Davenport Psychology

Licensed Psychologist PY7978
Phone: (941) 321-1971 • Fax: (941) 866-0936
crd@drcharlesdavenport.com
1608 Oak St
Sarasota, Florida 34236
www.drcharlesdavenport.com

Adult Patient Information Form

Today's date: _____

A. Identification

Your name: _____ Date of birth: _____ Age: _____

Nicknames: _____ Social Security #: _____

Home street address: _____ Apt.: _____

City: _____ State: _____ Zip: _____

Home/evening phone: _____ Mobile phone:_____

May I call you? ☐ Yes ☐ No May I leave a message for you?: ☐ Yes ☐ No

Calls will be discreet, but please indicate any restrictions: _____

Email Address (optional see informed consent): _____ May I email you? ☐ Yes ☐ No

Emails will be discreet, but please indicate any restrictions: _____

Person Responsible for account:_____

Telephone:_____ Address:_____

B. Referral: Who gave you my name to call?

Name: _____ Phone: _____

Address: _____

May I have your permission to thank this person for the referral? ☐ Yes ☐ No

C. Your medical care: From whom or where do you get your medical care?

Clinic/doctor's name: _____ Phone: _____

Address: _____

If you enter treatment with me for psychological problems, may I tell your medical doctor so that he or she can be fully informed and we can coordinate your treatment? ☐ Yes ☐ No

Do you have or have you had any medical problems, hospitalizations, or serious illnesses?: ☐ Yes ☐ No;

If yes please list: _____

_____

_____

Do you have vision problems? ☐ Yes ☐ No Hearing Problems? ☐ Yes ☐ No

Do you have any allergies to medications?: ☐ Yes ☐ No; If yes please list: _____

Are you currently prescribed any medications?: ☐ No ☐ Yes. If yes what medication(s), what dose and who prescribes them?:_____

_____

D. Treatment

Have you ever received psychological or psychiatric treatment, or counseling services before?

☐ No ☐ Yes

E. Your current employer

Employer: _____ Address: _____

Work phone: _____ Occupation/Position:_____

May I call you? ☐ Yes ☐ No May I leave a message for you?: ☐ Yes ☐ No

Calls will be discreet, but please indicate any restrictions: _____

Education/Training:_____

F. Emergency information

If some kind of emergency arises and we cannot reach you directly, or we need to reach someone close to you, whom should we call?

Name: _____ Phone: _____ Relationship: _____

Address: _____

Significant other/nearest friend or relative not residing with you: _____

H. Relationships in your family of origin.

Please describe the following:

Your parents' relationship with each other: _____

_____

_____

_____

Your relationship with each parent and with any other adults present: _____

_____

_____

_____

Your parents' medical problems, drug or alcohol use, and mental or emotional difficulties: _____

_____

_____

_____

Your relationship with your brothers and sisters, in the past and present: _____

_____

_____

_____

I. Present relationships

How do you get along with your present spouse, partner, or others in your life? _____

_____

_____

_____

How do you get along with your children? _____

_____

_____

_____

Your important friends/relationships, past and present:

Names Good parts of relationship Bad parts of relationship

_____

_____

_____

J. Chemical use

How many cups of regular coffee do you drink each day? _____ How many cups of tea? ____ How many sodas/pop with caffeine (Coke, Pepsi, Mountain Dew, Dr. Pepper, Orange Crush, etc.)? ____ How many "energy drinks"? ____ How often do you use No Doz or similar caffeine pills? _____ .

How much tobacco do you smoke or chew each week? _____

Have you ever felt the need to cut down on your drinking? ☐ No ☐ Yes

Have you ever felt annoyed by criticism of your drinking? ☐ No ☐ Yes

Have you ever felt guilty about your drinking? ☐ No ☐ Yes

Have you ever taken a morning "eye-opener"? ☐ No ☐ Yes

How much beer, wine, or hard liquor do you consume each week, on the average? _____

Please provide other details about your use of drugs or other chemicals:_____

_____

_____

K. Legal history

Are you presently suing anyone or thinking of suing anyone? ❑ No ❑ Yes. If yes, please explain: _____

_____

_____

Is your reason for coming to see me related to an accident or injury? ❑ No ❑ Yes If yes, please explain: _____

_____

_____

Are you required by a court, the police, or a probation/parole officer to have this appointment? ❑ No ❑ Yes.

If yes, please explain: _____

_____

_____

L. Is there any other information you think I should know?_____

_____

_____

_____

_____

_____

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Adult Checklist of Concerns

Name: _____ Date of Birth: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked.

