that the insurance company misquoted your benefits, changed your benefits, or any other reason that the insurance company denies your claim, you will be responsible for any unpaid balances not covered by your insurance company.

Clients utilizing Insurance (out-of-network): If I am an in-network provider for your insurance carrier, then you are responsible for making payment of the agreed upon fee for services at the beginning of each session. Unless agreed upon differently, I will provide you with a receipt on a monthly basis, which you can then submit to your insurance company for reimbursement.

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PSYCHOLOGICAL SERVICES AGREEMENT & POLICIES: PAGE 2 OF 2

RESPONSIBILITY FOR UNPAID BALANCES

Payments, co-payments, and deductible amounts are due at the time of service unless special arrangements have been made. I understand that the billing department of Dynamic Behavioral Consulting will gladly file insurance claims on my behalf; however, payment cannot be guaranteed. I understand that the billing department will make every effort and several attempts to obtain payments and/or clarify my insurance carrier's decisions regarding my outstanding balance. In the event that the insurance company misquoted my benefits, my benefits changed, or any other reason that the insurance company denies my claim, I will be responsible for any unpaid balances not covered by my insurance company.

Client's Signature:

Date:

Parent / Guardian's Signature:

Date:

CANCELLATION POLICY

I am also acknowledging my understanding that since my appointment time has been set aside exclusively for me, that I am responsible for notifying my practitioner 24 hours in advance to avoid a \$55 cancellation fee. I am aware that my insurance company will not pay for missed appointments.

Client's Signature:

Date:

Parent / Guardian's Signature:

Date:

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CLIENT INFORMATION & HISTORY FORM: PAGE 1 OF 2

Name: _____ Date of Birth _____ Today's Date _____
Address: _____ Gender ____ Race ____ Marital Status _____
_____ Eye Color ____ Hair Color ____ Height ____ Lbs. ____
Home Phone #: _____ Safe to call? Y N Cell Phone #: _____
Employer: _____ Occupation: _____
Work Phone #: _____ OK to call? Y N Social Security #: _____
E-Mail: _____

Emergency Contact:

Name: _____ Relationship to you _____
Address: _____
_____ Phone #: _____ Other Phone #: _____

Please state in your own words your reason for seeking Therapy:

Please check any areas where you are experiencing challenges:

Grief, death, illness	___	Financial stressors	___	Legal issues	___
Work, profession	___	Family stressors	___	Health, sleep, physical challenges	___
School	___	Change in residence	___	Other loss: _____	___
Relationships	___	Loss / promotion of a job	___	Other big change: _____	___
Marriage, separation, divorce	___	Pregnancy, miscarriage birth, abortion	___	Other _____	___

Have you experienced any of the following in the past year?

Fatigue	___	Mood swings	___	Isolation / loneliness	___
Intrusive thoughts	___	Decreased concentration	___	Loss of interest in daily activities	___
Panic / anxiety	___	Memory loss	___	Feelings of guilt, worthlessness	___
Depression	___	Weight gain / loss	___	Other: _____	___
Physical violence	___	Sleep disturbances	___	Other _____	___

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CLIENT INFORMATION & HISTORY FORM: PAGE 2 OF 2

What role (if any) does spirituality or religion play in your life? _____

How will you know when you overcome your challenges? What will be different? _____

How did you find out about my services? _____

Relationships:

Relationship / Marital History (Give names, Ages & Duration): _____

Children (Give names & DOB): _____

Family of Origin (Give names & DOB): _____

Support Systems:

Coping Skills / Self Care: _____

Education / Degrees: _____

Friendships: _____

Work / Hobbies / Interests: _____

Medical & Mental Health History:

Medical History: _____

Current MD: _____ Date of Last Visit: _____

Current Psychiatrist: _____ Date of Last Visit: _____

Current Medications & Dosages: _____

Previous Therapist: _____ Date of Last Visit: _____

Previous Therapy for: _____

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HEALTH INSURANCE INFORMATION AND CONSENT

Client's Name: _____ Date of Birth: _____

Primary Insurance Company: _____

Insurance Company Contact Numbers: _____

Policy Number: _____ Group Number: _____

Name of Insured: _____ Insured's DOB# _____

Insured's SS# _____ Insured's Employer: _____

Client's relationship to Insured: Self () Spouse () Child () Other ()

Do you have secondary insurance? If so, please fill out the following:

Secondary Insurance Company: _____

Insurance Company Contact Numbers: _____

Policy Number: _____ Group Number: _____

Name of Insured: _____ Insured's DOB# _____

Insured's SS# _____ Insured's Employer: _____

Client's relationship to Insured: Self () Spouse () Child () Other ()

I authorize Dynamic Behavioral Consulting to obtain insurance benefits, submit claims, and receive payments of medical / mental health benefits on my behalf. By choosing to use my insurance for psychological services, my practitioner may be required to release certain information to the insurance company at their request. Information which may be requested includes types of services, dates / times of services, diagnosis, treatment plans, descriptions of impairment, progress of therapy, and at times case notes and summaries. If it is the case that my insurance company utilizes a managed care company, my practitioner / evaluator may need to discuss my treatment with a case manager. I understand that my confidentiality may be compromised in such as case. I realize that his / her doing so is a necessity in the efforts to secure ongoing care.

