Lantern of Hope Family Psychology Practice

CHILD PATIENT REGISTRATION FORM

Child's First Name: _____ Middle: _____ Last Name: _____

Street Address: _____ City: _____ State: ___ Zip: _____

DOB: ____/____/____ Age: ____ Sex: Male/Female Social Security #: _____/_____/_____

Mother's First Name: _____ Middle: _____ Last Name: _____

Mother's Home Phone: (____)_____-_____ Is it okay to leave a message: YES/NO

Mother's Cell Phone: (____)_____-_____ Is it okay to leave a message: YES/NO Text: YES/NO

Mother's Work Phone: (____)_____-_____ Is it okay to leave a message: YES/NO

Father's First Name: _____ Middle: _____ Last Name: _____

Father's Home Phone: (____)_____-_____ Is it okay to leave a message: YES/NO

Father's Cell Phone: (____)_____-_____ Is it okay to leave a message: YES/NO Text: YES/NO

Father's Work Phone: (____)_____-_____ Is it okay to leave a message: YES/NO

If you are interested, Lantern of Hope will remind you of scheduled appointments by e-mail and/or text message. *Please choose from the following options:*

___ E-mail reminders to this e-mail address: _____

___ Text reminders to this cell phone number: (____)_____-_____

___ I do not wish to receive e-mail or text reminders. I understand that a printed list of sessions is available upon request.

Child's Pediatrician: _____ Referred by: _____

Name of School: _____ Current Grade: ____

Emergency Contact: _____ Relation: _____ Phone: (____)_____-_____

If parents are divorced, please briefly explain the custody and visitation arrangement:

Financially Responsible Party (must be the parent completing this form):

First Name: _____ Middle: _____ Last Name: _____

Street Address: _____ City: _____ State: ___ Zip: _____

Social Security #: _____/_____/_____ DOB: ____/____/____ Employer: _____

I certify that all of this information is true to the best of my knowledge.

Parent's Signature: _____ Date: _____

Lantern of Hope Family Psychology Practice

SYMPTOM CHECKLIST

Please circle item(s) if the patient has experienced any of the following in the past 6 months:

Anxiety	Extreme fears/phobias	Inferior feelings
Depression	Shyness	Bullying
Panic attacks	Sexual concerns	Drug and/or alcohol abuse
Nightmares	Sleep problems	Overtiredness
Family conflict	Financial issues	Memory problems
Eating problems	Unhappiness	Lack of energy
Academic problems	Conflict with friends	Indecisiveness
Loneliness	Frequent crying	Work problems
Legal problems	Lack of self-control	Compulsive behavior
Lack of motivation	Anger outbursts	Death of a loved one
Health problems	Difficulty concentrating	Divorce/separation
Suicidal feelings	Homicidal feelings	Undue stress
Loss of dating relationship	School suspension/expulsion	Unemployment

If there are other concerns that you feel are important to mention, please list them below:

Name of patient: _____

Name of person completing this form (if other than patient): _____

Date: _____

Lantern of Hope Family Psychology Practice

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. If you have any questions about this Notice of Privacy Practices, please contact Heather Bender, Ph.D., L.C.P. of Lantern of Hope Family Psychology Practice at 804-307-6514.

I. **COMMITMENT TO PROTECTING PHI.** Lantern of Hope Family Psychology Practice (referred to as the "Practice") is committed to protecting medical information about you and your health, including all demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services ("protected health information" or "PHI"). This Policy describes how the Practice may use and disclose your PHI to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. This Policy also describes your rights to access and certain obligations we have regarding the use and disclosure of your PHI. This Policy is in compliance with the requirements set forth under The Health Insurance Portability and Accountability Act ("HIPAA") and those requirements as set forth by the Secretary of the Department of Health and Human Services (the "Secretary"), as may be modified or adopted from time to time.

II. **USES AND DISCLOSURES.**

A. **Treatment, Payment and Health Care Operations.** The Practice may use and disclose PHI for the following purposes:

1. Treatment: To provide, coordinate, or manage your health care and related services, such as disclosing PHI to other healthcare professionals involved in your care. For example, phoning in prescriptions to your pharmacy or scheduling lab work.

