INTERACTIONAL SERVICES

707 Southfield Road / Shreveport, Louisiana 71106
318-869-1632 (phone) / 318-869-1633 (fax)

Adult Patient Information

Please complete ALL information

Clinician: Dr. Sarah Drummond, PsyD Date: _____
Patient Name: _____ Date of Birth: _____ Age: _____
Address: _____ City, State, Zip: _____
Phone: _____ Email: _____
Ok to leave you a voicemail? ___ Yes ___ No Ok to contact you via email? ___Yes ___No
Would you like a reminder email for your appointments? ___Yes ___No
How were you referred to our office? _____
Services Requested? _____
Emergency Contact (name, relationship, & #): _____

If you are using insurance, who is your insurance company: _____
Policy Holder: _____Policy Holder's SSN: _____
***Note**: If you are filing a secondary insurance please present both insurance cards.*

Consent for Treatment

By signing below, you acknowledge that you have reviewed the ***psychologist-patient agreement*** in ***Appendix A*** and you give your consent to receive psychological services from Interactional Services. You understand that you have the right not to sign this form. Your signature below indicates you have read and discussed this agreement and that you agree to abide by its terms. It does not indicate that you are waiving any of your rights. You understand that you can choose to discuss any concerns with your clinician before you receive services. You understand that you have the right to discontinue services and withdraw your consent at any time, for any reason. However, you agree to make every effort to discuss your concerns with your clinician prior to discontinuing services. Please sign below to indicate that you understand and agree to participate in accord with the policies outlined above.

Signature: _____ Date: _____

Printed Name: _____

Information Regarding Payment for Services

By signing below, you acknowledge that you have reviewed the ***information regarding payment for services*** in ***Appendix B*** and you understand that you are responsible for payment of services at the time rendered. By signing below, you also acknowledge that you understand you are financially responsible for payment for services rendered if you are denied coverage by your insurance company.

Signature: _____ Date: _____

Social Security Number (SSN): _____

INSURANCE AUTHORIZATION- SIGNATURE ON FILE

(*Your signature is required in this section if you are filing insurance*)

I permit this authorization to be used in place of the original signature on all of my insurance claim forms.

I authorize release of information to all of my insurance carriers.

I authorize Interactional Services to act as my agent in helping me obtain payment from my insurance carrier(s).

I authorize direct payment to Interactional Services.

I understand that I am responsible for all charges incurred in the event services are not paid or covered by my insurance carrier(s).

Note: Patients that are incapable of signing, or are under the age of 18, must obtain the signature of a parent or legal guarding in the patient's place.

_____ _____

Signature Date

Acknowledgement of Receipt of Privacy Practices

By signing below, you acknowledge that you have reviewed the ***Notice of Privacy Practices*** for Interactional Services in ***Appendix C***.

_____

Name of Patient/Patient Representative

_____

Signature

_____

Date

_____

Relationship of Patient Representative to Patient

(Required if the patient is a minor or adult who is unable to sign the form.)

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Please return the first two pages of this packet and feel free to keep the attached appendices for your personal records.

Appendix A
Psychologist-Patient Agreement
Sarah W. Drummond, PsyD
Louisiana Licensed Psychologist #1365

Services Provided
Dr. Drummond offers individual and couples' psychotherapy for adults and psychological evaluations for adults, adolescents, and children. Psychotherapy sessions are 50 minutes in length and occur at least once per week, unless otherwise agreed. Sessions may sometimes be longer or more frequent, as agreed between you and Dr. Drummond. Psychological evaluations typically involve a diagnostic interview, psychological testing, and a feedback appointment.

Psychotherapy
Psychotherapy can have both risks and benefits. The therapy process may include discussions of your personal challenges and difficulties which can elicit uncomfortable feelings such as sadness, guilt, anger and frustration. However, research indicates that psychotherapy also has many benefits. It can often lead to better interpersonal relationships, improved academic or occupational performance, solutions to specific problems, and reduction in your feelings of distress. There is, however, no assurance of these benefits. Psychotherapy involves a very active effort on your part and for therapy to be most successful, you will need to work on things we discuss both during our sessions and at home.