Client's name _____ Date _____

Insured's Signature (if different from patient) _____ Date _____

Parent / Guardian's Signature _____ Date _____

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PAYMENT CONTRACT FOR SERVICES

Name of Client: _____

Street Address of Client _____ City _____ State _____ Zip _____

Name and address of person responsible for payment of services (if different from above): _____

Federal Truth in Lending Disclosure Statement for Professional Services Part One: Fees for Professional Services / Self Pay Arrangements

I (we) agree to pay Dynamic Behavioral Consulting, hereafter referred to as "the office," a rate of \$_____ for an initial session (defined as 60 minutes consisting of a clinical intake) and a rate of \$_____ per each subsequent clinical unit (defined as 50 minutes for assessment, testing, individual psychotherapy, and relationship counseling). I (we) agree to pay a fee of \$55 for missed appointments or cancellations when notice to the office is made less than 24 hours of the scheduled visit or if I arrive more than 15 minutes late for my appointment, which would constitute the need for rescheduling my appointment and result in a missed appointment without 24 hours notice. If payment is not received at the time of service, a late fee of \$10 will be applied to your account. Payments may be made with cash or check. All checks returned for insufficient funds will incur an extra charge of \$15.00.

Part Two: Clients with Insurance (Deductible and Co-payment Agreement)

This office has been informed by either you or your insurance company that your policy contains (but is not limited to) the following provisions for mental health services:

Estimated Insurance Benefits

- 1) \$_____ Deductible Amount (Paid by Insured Party)
- 2) Co-payment _____% (\$_____/clinical unit) for first_____ visits.
- 3) Co-payment _____% (\$_____/clinical unit) up to_____ visits.
- 4) The policy limit is _____per year: _____ annual _____ calendar

While the office will attempt to verify the above amounts with the insurance company, it is suggested that you confirm these provisions with your insurance company. The person responsible for payment shall make payment for services which are not paid by your insurance policy, all co-payments, and deductibles. Your insurance company may not pay for services that they consider to be non-efficacious, not medically or therapeutically necessary, or ineligible (e.g., instances where you receive services not covered by your policy, the policy has expired, or is not in effect for you or other people receiving services). If the insurance company does not pay the estimated amount, you are responsible for the balance. The amounts charged for professional services are explained in Part One above.

Part Three: All Clients

Payments, co-payments, and deductible amounts are due at the time of service.

I HEREBY CERTIFY that I have read and agree to the conditions and have received a copy of the Federal Truth in Lending Disclosure Statement for Professional Services.

Signature(s) of Person(s) Receiving Services _____ Date _____

Signature(s) of Person(s) Receiving Services _____ Date _____

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HIPAA Leaflet: PAGE 1 OF 3

FLORIDA NOTICE FORM Notice of Mental Health Practitioner's Policies & Privacy Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL
INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW
YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The law required that you be provided with this Notice of the legal duties and the privacy practices with respect to your PHI (Protected Health Information). We are committed to maintaining the privacy of your health information and we have implemented numerous procedures to ensure that we do so.

Florida Law and Health Insurance Portability & Accountability Act of 1998 (HIPAA) require practitioner's to maintain the confidentiality of all your health care records and other individually identifiable health information used by or disclosed to us in any form, whether electronically, on paper, or orally. It is a federal law that gives you significant new rights to understand and control how your health information is used. If you have any questions about this Notice, please ask your behavioral healthcare practitioner.

- I. Uses and Disclosures for Treatment, Payment, and Health Care Operations
- II. Uses and Disclosures Requiring Authorization
- III. Uses and Disclosures with Neither Consent nor Authorization
- IV. Patient's Right and Mental Health Practitioner's Duties
- V. Complaints
- VI. Effective Date, Restrictions and Changes to Private Policy

I. USES AND DISCLOSURES FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Your protected health information (PHI) may be used or disclosed for treatment, payment, and health care operation purposes with your consent. In order to provide you with or coordinate health care treatment and services, your behavioral healthcare provider may review your health history to form a diagnosis and treatment plan, consult with other practitioners about your care, delegate tasks to ancillary staff, disclose needed information to your family or others so they may assist you with home care, arrange appointments with other providers, etc.

In order to bill or collect payment from you, an insurance company, a managed care organization, a health benefits plan, or a third party your behavioral healthcare practitioner may need to verify your insurance coverage. Your behavioral healthcare practitioner may also need to submit your PHI on claim forms in order to get reimbursed for services, obtain pre-treatment estimates or prior authorizations from your health plan.

