*The Office of Kevin Harrington, Ph.D., L.P.*

# Adult Registration Form

Date_____

Patient Name (Print) _____Date of Birth_____
Last First MI

Address_____
Street City State Zip

Home Phone_____OK To Call?____Yes _____No

Cell Phone_____ Ok To Call?____Yes _____No

Work Phone_____ Ok To Call?____Yes _____No

E-mail_____

Emergency Contact_____Phone_____

Name of Spouse (If applicable) _____ Who Referred You?_____

**Primary Insurance**

Primary Insurance Company_____ Phone_____

Insurance Claims Address_____ City_____ State_____ Zip _____

Policy/ID #_____ Group/Plan #_____

Policy Holder Information (if the patient is not the employee/policy holder)

Name_____ Relationship_____
Last First MI

Address_____ City_____ State_____ Zip_____

**DOB_____ Employer_____**

## CONSENT FOR THE RELEASE OF PRIVATE INFORMATION TO INSURER

I/We hereby authorize Kevin Harrington ,Ph.D,L.P. to disclose to the Insurance carrier, the following information: a statement of my diagnosis, the services I/We received, the person's providing and supervising these services, the dates of service, and any required narrative. The insurer and provider of services will use this information to process and/or determine reimbursement for services provided.

I/We understand that no other information will be released and no other uses will be made of this information, except for those previously communicated to me or as otherwise authorized by law, and that access to it will be limited to persons whose work assignments reasonably require access to accomplish the purpose stated above. I/We understand that this consent may be revoked at any time, and in any event, it expires automatically as described below.

This consent expires within one year of this date or when the purposes for which it was granted have been accomplished, whichever occurs first. A copy of this authorization shall be as valid as the original. I hereby authorize payment of medical insurance benefits to Kevin Harrington,Ph.D.,L.P. for services rendered to me and/or my dependents.

***SIGNATURE***_____ ***DATE***_____

**Kevin M. Harrington, Ph.D.**

**Licensed Psychologist**
**Riverview Office Tower, Suite 1490**
**8009 34th Avenue South**
**Bloomington, Minnesota 55425**
**Phone: 612-766-9255**

# OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our initial meeting. When you sign this document, it will represent an agreement between us.

## MY BACKGROUND

I hold a Ph.D. in Counseling Psychology from the University of Minnesota and I am a Licensed Psychologist in the State of Minnesota. My areas of competency are adult and child individual psychotherapy, marriage and family therapy, and the assessment of intellectual and personality functioning.

## PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods I may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow. You should evaluate this information along with your own opinions of whether you feel comfortable working with me. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about my procedures, we should discuss

them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

**MEETINGS**

I normally conduct an evaluation that will last 1to 2 sessions. During this time, we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one or more sessions (one appointment hour of 55 minutes duration) every week or two weeks at a time we agree. **If you have to cancel an appointment, please provide me with 48 hours advance notice so I can fill your spot with someone else. If you cancel after 48 hours you will be responsible for the payment of the session.** It is important to note that insurance companies do not provide reimbursement for the cancellation fee.

**PROFESSIONAL FEES**

My hourly fee is $185.00 for on-going therapy and $200.00 for the initial visit. In addition to weekly appointments, I charge this amount for other professional services you may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

**BILLING AND PAYMENTS**

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you are going to use your health insurance, please find out if you have coverage for mental health treatment. If I am a participating provider, you can use your in network benefits. I will bill the insurance company electronically. If I am not a participating provider, you can use your out of network benefits. After you make a payment, I will provide you with a receipt to submit to your insurance company.

I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. If you have questions about the coverage, call your plan administrator. Of course I will provide you with whatever information I can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record. If the insurance company requests additional information, I will contact you directly before sending in the information. In circumstances of unusual financial hardship, I may be willing to negotiate a

payment plan. It is important to remember that you always have the right to pay for my services yourself if you do not want to go through your insurance company.

**CONTACTING ME**

I am often not immediately available by telephone. My telephone is answered by voice mail that I monitor frequently. I will make every effort to return your call within one business day, with the exception of weekends and holidays. When you call, please inform me of times when you will be available. If you are unable to reach me and feel that you can't wait for me to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

You can also use e-mail to schedule and cancel appointments. Due to confidentiality, I can only communicate about appointments through e-mail. I cannot provide any other information or recommendations through e-mail.

**PROFESSIONAL RECORDS**

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. I recommend that you review them in my presence so that we can discuss the contents.

**MINORS**

If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. It is my policy to request an agreement from parents that they agree to give up access to your records. If they agree, I will provide them only with general information about our work together, unless I feel there is a high risk that you will seriously harm yourself or someone else. Parents will be invited into their child's session for updates on treatment progress on a regular basis.