- ❑ I have no problem or concern bringing me here
- ❑ Childhood issues (your own childhood)
- ❑ Anger, hostility, arguing, irritability
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Decision making, indecision, putting off decisions
- ❑ Divorce, separation
- ❑ Failure
- ❑ Friendships
- ❑ Guilt
- ❑ Illness, medical concerns, physical problems
- ❑ Inferiority feelings
- ❑ Legal matters, charges, suits
- ❑ Memory problems
- ❑ Thoughts or actions that repeat themselves
- ❑ Panic or anxiety attacks
- ❑ Pessimism
- ❑ School problems
- ❑ Self-centeredness
- ❑ Shyness, oversensitivity to criticism
- ❑ Smoking and tobacco use
- ❑ Stress, stress management, tension
- ❑ Suicidal thoughts
- ❑ Thought disorganization and confusion
- ❑ Withdrawal, isolating
- ❑ Aggression, violence, harm to others
- ❑ Alcohol use
- ❑ Anxiety, nervousness
- ❑ Relationship problems
- ❑ Custody of children
- ❑ Delusions (false ideas)
- ❑ Eating problems
- ❑ Fatigue, tiredness, low energy
- ❑ Flashbacks
- ❑ Headaches, other kinds of pains
- ❑ Housework/chores, sharing duties
- ❑ Impulsiveness, outbursts
- ❑ Judgment problems, risk taking
- ❑ Motivation, laziness
- ❑ Oversensitivity to rejection
- ❑ Parenting, child management, single parenthood
- ❑ Procrastination, work inhibitions, laziness
- ❑ Sexual issues, dysfunctions, conflicts, other
- ❑ Self-neglect, poor self-care
- ❑ Sleep problems—too much, too little, insomnia, nightmares
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Suspiciousness, distrust
- ❑ Temper problems, self-control, low frustration tolerance
- ❑ Threats, violence
- ❑ Weight and diet issues
- ❑ Self-esteem
- ❑ Codependence
- ❑ Confusion
- ❑ Compulsions
- ❑ Drug use
- ❑ Dependence
- ❑ Emptiness
- ❑ Fears, phobias
- ❑ Gambling
- ❑ Pain, chronic
- ❑ Perfectionism
- ❑ Irresponsibility
- ❑ Loneliness
- ❑ Mood swings
- ❑ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition
- ❑ Other concerns or issues: _____

_____

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PSYCHOLOGIST-PATIENT SERVICES AGREEMENT & INFORMED CONSENT

Welcome to our practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which I provide to you at the end of our first session, explains HIPAA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next session. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in simple statements. It varies depending on the personal characteristics of the psychologist and patient, and the particular problems the patient is experiencing. There are several different methods that 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 that 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 many benefits. 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 psychological and behavioral 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, if you decide to continue with therapy. You should evaluate this information and 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.

During our meetings, your therapy will progress more effectively if you talk as freely as you can about any of the problems that may be affecting you at the time of our session. If there are no difficulties that you are aware of at that particular moment, try to talk as freely as you can about everything that is on your mind. This includes thoughts, feelings, memories, perceptions, dreams, and questions. The more open and honest you can be and communicate fully whatever is on your mind, the better. When a person speaks freely about whatever it is that comes to his/her mind, the important issues that relate to their difficulties tend to emerge naturally. Therefore, regardless of whether what comes to your mind seems trivial or important, it will help the progress of your treatment if you go ahead and talk about it in the session.

My task will be to try to assist you to gain understanding of what is unknown to you. The way that I do this is by listening closely to your efforts to explain to me everything that you do know and are aware of about yourself. At times, your thoughts about yourself may be expressed in the form of questions. I may or may not answer your questions according to what I think will be most helpful. This may feel awkward and

uncomfortable to you at first and it is one of the unique things you will find about therapy that makes it different from other relationships that you have.

MEETINGS

I normally conduct an evaluation that will last from 2 to 4 sessions. During this time, we can both decide if I am the best person to provide the services that you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one session per week at a time we agree on (sessions are 45 to 55 minutes for individuals and 50-55 minutes for couples and families), although I may recommend to have sessions more or less frequently. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide a minimum of 24 business hours during which my office is open (M., T., W., Thu., Fri.) advance notice of cancellation [unless we both agree that you were unable to attend or to cancel the appointment due to circumstances beyond your control].

It is important to note that insurance companies do not provide reimbursement for cancelled sessions. If it is possible, I will try to fill your appointment hour and when I can, you will not be charged even if you have not given 24 hours advance notification. Therefore, if you do not provide any notification when you otherwise could have to allow me the opportunity to fill your appointment hour for that day, you will be personally responsible for the charges. If you have any questions about this policy, please be sure to discuss this with me at your next appointment.