Confidentiality
In keeping with professional ethical standards and state and federal law, all services provided by Dr. Drummond are kept confidential except as noted below and in the accompanying *Notice of Privacy Practices*. As required by psychological practice guidelines and current standards of care, Dr. Drummond keeps records of all appointments. These records are stored securely consistent with federal and professional security standards for medical records.

Dr. Drummond has a legal responsibility to disclose patient information without prior consent when: (1) a patient is likely to harm themselves or others unless protective measures are taken, (2) when there is reasonable suspicion of abuse of children, dependent adults, or the elderly, (3) when the patient lacks the capacity to care for him or herself, (4) when a mental health professional has been sexually inappropriate with a patient, and (5) when there is a valid court order for the disclosure of patient files. By signing this form, you also give Dr. Drummond permission to communicate with the Emergency Contact that you have designated if she believes that you are at risk. Finally, Dr. Drummond aspires to provide high-quality treatment by consulting with colleagues and experts on a regular basis. During these times, she may sometimes talk about part of your case with another psychologist or other professional. The individuals she consults with are bound by the same confidentiality standards and are also required to keep your information private.

Legal and Forensic Disclaimer
Please be advised that Dr. Drummond provides clinical, not forensic, services. By signing this form, you agree that neither you, your attorneys, nor anyone acting on your behalf will subpoena records from Dr. Drummond or subpoena her to testify in court or in any legal proceeding. If you require legal or forensic services, Dr. Drummond will be happy to provide you with a referral. If you are suing someone or being sued, if you are charged with a crime, or if you are involved in custody proceedings, and you tell the court that you are a patient of Dr. Drummond's, Dr. Drummond may then be ordered to show the court your records. Please consult your lawyer about these issues. If Dr. Drummond is subpoenaed to provide records or testimony in violation of this agreement, you will be expected to pay for all of her professional time, including preparation and transportation costs, even if she is called to testify by another party. Because of the complexity of legal involvement, Dr. Drummond charges $400 per hour for preparation and attendance at any legal proceeding.

Insurance Reimbursement

Please be advised that should you choose to request reimbursement for psychological services, your contract with your health insurance company requires that Dr. Drummond provide them with information relevant to the services that she provides to you. She is required to provide a clinical diagnosis and sometimes she is required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, Dr. Drummond will make every effort to release only the minimum information that is necessary for the purpose requested. She has no control over what the insurance company will do with it once it is in their possession.

Office Policies

Interactional Services is not an emergency or crisis intervention facility. Clinicians are not available 24 hours per day; however, you can always leave a message at 318-869-1632 and Dr. Drummond will contact you as soon as possible. In the event of an emergency or crisis between scheduled appointments, go to the nearest emergency room or seek help by calling the National Suicide Prevention 24-Hour Lifeline at 1-800-273-TALK, or call 911 if it is a life-threatening situation.

Your initial sessions include an evaluation of current concerns and needs and are therefore devoted to gathering information about you, your current difficulties, and biographical information that will assist Dr. Drummond in developing an assessment battery or treatment plan and interventions that are specific to you. If at any point it is determined that other services are more suitable or would be beneficial in addition to the services provided by Dr. Drummond, she will help you obtain assistance from appropriate providers. Noncompliance with treatment could result in the termination of services.

Please arrive on time for your appointments. If you are unable to keep your appointment, please call to cancel at least 72 hours in advance. If you miss or cancel an appointment without giving 72 hours' notice for an assessment appointment or 24 hours' notice for therapy sessions, you will be required to pay a fee for the missed appointment according to the time that was scheduled. Repeated cancellations or missed appointments may result in the termination of services.

Use of Electronic Mail

Please be aware that e-mail may not be private or confidential and may not be read by the recipient in a timely fashion.

Contacting Dr. Drummond

Due to Dr. Drummond's work schedule, she is often not immediately available by telephone. When she is not available, you may leave a voicemail message, which will be checked by the office manager and delivered to her during business hours. She will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform Dr. Drummond of times you might be available. Please be aware that e-mail may not be private or confidential and may not be read by the recipient in a timely fashion. In the case of an emergency, please call 911, your family physician, or the nearest emergency room and ask for the psychologist or psychiatrist on call.