**CONFIDENTIALITY**

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings, a judge may order my testimony if he/she determines that the issues demand it.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a patient's treatment. For example, if I believe that a child, an elderly person, or a disabled person is being abused, I must file a report with the appropriate state agency. If I believe that a patient is threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection. These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you before taking any action.

I may occasionally find it helpful to consult other professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The consultant is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and I am not an attorney.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____ _____

Patient Signature (or parent, if patient is a minor) date

ADULT INTAKE QUESTIONAIRE

Please answer the questions as thoroughly as possible.

DATE_____

NAME_____ DOB_____

AGE_____ MARITAL STATUS_____

Current Primary Care Physician (PCP): _____

PCP Phone: _____ Fax: _____

Current Psychiatrist (if applicable):_____

Phone:_____ Fax:_____ _____

Reason for seeing this doctor:

Other health care provider currently involved with your care:

Name:_____

Phone:_____ Fax: _____ _____

Reason child seen by this provider:

Please summarize in 3-5 sentences your main concerns at this time:

HAVE YOU EVER BEEN MARRIED? Y N IF SO, PLEASE DESCRIBE THE NUMBER AND DURATIONS OF EACH_____

DO YOU HAVE ANY CHILDREN? PLEASE LIST THEIR AGES AND WITH WHOM THEY LIVE.

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PLEASE LIST THE HIGHEST LEVEL OF SCHOOL YOU HAVE COMPLETED._____

CURRENT AND PAST
EMPLOYMENT_____

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HAVE YOU EVER HAD WORKED WITH A MENTAL HEALTH PROVIDER IN THE PAST? Y N

NAMES AND DATES_____

**Please check any areas that may be stressful for you now or within the last 6 months:**

__ Work situation __ Dating relationship __ Marital relationship

__ Financial difficulty __ Family medical illness __ Parenting

__ Relocation/family move __ Death of loved one __ Divorce

__ Parents/siblings Other _____ Other _____

**Describe current and past drug use_____**

**Describe current and past alcohol use_____**

**Have you ever tried to harm yourself ? Y N If so, please describe the incident, stressors which may have contributed to the incident, and when the incident occurred:_____ _____**

**_____**

**Have you ever been sexually abused? Y N**

**Have you ever been physically abused? Y N**

**Have you ever been emotionally abused? Y N**

**Have you ever had basic needs neglected? Y N**

MEDICAL HISTORY

ARE YOU BEING TREATED FOR ANY MEDICAL CONDITION? YES NO IF YES, PLEASE PROVIDE DIAGNOIS,MEDICATIONS AND TREATING HEALYH CARE PROVIDER._____

_____

PRIOR HOSPITALIZATIONS (PLEASE LIS T PLACE, DATE, REASON, OUTCOME):_____

_____

**_____**

**Past Medical History:**

**Please indicate if you have ever had problems with the following medical conditions.**

**___Chronic pain___Allergies___ Tics___Auto immune**

**___Asthma ___Glaucoma ___Heart Problems ___Seizures**

**___Cancer ___Head Aches ___Kidney Problems ___Thyroid Problems**

**___Diabetes ___Head Trauma ___Liver Problems ___Memory problems**

**Please describe the severity and time course for any of these conditions and describe any other medical conditions which were not listed above:_____**
**_____ _____**

**_____**
**_____ _____**

**Current medications and supplements_____**

SLEEP DIFFICULTY FALLING ASLEEP_____ DIFFICULTY STAYING ASLEEP_____

HOURS OF SLEEP_____ WAKEUP RESTED_____

**Exercise ( Frequency and type)_____**

**_____**

**Family History Please *check* if anyone in your family (including extended family) has had a history of:**

| | NO | YES | Mother | Father |
|---|---|---|---|---|
| Learning Disability | | | | |
| Attention Deficit Hyperactivity Disorder (ADHD or ADD) | | | | |
| Mental Retardation | | | | |
| Tic Disorder or Tourette's Disorder | | | | |
| Autism or Developmental Disability | | | | |
| Anxiety (e.g. Panic Attacks, Generalized Anxiety) | | | | |
| Obsessive Compulsive Disorder | | | | |
| Major Depression | | | | |
| Bipolar Depression | | | | |
| Suicide (attempts and/or completions) | | | | |
| Schizophrenia | | | | |
| Psychiatric Hospitalization | | | | |
| Severe behavior problems or criminal activities | | | | |
| Chronic medical illness (please list)<br><br>Examples: asthma, migraines, fibromyalgia, IBD | | | | |
| Thyroid disease | | | | |
| Seizures | | | | |
| Cancer | | | | |
| Heart Disease | | | | |
| Autoimmune Disorders | | | | |
| Alcohol or chemical dependency | | | | |
| Other: | | | | |