PROFESSIONAL FEES

The hourly rate for Dr. Davenport, Licensed Psychologist is $300, $200 for Dr. Gohil, Provisional Psychologist Licensee, and $200 for Alejandro Sanchez, Psy.D., Psychology Resident and this is the fee that we charge for the first appointment which is 45 - 60 minutes and covers the additional time and costs involved in gathering much of your history and background information which may involve securing copies of records, having contact with previous providers, contacting your insurance provider and to create a new patient file. The per session fee is $300 for Dr. Davenport, $200 for Dr. Gohil, and $200 for Dr. Sanchez, for a 45 - 55 minute session, 45 to 55 minutes for individuals and 50 to 55 minutes for couples/families. 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, psychological testing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me. Dr. Gohil and Dr. Sanchez, are an independent contractors for Charles R. Davenport, Psy.D., LLC.

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Please discuss this with me as early as possible if you believe you will want me to be involved in this type of work on your behalf. Out-of-office time for legal matters is computed on a portal-to-portal basis. My fee for any legal or forensic work is $550 (Same rate for all providers) per hour billed in one hour increments.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone. While I am usually in my office between 9 AM and 7 PM, I will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by voice mail, which I monitor frequently between the hours of 9:00 AM and 7:00 PM. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform me of some times when you will be available. If you are unable to reach me and feel that you cannot 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. You may also contact:

Bayside Center for Behavioral Health (800) 764-8477
Coastal Behavioral Healthcare, Inc. (941) 552-1950

I may also be contacted by email, and by fax. My email and fax accounts are private and confidential and only I have access to them. Please be aware, however, that it is possible for these types of communications to be misrouted or otherwise intercepted so please take this into account if you utilize these forms of contact or provide an email address to the office. If you choose to use email for communication or provide an email address on intake forms or by sending an email to the office, it will be assumed that you understand and consent to use of email communication. If at anytime you have questions, would like to revoke use of email, or change your email address of record, please contact the office to do so.

I usually take vacations twice a year for 2-3 weeks at a time in July, and again in December. I will always discuss upcoming breaks in advance so that we can prepare for the interruption in the treatment or other services. I will offer to provide you with the name of a colleague to contact during these breaks, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, I can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on the accompanying Acknowledgement Receipt provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record (which is called "PHI" in my Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- I also may have contracts with accounting services, collection agencies and legal services. As required by HIPAA, if contracted I will have a formal business associate contract with these business(es), in which they are duty bound to maintain the confidentiality of this data, except as specifically allowed in the contract or otherwise required by law. If you wish, I can provide you with the names of these organizations and/or a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is potentially protected by the psychologist-patient privilege law. I cannot provide any information without your (or your legal representative's) written authorization, or a court order, or if I receive a subpoena of which you have been properly notified and you have failed to inform me in writing that you oppose the subpoena. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- If a government agency is requesting the information for health oversight activities, within its appropriate legal authority, I may be required to provide it for them.
- If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim and I am providing necessary treatment related to that claim, I must, upon appropriate request, submit treatment reports to the appropriate parties, including the patient's employer, the insurance carrier or an authorized qualified rehabilitation provider.

There are some situations in which I am legally obligated to take actions which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment.

- If I know or have reason to suspect that a child under 18 is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or any other person responsible for the child's welfare, the law requires that I file a report with the Florida Department of Child and Family Services. Once such a report is filed, I may be required to provide additional information.
- If I know or have reasonable cause to suspect that there is domestic violence occurring in a home where a minor is residing, the law requires that I file a report with the Florida Department of Child and Family Services. Once such a report is filed, I may be required to provide additional information.
- If I know or have reasonable cause to suspect that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, the law requires that I file a report with the Florida Department of Child and Family Services. Once such a report is filed, I may be required to provide additional information.
- If I believe that there is a clear and immediate probability of physical harm to the patient, to other individuals, or to society, I may be required to disclose information to take protective action, including communicating the information to the potential victim, and/or appropriate family member, and/or the police or seeking hospitalization of the patient.
- If you inform me that another licensed health care professional in the State of Florida has engaged in any form of sexual behavior with a patient, I must report this to the appropriate licensing board in the state.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is seemingly reasonable and appropriate. 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 now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of my profession require that the practice keep Protected Health Information (PHI) about you in your Clinical Record. Except in unusual circumstances that disclosure would physically endanger you and/or others or makes reference to another person (other than a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record, except for "psychotherapy notes" at my discretion, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, the practice is allowed to charge a copying fee (and for certain other expenses). The practice may withhold copies of your records until payment of the copying fees has been made. The exceptions to this policy are contained in the attached Notice Form. If the practice refuses your request for access to your records, you have a right of review, which the practice will discuss with you upon request.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and my privacy policies and procedures. I am happy to discuss any of these rights with you.