2. Payment: To bill and collect payment from you, an insurance company or a third party. For example, to obtain prior approval of a particular treatment, or to substantiate services rendered for payment purposes.

3. Health Care Operations: To ensure that you receive quality care. For example, to evaluate the performance of our staff in caring for you, to help us decide what additional services we should offer, or whether certain new treatments are effective.

4. Appointment Reminders: We may contact you as a reminder that you have an appointment for treatment or medical care at this office.

5. Treatment Alternatives and Health-Related Products and Services: The Practice may recommend possible treatment alternatives or other health-related benefits and services that may be of interest to you. For example, to send you a brochure about products or services that may be beneficial to you.

B. **Special Situations.** Subject to all applicable legal requirements and limitations, the Practice may use or disclose PHI without your permission for the following purposes:

1. Required By Law: The Practice will disclose PHI about you when required to do so by federal, state or local law.

2. Public Health: The Practice may disclose PHI about you for public health activities, including disclosures:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to persons subject to the jurisdiction of the Food and Drug Administration (FDA) for activities related to the quality, safety, or effectiveness of FDA-regulated products of services and to report reactions to medications or problems with products;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that an adult patient has been the victim of abuse, neglect or domestic violence. (The Practice will only make this disclosure if the patient agrees or when required or authorized by law.)

3. Victims of Abuse, Neglect or Domestic Violence: The Practice may disclose PHI about you to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic if we reasonably believe you to be a victim of abuse, neglect, or domestic violence to the extent the disclosure is required by law and the disclosure complies with and is limited to the relevant requirements of such law, you agree to the disclosure; or to the extent the disclosure is expressly authorized by statute or regulation.

4. Health Oversight: The Practice may disclose PHI to a health oversight agency for audits, investigations, inspections or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs and compliance with civil rights laws or other legal or regulatory requirements.

5. Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, the Practice may disclose PHI in response to a court or administrative order. Subject to all applicable legal requirements, the Practice may also disclose PHI in response to a subpoena or other legal process.

6. Law Enforcement: The Practice may release PHI if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime under certain limited circumstances;
- about a death we believe may be the result of criminal conduct;

- in emergency circumstances, to report a crime, the location thereof the victim or the identity, description or location of the perpetrator.

7. Coroners, Medical Examiners and Funeral Directors: The Practice may release PHI to coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Practice may release information to a Funeral Director, consistent with applicable law, as necessary to carry out their duties with respect the decedent. '

8. Organ and Tissue Donation: If you are an organ donor, the Practice may release PHI organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.

9. Research: The Practice may use and disclose PHI for research projects that are subject to a special approval process and the requirements of applicable law.

10. To Avert a Serious Threat to Health or Safety: Subject to applicable law, the Practice may use and disclose PHI when necessary to prevent or lessen a serious and imminent threat to your health and safety or the health and safety of the public or another person. The Practice may also use and disclose PHI if necessary for law enforcement authorities to identify or apprehend an individual. .

11. Specialized Governmental Functions: In certain circumstances the Practice may be required to disclose PHI to authorized governmental agencies for national security activity or for protective services for the President or other authorized persons. If you are a member of the Armed Forces, we may release PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

12. Workers' Compensation: The Practice may release PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

13 Disaster Recovery Efforts: When permitted by law, the Practice may coordinate our uses and disclosures of protected PHI with public entities authorized by law or by charter to assist in disaster relief efforts.

14. Incidental Disclosures: Subject to applicable law, the Practice may make incidental use and disclosures, by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented, of PHI.

15. Family and Friends: The Practice may disclose to your family members or friends PHI which is directly relevant to their involvement in your care or payment for your care, if the Practice obtains your verbal agreement to do so or if the Practice gives you an opportunity to object to such a disclosure and you do not raise an objection. The Practice may also disclose PHI to your family or friends if the Practice infers from the circumstances, based on professional judgment that you would not object. For example, the Practice may assume you agree to the disclosure of your PHI to your spouse when you bring your spouse with you into the office during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), the Practice may, using professional judgment, determine that a disclosure to a family member or friend is in your best interest In that situation, the Practice will disclose only PHI relevant to the person's involvement in your care. The Practice may also use professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up your PHI or records, for example, X-rays. Additionally, the Practice may use or disclose your protected PHI to notify or assist a family member or friend responsible for your care of your location, general condition or death.

