DAYNA NELSON, PSY.D – INTAKE

Date_____Referred by_____To be seen__ASAP__1__2__3__4wks

Name of Client/Parent_____Phone/cell_____

DOB_____Employer _____

Minor's name:_____Age____DOB_____

Email:_____

Best way to contact?_____ OK to text appt confirmations? Y N

Children/sibling names and ages (if client is minor):_____

_____

Address_____

City/State/zip_____

School_____Grade_____

Services Requesting
___Therapy___Testing/assessment__Other:_____

___Self pay Ins._____

SubscriberID#_____

Subscriber(if different) _____DOB_____

Secondary Insurance?_____

Previous mental health services?_____

Medications	Dosage	Prescribed by	How long

Religious Affiliation: _____ None:_____

Symptoms/Problems:

_____

_____

_____

_____

_____

How would you rate your readiness for change on a scale of 1 to 5 (5=very ready)?_____

Special needs? _____ Best day/time for apt?_____

Dayna Nelson, Psy.D.
TX Licensed Psychologist # 36957
6675 Mediterranean Drive, Suite 507
Mckinney, TX 75070
(214) 250-4763
Email: info@drdaynanelson.com

OFFICE POLICIES AND CONSENT FOR TREATMENT

FEE FOR SERVICE PAYMENT: Full payment of $125 or_____ per 50-60 minute session is due at the end of each session unless other arrangements are made. Telephone conversations over 5 minutes, site visits, psychological testing, report writing and reading, and longer sessions will be charged at the same rate and prorated to each 15-minute interval, unless agreed otherwise. Please notify me if any problem arises during the course of your therapy regarding your ability to make timely payment.

INSURANCE: I am currently on the Blue Cross Blue Shield, Amerigroup, Aetna, and Tricare insurance panels. These will be billed directly by my billing service. Co-payments and deductible payments are due at the end of each session. **Please note: Every plan has different mental health coverage. Clients are responsible for verifying benefits and will be billed for denied claims at a negotiated rate. Typically, an individual must have a qualifying psychological diagnosis in order for their mental health care to be covered by insurance. The diagnosis would be determined after the initial session.**

Clients who carry other insurance should remember that professional services are rendered and charged to the client and not to the insurance company. I will provide you with an insurance copy of your receipt which you can submit to your insurance company for reimbursement**.**

CANCELLATION: The scheduling of an appointment involves the reservation of time specifically for us. To avoid being charged for a missed session, please inform me of your cancellation at least 24 hours in advance. Missed appointments will be billed to you directly at 50% of the regular rate.

CONFIDENTIALITY: All information disclosed within sessions, including that of minors, is confidential and may not be revealed to anyone without written permission except where disclosure is permitted or required by law. When the client is a couple or family, information disclosed by one individual may not always be kept confidential from the other partner or family members. Disclosure may be required by law in the following circumstances:

1. When there is a reasonable suspicion of child abuse or abuse to a dependent or elder adult.
2. When the client communicates a threat of bodily injury to others.
3. When the client communicates intent to commit suicide or serious harm to self.
4. Physical injury due to violence.
5. When disclosure is required pursuant to a legal proceeding.

I receive regular professional consultation. In such cases, neither your name nor any identifying information about you is revealed.
Patient Health Information (PHI) may be given to my billing service in order to submit insurance claims.

EMERGENCY PROCEDURES: If you need to contact me between sessions, please leave a message on my voice mail service and your call will be returned within 24 hours. If an emergency situation arises, please use the following emergency contact phone numbers:

- **Emergency Services** **911**
- **Suicide Prevention Center** **(877) 727-4747**
- **National Certified Crisis Hotline** **(800) 784-2433**
- **Personal Cell phone** **(214) 250-4750**

CONSENT FOR TREATMENT

I, _____, authorize and request that Dayna Nelson, Psy.D. provide psychological examinations, treatment and/or diagnostic procedures which now or during the course of my care as a client are advisable. The frequency and type of treatment will be decided between my therapist and me.

I understand that the purpose of these procedures will be explained to me and be subject to my verbal agreement.

I understand that there is an expectation that I will benefit from psychotherapy but there is no guarantee that this will occur.

I understand that maximum benefit will occur with consistent attendance and that at times I may feel conflicted about my therapy as the process can sometimes be uncomfortable.

I understand that I am responsible for canceling appointments within 24 hours, unless of an emergency, or I will be billed for the regular session fee.

I have read and fully understand the Office Policies and Consent for Treatment Form.

I have received HIPPA Notice (Please initial)_____

_____	_____	_____
Signature - Client	**Print Name**	**Date**
_____	_____	_____

Signature – Parent/Guardian **Print Name** **Date**

_____ _____

Dr. Dayna Nelson Psy.D **Date**

HIPAA NOTICE OF PRIVACY PRACTICES

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.

HOW I WILL USE AND DISCLOSE YOUR PHI
I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent. I may use and disclose your PHI without your consent for the following reasons:

Treatment: I may disclose your PHI for physicians, psychiatrists, psychologists, and other licensed health care providers who provide you with health care services or are otherwise involved in your care.

Payment: We may use or disclose your mental health information to obtain payment for services we provide to you.

Mental Healthcare business operations: We may use or disclose your mental health information in connection with our mental healthcare business operations. These operations include quality assessment and improvement activities, reviewing the competence or qualifications of mental health care professional, evaluation practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your authorization: In addition to our use of your mental health information in connection with our mental health care business operations, you may give us written authorization to use your mental health information or to disclose it to anyone for any purpose. Unless you give us written authorized station, we cannot use or disclose your mental health information for any reason except those described in the Notice. I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment of your healthcare, un less you object in whole or in part. Retroactive consent may be obtained in emergency situations.

Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

Required by Law: We may use or disclose your mental health information when we are required to do so by law, as indicated below:

To avoid harm: I may provide PHI to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health and safety of a person or the public. If disclosure is compelled or committed by the facts that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.

Abuse or neglect: If there is a reasonable suspicion of elder abuse (65+), child abuse or dependent adult

abuse. If disclosure is compelled or permitted by the fact, that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.

National security: I may disclose PHI of military personnel and veterans under certain circumstances, such as the interests of national security, protecting the President of the United States or assisting with intelligence operations.

Persons involved in care: We may use or disclose mental health information to notify, or assist in the notification of a family member, their personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, prior to use or disclosure of your mental health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose mental health information based on a determination using our professional judgment disclosing only mental health information that is directly relevant to the requesting individual's involvement in your mental healthcare.

Appointment reminders: We may use or disclose your mental health information to provide you with appointment reminders (such as voicemail messages, text, postcards, or letters) this may be required in some Workers Compensation cases.

PATIENTS RIGHTS

Access: In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. You will be charged a reasonable cost-based fee for expenses such as copies and staff time or it if you request copies. We will charge you $1 for each page, $50 per hour for staff time to locate and copy your mental health information, and postage if you want the copies mailed to you. If you wish, we will prepare a summary or explanation of your mental health information for a fee.

Restrictions: You have the right to ask that I limit how I use and disclose your PHI. I will consider your request, however you do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

Disclosure accounting: You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel. Disclosure records will be held for seven years; or, for a minor, until the age of 18, whichever is longer.

HIPAA OFFICER:

If you have any questions about this notice or complaints about my privacy practices, please contact Dr. Dayna Nelson at (214) 250-4763, 6675 Mediterranean Dr., Suite 507, Mckinney, TX 75070.