MINORS & PARENTS
Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Children between 13 and 17 may independently consent to (and potentially control access to the records of) diagnosis and treatment in a crisis situation. When a crisis situation is not present, then parental consent must be obtained for any person under the age of 18 from their parent or legal guardian prior to the start of treatment. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, and parental involvement is also essential, it is usually my policy to request an agreement with minors and their parents about access to information. This agreement provides that during treatment, I will provide parents with only general information about the progress of the treatment, and the patient's attendance at scheduled sessions upon their request. I will also provide parents with a summary of their child's treatment when it is complete upon their request. Any other communication will require the child's written Authorization, unless I believe that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

BILLING AND PAYMENTS
You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, the practice may be willing to negotiate a fee adjustment or payment installment plan.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, the practice has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information that I release in regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. A service charge of **3**% per month will be added to all accounts over 60 days late If legal or collections action is necessary, all of its costs will also be included in the claim.

INSURANCE REIMBURSEMENT
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 have a health insurance policy, it will usually provide some coverage for mental health treatment. I am not an in-network provider for any insurance and do not file claims, submit diagnoses, or complete related forms for you. If you choose to use your health insurance for "out-of-network" reimbursement, you (not your insurance company) are responsible for full payment of my fees and filing all paperwork as required by your policy. It is very important that you find out exactly what mental health services your insurance policy covers and what forms need to be filed when for out-of-network coverage.

You should carefully read the section in your insurance coverage booklet that describes mental health services. 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.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients believe that they need more services after insurance benefits end.

You should also be aware that your contract with your health insurance company may require that you provide it with information relevant to the services that I provide to you. They may need a clinical diagnosis. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank.

If you are eligible for Medicare or a Medicare replacement/advantage plan you must complete the attached "Private Contact for Services." This form must be completed due to me being an "opt-out" provider with Medicare. You will be responsible for paying for sessions at the time of service and are restricted from filing for reimbursement from Medicare or any related replacement/advantage plans. Please see the attached contract for more information in this area and discuss any questions with me.

SUPERVISORY RELATIONSHIP

Swapnil Gohil, Psy.D., PPY326 is a Provisional Psychologist Licensee working under the direct supervision of Charles R. Davenport, Psy.D.. Dr. Davenport will supervise all of Dr. Gohil's clinical work and delivery of professional services. Any concerns or complaints regarding Dr. Gohil or his provision of psychological services should be directed to: Charles R. Davenport, Psy.D.: crd@davenportpsychology.com or 941-702-2457.

Alejandro Sanchez, Psy.D. is a Psychology Resident working under the direct supervision of Charles R. Davenport, Psy.D.. Dr. Davenport will supervise all of Dr. Sanchez's clinical work and delivery of professional services. Any concerns or complaints regarding Dr. Sanchez or his provision of psychological services should be directed to: Charles R. Davenport, Psy.D.: crd@davenportpsychology.com or 941-702-2457.

INFORMED CONSENT

- I do hereby seek and voluntarily consent to take part in treatment with Davenport Psychology, its employees, and independent contractors. I understand that in this treatment, we will be working on goals to lessen the problems and concerns that we identify and discuss. As time goes on, we will review our goals and additional goals may be defined. I understand that the development and regular review of these goals are in my best interest and I agree to play an active role in this process.
- I am aware that during the course of treatment, there is a risk that I may have uncomfortable or upsetting feelings. I also understand that my problems and symptoms may temporarily worsen at times during my treatment and my relationships with others may be disrupted as a result of my attempt to make important changes in my life. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by Davenport Psychology or its independent contractors.
- I am aware that I may stop my treatment at any time. Should I do so, I will only be responsible for the payment of services I have already received.

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

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WWW.DAVENPORTPSYCHOLOGY.COM

****FOR MEDICARE or MEDICARE ADVANTAGE PATIENTS****

PRIVATE CONTRACT FOR SERVICES

This agreement is between Supervising Psychologist, Charles R. Davenport, Psy.D., Swapnil Gohil, Psy.D., or Alejandro Sanchez, Psy.D. ("Therapist"), and _____ ("Patient"), who resides:

_____

_____

and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Therapist has informed Patient that therapist has opted out of the Medicare program effective on July 1, 2013 for a period of at least two years, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Therapist agrees to provide the following medical services to Patient (the "Services"):

90791 Psychiatric diagnostic evaluation
90837 Psychotherapy, 60 min, with patient and/or family member
90834 Psychotherapy, 45 min. with patient and/or family member
96101-96103 Psychological testing

In exchange for the Services, the Patient agrees to make payments to Therapist pursuant to the Attached Fee Schedule. Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that therapist or practice submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from Psychologists and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other Psychologists or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Therapist will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.