III. **OTHER USES AND DISCLOSURES OF PHI.** The Practice will not use or disclose your PHI for any purpose other than those identified in the previous sections without your specific, written authorization. Any authorization to use or disclose PHI may be revoked at any time so long as the revocation is in writing. If you revoke your authorization, the Practice will no longer use or disclose PHI for the reasons covered by your written *Authorization,* except to the extent that the Practice has already used or disclosed PHI in reliance on your authorization.

IV. **SPECIAL AUTHORIZATION.** The Practice may not use or disclose PHI under the following circumstances without a valid authorization, and any such use or disclosure by the Practice must be consistent with such authorization.

1. HIV/Substance or Alcohol Abuse/Mental Health: The Practice may not release HIV, substance or alcohol abuse or mental health information about you without a specific written authorization in the form to be provided to you by the Practice. Upon diagnoses of HIV, substance or alcohol abuse or related to mental health, you will be required for purposes' of treatment, payment and health care operations to execute an authorization that complies with the law governing such records, when required by applicable law.

2. Psychotherapy Notes: The Practice must obtain a valid authorization for any use or disclosure of, psychotherapy notes, except to carry out the following treatment, payment or health care operations: (A) use by the originator of the psychotherapy notes for treatment; (B) use or disclosure by the Practice for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family or individual counseling; (C) use or disclosure by the Practice to defend itself in,a legal action or other proceeding brought by the individual; (D) when required by the Secretary to investigate or determine the Practice's compliance with HIPAA; (E) as required by law and the use or disclosure complies with and is limited to the relevant requirements of such law; (F) to a health oversight agency for oversight activities authorized by law, with respect to the oversight of the originator of the psychotherapy notes; (G) to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law; and (H) use or disclose PHI if the Practice: in good faith, believes the use or disclosure: (i) is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and (ii) is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

3. Marketing: The Practice must obtain an authorization for any use or disclosure of PHI for marketing, except if the

communication is in the form of: (A) a face-to-face communication made' by the Practice to an individual: or (B) a promotional gift of nominal value provided by the Practice. If the marketing involves financial remuneration to the Practice from a third party, the authorization shall state that remuneration is involved.

4. Sale:of PHI: Other than the transition provisions in 45 CFR 164.532. the Practice must obtain an authorization for any disclosure of PHI which is a sale of PHI. and such authorization must state that the disclosure will result in remuneration to the Practice, if any.

Revocation of .Authorizations: You may revoke an authorization provided under this section at any time. provided that the revocation is in writing and addressed to the Privacy Officer designated below. except that no such authorization may be revoked to the extent that: (A) the Practice has taken action in reliance thereon: or (B) if the authorization was obtained as a condition of obtaining insurance coverage. other law provides the insurer with the right to contest a claim under the policy or the policy itself.

V. **FUNDRAISING ACTIVITIES.** The Practice may utilize your PHI to contact you in an effort to raise money for a disease specific-nonprofit foundation affiliated with the Practice and its operations. If you do not want the Practice to contact you for fund raising efforts, you must notify the Practice in writing.

VI. **YOUR RIGHTS REGARDING PHI.** You have the following rights regarding your PHI:

1. Right to Inspect and Copy: You have the right to inspect and copy your PH I for as long as we maintain that information. You must submit a written request in order to inspect and/or copy your PHI. If you request a copy of the information. we may charge a fee for the costs of copying as approved by state law. We may deny your request to inspect and/or copy your PHI under certain limited circumstances. In some circumstances. you may have the right to have this decision reviewed. Please contact the Practice if you have questions about access to your medical record.

2. Right to Amend: You have the right to request amendment of incorrect or incomplete PHI so long as the information is kept by this office. To request an amendment. complete and submit a Medical Record Amendment/Correction Form to this office. The Practice may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition. the Practice may deny your request if:

- the Practice did not create the PHI (unless the person or entity that created the PHI is no longer available to make this amendment):
- the Practice is no longer in possession of the PHI:
- you would not be permitted to inspect and copy the record at issue: or
- is accurate and complete.