Appendix B
Information Regarding Payment for Services

The patient's portion of payment for the requested services is due on the date services are rendered. If we are in-network with your insurance company, we will check your benefits and relay to you the information they provide regarding co-pays, co-insurance, and deductibles. You may want to verify this information for yourself, as insurance companies sometimes handle claims differently than what they quoted initially. We will file your claim according to their requirements.

Please be aware that insurance companies will only cover medically necessary services; they do not consider academic testing medically necessary and will not pay for this type of testing. This includes testing for learning disabilities, including dyslexia or reading learning disability, dyscalculia or math learning disability, dysgraphia or written language/handwriting disability. We are happy to provide this service for you; however, there is a fee for this in addition to your insurance company's co-pay and/or co-insurance; this fee will be discussed with you in advance.

If we are out-of-network for your insurance company, we will let you know the fee for the requested service, which is due at the time of service. It will be up to you to provide any documentation your insurance company may request to consider payment of the claim. We will be happy to provide you with any documentation necessary for you to file a claim if we are out-of-network with your insurance.

Whether the services we provide are covered by your insurance company depends on the provisions of your plan. Please be aware that there is no guarantee that your insurance company will cover the service(s), even if they initially say they will do so. It has been our experience that insurance companies sometimes deny or reduce coverage based on the terms of your particular plan, the diagnosis, and/or their beliefs about whether the service is medically necessary. Their beliefs may differ from your beliefs, ours, and/or those of the referring physician.

Dr. Drummond's session fee is $150 for a 50-minute psychotherapy session. Her hourly fee for other professional services is also $150 and is broken down (i.e., prorated) if periods of less than one hour are worked. Other services include report writing, telephone conversations lasting more than five minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spend performing other requested services. If you become involved in legal proceedings that require Dr. Drummond's participation in violation of the above psychologist-patient agreement, you will be expected to pay for all of her professional time, including preparation and transportation costs, even if she is called to testify by another party. Because of the complexity of legal involvement, Dr. Drummond charges $400 per hour for preparation and attendance at any legal proceeding.

Payment is accepted in the form of cash, check, or credit card and is respectfully due at the time services are rendered.

Appendix C
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.

Uses and Disclosures

Treatment- Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of your therapy evaluation and plan of treatment will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment- Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Healthcare operations- Your health information may be used or disclosed in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, and credentialing activities.

Law Enforcement- Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Abuse or Neglect- Your health information may be disclosed to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Public health reporting- Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable disease to the state's public health department.

Appointments- Your health information will be used by our staff to schedule appointments and verify your insurance benefits.

Information about treatments- Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest.

Marketing Health-Related Services/Fundraising- We will not use your health information without your written consent.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing use or disclosure of your information, you may submit a written revocation of authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Individual Rights

You have rights under the federal privacy standards. These include:

- The right to receive confidential communications concerning your medical conditions and treatment
- The right to request restrictions on the use and disclosure of your protected health information
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy practices that are outlined in this notice.

Rights to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting The Front Office Staff or The Privacy Contact.

Complaints

If you would like to submit a comment or complaint about our privacy practices or if you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to this address. You will not be penalized or otherwise retaliated against for filing a complaint.

Privacy Contact: Office Manager
707 Southfield Road
Shreveport, LA 71106

This notice is effective on or after April 14, 2003 and will remain in effect until replaced.

Appendix D

INTERACTIONAL SERVICES

707 Southfield Road / Shreveport, Louisiana 71106
318-869-1632 (phone) / 318-869-1633 (fax)

REQUEST AND AUTHORIZATION TO EXCHANGE INFORMATION

_____ _____
Patient Name Date of Birth

I, _____,
Patient's name or parent, guardian or authorized representative

Authorize- Interactional Services, Inc.
Attn: Dr. Sarah Drummond, PsyD

and

_____

Phone (_____) _____ Fax (_____) _____

To release and exchange with each other written/oral reports concerning the above named person's:

_____ Attendance

_____ Participation in counseling

_____ Results in evaluations

_____ Clinical progress

_____ Billing

_____ Other_____

I understand that no disclosure of my records can be made without my written consent unless otherwise provided in legal statues and judicial decisions. I also understand that I may revoke this consent at any time except to the extent that action has already been taken upon this release.

_____ _____
Patient Signature Date

_____ _____
Witness Signature of parent, guardian, or authorized representative (if required)