- Patient understands that Medicare payment will not be made for any items or services furnished by the Therapist that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him.
- Patient agrees to reimburse Therapist for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.]

Executed on _____ by _____
and _____(Therapists' name)

_____ _____
[Patient] Therapist
Contractor/EmployeeDavenport Psychology

FEE SCHEDULE

90791 Psychiatric diagnostic evaluation..... .....$300/$200 Gohil & Sanchez
90837 Psychotherapy, 60 min, with patient and/or family member....$300/$200 Gohil & Sanchez
90834 Psychotherapy, 45 min. with patient and/or family member....$300/$200 Gohil & Sanchez
96101-96103 Psychological testing per hour……..…$300/$200 Gohil & Sanchez

Davenport Psychology

1608 Oak St
Sarasota, Florida 34236

Phone: (941) 702-2457 • Fax: (941) 866-0936
www.davenportpsychology.com

Acknowledgement Receipt
Consent to Treatment

I acknowledge that I have received, have read (or have had read to me), and understand the "Psychologist-Patient Services Agreement & Informed Consent" brochure and/or other information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.)

I know that I must call and speak to the doctor to cancel an appointment at least 24 business hours (1 business day (M,T,W,Th, F) before the time of the appointment. If I do not cancel and do not show up, I will be charged the full rate ($300 Dr. Davenport, Licensed Psychologist/ $200 Dr. Gohil, Provisional Psychologist Licensee / $200 Dr. Sanchez, Psy.D., Psychology Resident) for that appointment. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of patient (or person acting for patient) Date

_____ _____

Printed name Relationship to patient (if necessary)

I, the therapist, have discussed the issues above with the patient (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____ _____

Signature of therapist Date

❑ Copy accepted by client ❑ Copy kept by therapist

Davenport Psychology
Notice of Privacy For Protected Health Information
(Notice Form)

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information (PHI),* for *treatment, payment, and health care operations* purposes with your written *consent.* To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  -*Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities within my office, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate written authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about
our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your clinical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.
I will also obtain an authorization from you before using or disclosing:
· PHI in a way that is not described in this Notice.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I know or have reasonable cause to suspect that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that I report such knowledge or suspicion to the Florida Department of Child and Family Services.
- **Domestic Violence with Minors Present:** lf I know or have reasonable cause to suspect that there is domestic violence between adult partners occurring in a home where minors are residing, the law requires that I report such knowledge or suspicion to the Florida Department of Child and Family Services.
- **Adult and Domestic Abuse:** If I know, or have reasonable cause to suspect, that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, I am required by law to immediately report such knowledge or suspicion to the Central Abuse Hotline.
- **Licensed Professional Sexual Misconduct:** If I know or have reasonable cause to suspect that another licensed health care professional in the State of Florida has engaged in any form of sexual behavior with a patient, I must report this to the appropriate licensing board.
- **Health Oversight:** If a complaint is filed against me with the Florida Department of Health on behalf of the Board of Psychology, the Department has the authority to subpoena confidential mental health information from me relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis or treatment and the records thereof, such information is privileged under state law, and I will not release information without written authorization from you or your legal representative, or a subpoena of which you have been properly notified and you have failed to inform me that you are opposing the subpoena or a court order. The privilege does not apply when you are being (*continued*) evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, I may communicate relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.
- **Worker's Compensation:** If you file a worker's compensation claim, I must, upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier, furnish your relevant records to those persons.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.
- *Right to Inspect and Copy*- You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, I will discuss with you the details of the request process.
- *Right to Amend*- You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting*- You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy-You* have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.
- Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket. You have the right to restrict certain
- disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.
- Right to Be Notified if There is a Breach of Your Unsecured PHI. You have a right to be notified if: (a) there is a breach (a
- use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted
- to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been
- compromised.

Psychologist's Duties:

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will notify you of any such changes either verbally or in writing.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Dr. Davenport at (941) 321-1971.
If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to:
Davenport Psychology
1608 Oak St, Sarasota, FL 34236
crd@drcharlesdavenport.com
You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on December 21, 2020.
I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by either discussing this with you verbally and/or informing you in writing.