3. Right to an Accounting of Disclosures: You have the right to request an "accounting disclosures." This is a list of certain limited disclosures the Practice made with respect your PHI. To obtain this list. you must submit your request in writing to this office. It must state a time period. which may not be longer than six years and may not include date before April 17. 2011. The Practice may charge you for the cost of providing the response to your request, but you may request one free accounting per year. The Practice will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

4. Right to Request Restrictions: You have the right to request a restriction or limitation (the PHI the Practice uses or discloses for treatment. payment and health care operation. You also have the right to request a limit on the PHI the Practice discloses about you or someone who is involved in your care. such as a family member or friend. To request restrictions. you must complete and submit the *Request For Restriction On Use/ Disclosure* Of *Medical Information and/or Confidential Communication Form* to this office. The Practice is NOT required to agree to your request.

5. Right to Request Confidential Communications: You have the right to request (with reason) that the Practice communicate with you in a certain manner. For example. you must request that the Practice only contact you at work or on your cell phone. The Practice will make every effort to honor reasonable requests made in writing and submitted to the Practice.

6. Right to a Paper Copy of This Notice: You have the right to request a paper copy of this Policy at any time. even if you have agreed to receive the Policy electronically. To obtain such a copy, please contact the Practice.

VII. **NOTIFICATION OF BREACH.** Should it be determined by the Practice that there is a breach of your PHI (the acquisition. access. use. or disclosure of PHI in a manner not permitted under 45 CFR 164 subpart E which compromises the security or privacy of your PHI). you will be notified in writing by the Practice no later than sixty calendar days after the discovery of the breach. If the breach involves the PHI of more than 500 individuals in any state. the Practice shall following discovery of the breach give notice of the breach to prominent media outlets in that state and will also notify the Secretary.

VIII. **MODIFICATION.** The Practice reserves the right to change 'this Policy at any time effective for previously obtained PHI as well as future PHI. The Practice will post a copy the current Policy in this office with the effective date. In addition. each time you register or are seen at the Practice for treatment or health care services. the Practice will offer you a copy of the current Policy in effect.

IX. **COMPLAINTS.** If you believe that your privacy rights have been violated. you may file written complaint with the Practice by mailing your complaint to Lantern of Hope Family Psychology Practice. 2567 Homeview Drive. Richmond. Virginia 23294. Attn: Heather Bender. Ph.D.. L.C.P.. Privacy Officer. or with the Secretary of the Department of Health and Human Services. This Practice maintains a non-retaliation Policy for complaints.

X. **PRACTICE REQUIREMENT.** The Practice is required by law to: (1) ensure all PHI maintained in a confidential manner; (2) abide by the terms of this Policy: and (3) notify patients of the Practice's legal duties and policies with respect to PHI.

Lantern of Hope Family Psychology Practice

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I understand that I can address any questions that I have regarding this notice to my psychologist, Dr. Heather Bender. My signature below indicates that I have received a copy, read, and understood the NOTICE OF PRIVACY PRACTICES and agree to the terms therein.

_____ _____

Patient Name Name of Parent or Guardian if patient is a minor

_____ _____

Signature of Patient Date

_____

Signature of Parent or Guardian if patient is a minor

Current Mailing Address: _____

_____

_____

Email address: _____

DISCLOSURE TO FAMILY MEMBERS AND FRIENDS

Patient does not have to sign

Disclosures related to the patient's health may be made to family and friends to keep them informed or as needed for payment of health care services. We will only disclose information relevant to the current treatment. I authorize Lantern of Hope Family Psychology Practice to disclose health care information to (check all that apply):

	In person with patient	By phone
Spouse Name: _____	_____	_____
Parent(s) Name: _____	_____	_____
Sibling(s) Name: _____	_____	_____
Other (Please list name and relationship):		
_____	_____	_____
_____	_____	_____
_____	_____	_____

Lantern of Hope Family Psychology Practice

SERVICE AGREEMENT

This document contains important information about the professional services and business policies of Lantern of Hope. It is important that you read it carefully and write down any questions you might have so that they can be discussed with Dr. Heather Bender. When you sign this document, it will represent an agreement between you and Lantern of Hope.

