Intake Date ___________________ Presenting Diagnosis _____________________

Patient Registration Form

Patient

Name: ____________________________ Date of Birth ______________________________

Address: __________________________ Relationship to Insured: Self Spouse Child Other

___________________________ Sex F ___ M _____

___________________________ Marital Status _________________________

Phone (h) __________________________ Student or Work Status: F/T P/T

Phone (w) __________________________ Employer ____________________________________

Phone (cell) ________________________ Referred By ___________________________________

Primary Care Physician Name ____________________________ Phone ____________________________

___ I give Kyoung-Hi Dickson, LMFT permission to contact my PCP to coordinate care.

Insured / Guarantor Information

Insured Name _______________________________ Date of Birth _____________________________

Address ____________________________________ Sex F ____ M_____

____ Employment Status F/T P/T Unempl Ret

Phone (h) ______________________________________ Phone (cell) ______________________________

Employer ______________________________________ Occupation ______________________________

Insurance Company Name ________________________ ID no. ___________________________________

Plan Type ______________________________________ Insurance Phone no. ______________________

** Please provide secondary insurance information for this patient on the back.

Beneficiary / Guarantor Signature (Initial & Sign)

____ I request that payment of authorized insurance benefits be made on my behalf or my child's behalf to Kyoung-Hi Dickson, LMFT for any medical services provided to me by her.

____ I authorize Kyoung-Hi Dickson to release to my insurance company any medical or other information necessary to determine the benefits payable for treatment-related services.

____ I understand that even though Kyoung-Hi Dickson will submit claims to my insurance, I am responsible for the co-payment, co-insurance, deductible or other charges not covered by insurance.

____ By signing this document, I also acknowledge that I have received a copy of the practice's Notice of Privacy Practices. This acknowledgement is required by the Health Insurance Portability and Accountability Act (HIPAA) to ensure that I have been made aware of my (or my child's) privacy rights.

Signature of Insured or Parent/Guardian ____ Date ______

Kyoung-Hi Dickson, LMFT
664 Prospect Avenue, Hartford, CT 06105
Ph (860) 236-8087 x.103/ Fax (860) 586-7422 / www.kdickson.com

ACKNOWLEDGEMENT & INFORMED CONSENT

Please read the following information about practice policies of Kyoung-Hi Dickson, LMFT ("the provider") and sign below to acknowledge your agreement and consent.

Fees: Initial 60-90 minute session: $150. Subsequent 60-minute sessions for couple/family: $130. Subsequent 60-minute sessions for individual: $120. You are responsible for any fees that insurance does not cover.

Other fees for which you are responsible include: fees incurred by returned checks, including bank fees; fees for written communication by the provider to a third party at the pro-rated hourly rate of $120/hour; $60 for last minute (less than 24 hours) cancellation of appointment.

Services: Therapy sessions are provided by appointment only. The provider is not available for consultation by phone or for crisis/emergency services. For emergencies, please call 911. The provider will attempt to return phone calls as promptly as possible within 24 hours for all other matters.

Records: Information regarding disclosure of your records is contained in the Notice of Privacy Practices which has been given to you by the provider.

Termination and Premature Discontinuation of Therapy: Therapy may be discontinued by the provider for any reason, including if 1) you exhibit physical violence, verbal abuse, or engage in illegal acts in the office; 2) you refuse to comply with these policies or the provider's treatment recommendations. In such a case, you will be notified by a letter and given two referrals to alternative providers.

Letters: With your written permission, the provider will provide written communication to a third party which will include dates of service, payments made and/or treatment focus. However, the provider will not provide assessments or evaluations in legal proceedings or disability claims.

By signing below, you consent to the treatment (or give your consent for the treatment of _________________ under your legal guardianship) by Kyoung-Hi Dickson, LMFT. You also acknowledge that you have read, understood and agree to the above policies AND that you have been given a copy of the Notice of Privacy Practices. You agree that a copy of this authorization may be used in place of the original.

Signature of Client: ____ Date: _________________

Printed Name of Client: ____

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 this notice carefully.

Your health record contains personal information about you and your health. This information that may identify you and relates to your health is referred to as Protected Health Information (PHI). This Notice of Privacy Practices ("NPP") describes how I may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rule, and the AAMFT Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of my NPP at any time and will provide you with a copy of the revised NPP at your next appointment.

How I may use and disclose your PHI.

I may use and disclose some part of your PHI to receive payment from your insurance company for the treatment services provided to you. You will be signing an authorization for this use.

Under the law, I must disclose your PHI to you upon your request. In addition, it may be necessary that I disclose your PHI to the Secretary of Department of Health and Human Services for the purpose of investigating or determining my compliance with the requirement of the Privacy Rule.

Without Authorization: The following is a list of the categories of uses and disclosures of your PHI permitted by HIPAA without a written authorization. It is my practice to adhere to more stringent privacy requirements for disclosures without an authorization.

- Child Abuse or Neglect: to a state or local agency that is authorized to receive reports of child abuse or neglect.
- Medical Emergencies: to medical personnel in medical emergency situation in order to prevent serious harm.
- Law Enforcement: to a law enforcement official as required by law, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.
- Public Health/Safety: to a public health authority for the purpose of preventing or controlling disease, injury or disability to a government public health authority in mandatory public health activities or to prevent or lessen a serious and imminent threat to the health and safety of a person or the public.
- Suicidal Plan and Intent to carry out the Plan: to a 911 staff if you express a suicidal plan and an intent to carry it out.

- Homicidal Plan and Intent to carry out the Plan: to a 911 staff or law enforcement official if you express a homicidal plan and intent to it carry out.
- Elder Abuse: to a state or local agency that is authorized to receive reports of elder abuse.

With Authorization: Uses and disclosures of your PHI not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that I have already made a use or disclosure based upon your authorization.

Your Rights Regarding Your PHI

You have the following rights regarding PHI I maintain about you. To exercise any of these rights, please submit your request in writing.

Right of Access to Inspect and Copy. You have the right to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health and billing records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted in situations where there is compelling evidence that access would cause serious harm to you or if the information is maintained in psychotherapy notes. You may also request that a copy of your PHI be provided to a third party.

Right to Amend. You may ask to amend the information that you believe is incorrect although I am not required to agree to the amendment. You have the right to file a statement of disagreement with me and I may provide you with a rebuttal to your statement.

Right to an Accounting Disclosure. You have the right to request an accounting of disclosures of your PHI that I make.

Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI. I am not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or healthcare operations, and the PH pertains to a service that you paid for out of pocket.

Right to Request Confidential Communication. You have the right to request that I communicate with you about health matters in a certain way or at a certain location. I will accommodate reasonable requests.

Breach Notification. If there is a breach of unsecured PHI concerning you, I may be required to notify you of this breach, including what happened and what you can do to protect yourself.

Right to a Copy of this Notice. You have the right to a copy of this notice.

Right to a Complaint regarding Violation of your Privacy Rights. If you believe I have violated your privacy rights, you have the right to file a complaint in writing with me or with the Secretary of Health and Human Services at www.hrsa.gov/about/contact or by calling 1800-221-9393.

Effective Date of this Notice: January 2016.