**Spiritual Orientation**

**Please list your spiritual orientation or religion:_____**

**How active are these beliefs in your life?**

**Very active** **Somewhat active** **Not very active**

Additional comments or concerns:

_____

_____

_____

_____

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**Kevin M. Harrington, Ph.D.**
**Licensed Psychologist**
**Riverview Office Tower, Suite 1490**
**8009 34th Avenue South**
**Bloomington, Minnesota 55425**
**612-766-9255 - 952-854-5062 FAX**

## NOTICE OF PRIVACY PRACTICES

This **Notice of Privacy Practices** (NPP) describes how I may use and disclose your **protected health information** (PHI) to carry out treatment, payment or healthcare 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 condition and related healthcare services. After you have read this NPP, I ask that you sign the enclosed slip declaring your consent to let this practice use and share your information, in accordance with the following stipulations. If you do not consent and sign this form, I cannot treat you.

An important understanding for anyone seeking psychotherapeutic services is the nature of confidentiality in their therapy. While all matters related to your therapy are held in the strictest professional confidence, there are some important details for you to know.

Clients have a clinic record that is kept locked in the office. A signed authorization, designating specifically what may be released, for what purpose, and to whom, is routinely required before any information from this record is shared with anyone. Each individual has his/her record kept separately. For couples seeking services together, or for families in joint sessions, combined records may be kept. To release combined records, all persons involved must sign an appropriate release form. If both or all parties involved with combined records are not in agreement with the release of information, then only the authorizing person's individual records will be released. While parents are legally allowed to obtain information about their minor children, parents are encouraged to respect the privacy and confidentiality of their children.

## HOW PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED

Information gathered from you during an interview, testing, or therapy session is generally classified as private, meaning that only you or other individuals you designate can see this information under legally specified circumstances. Information can only be released to your insurance company with your written consent.

Private information is only disclosed in the following circumstances:

- You provide written permission for me to release specific information to someone you designate. You can revoke this permission, in writing, at any time.
- Legally, there are a few instances when private information may be or must be released without your permission. Some examples of these instances include:
    - In a medical emergency.
    - Upon receipt of a valid court order or federal grand jury subpoena.
    - Under Minnesota Law, I am required to report allegations of abuse or neglect of minors or of vulnerable adults to the appropriate protective and/or a law enforcement agency (you can learn more about this law/requirement by contacting the Minnesota Health Information Clearinghouse, MN Department of Health at 651-282-6314).

- I am required to report, without your consent, to a law enforcement agency if you make a direct threat on the life of the President of the United States.
- I am required to act to protect you or another person if you make a direct threat to harm another person or yourself. This may involve informing the other person without your consent or contacting legal or medical emergency services without your consent.

Some information I obtain from you is classified as confidential. Confidential information is not open to anyone, even you. Information pertaining to this category consists of facts that deal with adoption, civil or criminal investigations, certain medical data (even for minors), and the names of persons who have reported child or vulnerable adult abuse or neglect.

If you have a third party HMO, PPO or insurance company and give your permission in writing for me to file for payment with the insurance company, your insurance company may request more detailed information about you. They, as well as I, are bound by the legal provision to request only "minimum medically necessary" information.

You have the right to request restrictions on certain uses and disclosures. However, I am not required to agree to your request to release only partial data. For example, you may request that I exclude the results of psychological testing to another provider who is making medical decisions about you. I may or may not agree to this restriction. You may be left with the choice of releasing more complete records or no records, rather than a partial set of records. Also, you have the right to request that I communicate with you confidentially. For example, to speak with you only in private; to send mail to an address you designate; or to telephone you at a number you designate. I ask that your request be made in writing, so that I can make every attempt to honor your request.

## HOW YOU CAN ACCESS YOUR RECORDS

You have a right to see a listing of all the disclosures I have made from your records. You may also request to seek or obtain copies of your records. To do this you must ask me to see your file and must make the request in writing if you want any copies. Normally, an examination of your file can occur as soon as is mutually convenient. The law requires me to respond to your request in no more than 10 working days. Your access to records is free of charge, but you will be charged for any copies.

Note that after viewing your file, you have the right to request an amendment to your records. For example, if there is a factual error, you can request, in writing, that it be amended.

## COMPLAINTS

If, for any reason you are not satisfied with the services you receive from me, please talk it over with me. I will make every effort to correct any situation which led to your concern if it appears to have a legitimate basis and was made in good faith. If my handling of the concern is still not satisfactory to you, or if you believe I have in some way violated your rights, you have the right to file a complaint with me, with the U.S. Department of Health and Human Services, and/or with the Minnesota Board of Psychology.

The effective date of this notice is 04/24/2009.

Kevin Harrington, PhD, LP.

I have received a copy of the document labeled “DATA PRIVACY” from Dr. Harrington.

_____ _____

Signature Date