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. Psychotherapy can have a number of risks and benefits. 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 numerous benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience. You have the right to withdraw your consent to therapy at any time, for any reason. You understand that no specific promises have been made by Dr. Heather Bender about the results of treatment, the benefits of her interventions, or the number of sessions necessary for therapy to be effective.

PROFESSIONAL FEES:

Initial Evaluation	60 minutes	$175
Follow-Up Sessions	60 minutes	$150
Extended Family Session or Couples/Marital Session	90 minutes	$225
Group Therapy		TBD
Telephone Calls	Per quarter hour	$37.50
Preparation of Non-Forensic Reports and Letters	Per quarter hour	$37.50
Off-Site Services (e.g., school observations, consultations with teachers and guidance counselors); portal-to-portal	Per hour	$150
All Forensic Services (including but not limited to court testimony, deposition, conferences, preparation of reports, travel, and records review). Unless otherwise arranged, estimated costs are due in advance of a court or deposition appearance.	Per hour	$350
Missed Appointment Fee		$150

MISSED APPOINTMENT/LATE CANCELLATION POLICY: A minimum of 24 hours' notice is required for cancellation of appointments. If you miss your appointment without cancelling or cancel less than 24 hours in advance, you will be charged $125 (or the full amount for that particular session). This policy will not apply in the case of emergencies, such as sudden illness, accident, or severe weather-related travel problems.

To cancel an appointment, you may leave a message on Lantern of Hope's confidential voicemail at (804) 307-6514. Please do not e-mail cancellations.

BILLING AND PAYMENTS: You are expected to pay for each therapy session at the time it is held. Fees for phone calls and preparation of reports are also due at the time these services are rendered. You may make payments by credit card only.

PAST DUE ACCOUNTS: If an account is past due by 60 days, unless arrangements have been made, the account may be sent to collections and/or small claims court, and you may be responsible for any additional collection agency fees, attorney fees, court costs, and other expenses incurred in the collection of the account. There will be a $10.00 late fee for each month the balance remains outstanding over 60 days.

INSURANCE REIMBURSEMENT: Upon request, Lantern of Hope will provide an invoice of services rendered, so that you may submit this information to your insurance company for possible out-of-network reimbursement. Please be aware that your insurance company may not reimburse you for any of these services or may only cover a portion of the cost. You are responsible for communicating with your insurance company about their out-of-network policies and submitting these claims.

CONTACTING LANTERN OF HOPE: Dr. Heather Bender is not always available by telephone. You may leave a message on her voicemail (804-307-6514), and you will be contacted as soon as possible after your message is received. Phone calls after 5:00 may not be returned until the following business day. If you feel unable to keep yourself safe or believe you may harm someone else, please go to your nearest emergency room or call 911.

E-MAIL: Therapy, appointment scheduling, and other clinical services are not offered through e-mail. It is important to understand that all e-mail messages sent over the Internet may not be encrypted, secure, and may be read by others. If you e-mail Dr. Heather Bender, you need to understand that you maybe compromising your confidentiality (this is particularly important to consider when using a computer through work or that is shared by individuals other than yourself such as a home computer.) Furthermore, any response in return may NOT be encrypted. The confidentiality and security of any information that is sent to me via e-mail cannot be guaranteed. E-mail communication should never be used for urgent or sensitive matters since technical or other factors may prevent a timely answer. If you have an urgent matter, please call the office directly. In addition, you should be aware that any e-mail communications may be made part of your medical record.

PROFESSIONAL RECORDS: The laws and standards of psychological practice require that treatment records be kept. For adults, these records are maintained for 7 years past the last date of treatment/evaluation; for minors, the records are kept for 7 years or until the child reaches the age of 21, whichever comes later. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, it is recommended that you review them in the presence of your psychologist. Under conditions where it is believed that viewing your records would be harmful to you, your psychologist may not agree to allow you access them. Patients will be charged an appropriate fee for any professional time spent in responding to information requests. A completed and signed Consent for Release of Confidential Information Form is required before releasing any documents to anyone, including the patient.