Your behavioral healthcare practitioner may contact you by telephone, electronic mail, or U.S. mail. Please inform your behavioral healthcare practitioner of the telephone number(s) that you want to be reached at and the procedure you want followed when or if another individual answers the call. Your behavioral healthcare practitioner will automatically leave a voicemail message with the number(s) you provide and mail information to the address you list us unless you indicate otherwise.

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HIPAA Leaflet: PAGE 2 OF 3

II. USES AND DISCLOSURES REQUIRING AUTHORIZATION

You may request "authorization" to use or disclose information for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when the practitioner is asked for information for purposes outside of treatment, payment and health care operation, the practitioner will obtain an authorization from you before releasing your psychotherapy notes.

"Psychotherapy notes" are notes that have made about conversations during a private, group, joint, or family counseling session, consultation, or testing administration which have been kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing.

You may not revoke an authorization to the extent that (1) Your behavioral healthcare practitioner has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer to the right to contest the claim under the policy.

III. USES AND DISCLOSURES WITH NEITHER CONSENT OR AUTHORIZATION

Exceptions to maintaining privacy occur under state law and under strictly limited circumstances. Under these circumstances, your PHI may be used or disclosed without your permission, consent, or authorization for the following purposes:

Serious Threat to Your Health or Safety or the Health or Safety of Other Persons: When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, communication and relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities will be disclosed.

Child Abuse: If there is a reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that the practitioner report such knowledge or suspicion to the Florida Department of Child and Family Services.

Adult and Domestic Abuse: If there is a reasonable cause to suspect that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, the law requires the practitioner to report such suspicion to the Central Abuse Hotline.

Health Oversight: If a complaint is filed against your mental health practitioner with the Florida Department of Health on behalf of the Board of Psychology, the Board of Clinical Social Work, Marriage & Family Therapy & Mental Health Counseling, or Florida Board of Medicine and Nursing, the Department has the authority to subpoena confidential mental health information from the practitioner relevant to that complaint.

Judicial or Administrative Proceedings: If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, information will not be released without the written\authorization of you or your legal representative, or a subpoena or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

Worker's Compensation: If you file a worker's compensation claim for a work related injury or illness, your PHI and relevant records must be furnished upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier.

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HIPAA Leaflet: PAGE 3 OF 3

To Family Members, Friends and Others: If you are in an emergency situation involving you or another person (e.g. your minor child) and you cannot consent to your care because you are incapable of doing so or you cannot consent to the other person's care because, after a reasonable attempt, we have been unable to locate you, we may, based on professional judgment and the surrounding circumstances, determine that disclose is in the best interests of you or the other person. In these emergency situations, your PHI will be disclosed, but only as it pertains to the care being provided and you will be notified of the specific disclosures as soon as possible after the care is completed.

IV. PATIENT'S RIGHTS

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, the provider is 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. (For example, you may not want a family member to know that you are being seen. Upon your request, your bills will be sent to another location).

Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI in the mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, your practitioner will discuss with you the details of the request process.

Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. This request may be denied. On your request, you will have a discussion with your practitioner about the details of the amendment process.

Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, you practitioner will discuss with you the details of the accounting process.

Right to a Paper Copy: You have the right to obtain a paper copy of the Notice even if you have agreed to receive the notice electronically.

V. COMPLAINTS

If you are concerned that your privacy rights have been violated, or you disagree with a decision that was made about access to your records, you may contact the Security of Department of Health & Human Services. There will not be any retaliation against you for exercising your right to file a complaint.

VI. EFFECTIVE DATE RESTRICTIONS AND CHANGES TO PRIVATE POLICY

This notice is currently in effect and has been so since May 1, 2006. Your behavioral healthcare practitioner reserves the right to change the terms of this notice at any time as authorized by law and to make the new notice provisions effective for all PHIs that your behavioral healthcare practitioner maintains. The changes will be effective immediately. If changes are made, they will be posted along with its effective date, in the business office. Also, upon request, you will be given a copy of the current Notice.

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HIPAA Leaflet Acknowledgement

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF POLICIES AND PRIVACY PRACTICES YOU MAY REFUSE TO SIGN THIS DOCUMENT

The undersigned acknowledges receipt of a copy of the currently effective Notice of
Mental Health Practitioner's Policies & Privacy Practices.

A copy of this signed, dated Acknowledgement shall be as effective as the original.

Please print your name

Please sign your name

Date signed

If you are the legal representative of the patient, please print the patient's name(s) and describe
your authority.

If you have any questions about this form, or the attached Notice, please contact our privacy
officer, Dr. Royce Jalazo.

Office Use Only

As a privacy officer, I attempted to obtain the patient's (or representative's) signature on
this acknowledgment but did not because:

It was emergency treatment

The client refused to sign

The client was unable to sign because: _____

Other (Please describe):

Signature of Privacy Officer