CONFIDENTIALITY: Lantern of Hope protects personal health information and confidential material according to the guidelines established by the Health Insurance Portability and Accountability Act (HIPAA). HIPAA, along with the ethical standards of the American Psychological Association, determine the handling of this information. The notice stating the specific privacy policy and practices, instructions for requesting accounting of any disclosures of this information, and restrictions on disclosures will be provided to you in printed form at your request.

In general, the privacy of all communications between a patient and a psychologist is protected by law, and this information can only be released to others with your written permission. There are a few exceptions, however.

In most legal proceedings, you have the right to prevent a psychologist from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it. If you are involved in a court proceeding and a request is made for information concerning the professional services that were provided to you, such information is protected by the psychologist-patient privilege law. Your psychologist cannot provide any information without your written authorization or a court order. If you are involved in or are contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order the disclosure of information.

There are some situations in which your psychologist is legally obligated to take action to protect others from harm, even if some information about a patient's treatment must be revealed. For example,

- If it is believed that a child, elderly person, or disabled person is being abused, your psychologist must file a report with the appropriate state agency.
- If it is believed that a patient is threatening serious bodily harm to another, your psychologist is required to take protective action. 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, your psychologist may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

Your psychologist may occasionally find it helpful to consult other professionals about a case. During a peer consultation, every effort is made to avoid revealing the identity of the patient. The consultant is also legally bound to keep the information confidential. If you do not object, your psychologist will not tell you about these consultations unless he/she feels that it is important to your work together.

I acknowledge that I have received a copy of Lantern of Hope Family Psychology Practice's **SERVICE AGREEMENT** and agree to abide by its terms.

_____ _____
Patient's Signature Date

_____
Printed Name

_____ _____
Parent/Guardian's Signature Date

_____ _____
Printed Name Relationship to Patient

_____
Dr. Heather Bender
Owner of Lantern of Hope/Licensed Clinical Psychologist

By providing my credit card account information to Lantern of Hope Family Psychology Practice, I, _____, hereby authorize payment for services as they are rendered. I agree to pay according to the card issuer's agreement.

CREDIT CARD INFORMATION

Type of Card
Visa/Mastercard/Discover/American Express (please circle)

_____
Name as it Appears on Credit Card

_____
Account Number

_____/_____/_____
Expiration Date

_____
3 or 4-digit security code

_____
Authorization Signature

Lantern of Hope Family Psychology Practice

HEALTH CARE COORDINATION FORM

In order to coordinate care, I wish to inform you that your patient, _____, (Date of Birth ____/____/____), was seen by me for an initial evaluation on ____/____/____.

This patient sought services for the following reasons:

_____

_____

The following services have been recommended:
___ Individual therapy
___ Family therapy
___ Parenting support and consultation
___ Couples therapy
___ Referral for psychiatric treatment
___ Referral for group therapy
___ Other: _____

If you have any questions or concerns, please feel free to contact me at (804) 307-6514.

Respectfully,

_____
Dr. Heather Bender
Owner, Lantern of Hope/Licensed Clinical Psychologist

Consent for Release of Confidential Information

I hereby authorize the disclosure of pertinent mental health/substance abuse information to my primary care physician or other mental health provider for the purpose of coordinating care. I understand that I may revoke this authorization at any time by notifying Lantern of Hope Family Psychology Practice in writing. Should consent be revoked, I understand that doing so will not have any effect on information disclosed prior to the revocation. Unless otherwise specified, this consent will remain in effect for one year from the date noted below.

___ I give permission to release information about my treatment to my primary care physician.

PCP Name: _____ Phone #: _____ Fax #: _____

___ I give permission to release information about my treatment to my psychiatrist, psychiatric nurse practitioner, or other mental health provider.

Mental Health Provider Name: _____ Phone #: _____ Fax #: _____

___ I decline release of information to other professionals at this time.

Patient (or Legal Guardian) Signature: _____ Date: _____