PATIENT REGISTRATION

DATE: _____
PATIENT NAME: _____ M / F SOCIAL SECURITY # : _____
DATE OF BIRTH: _____ DRIVERS LICENSE #: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
HOME PHONE #: (_____)_____CELL PHONE/WORK #: (_____)_____
CIRCLE PREFERRED NUMBER FOR CONTACTING YOU: HOME CELL WORK
MAY I LEAVE A MESSAGE ON THIS PHONE?
EMERGENCY PHONE #: (_____)_____ EMERGENCY PERSON: _____
MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOW
EMPLOYER: _____
EMPLOYER ADDRESS: _____
EMPLOYER PHONE #: _____
FAMILY MEMBER'S TELEPHONE # AND ADDRESS **NOT** LIVING WITH YOU_____
_____
_____**RESPONSIBLE PARTY**
NAME: _____ DATE OF BIRTH: _____ RELATIONSHIP: _____
ADDRESS: _____ STATE: _____ ZIP: _____
PHONE: (_____)_____ SOCIAL SECURITY #: _____
EMPLOYER: _____
ADDRESS OF EMPLOYER: _____

PATIENT RIGHTS AND RESPONSIBILITIES

RIGHTS:

You have the following rights:

- The right to participate in planning your treatment program.

- The right, to the extent permitted by the law, to refuse specific treatment, procedures, unless there is danger of harm.
- The right to file a grievance, should you feel you are treated unfairly.
- The right to confidentiality.
- The right to be free from discrimination including discrimination because of race, religion, sexual preference, age or disability.
- The right to privacy as appropriate to your treatment setting.

RESPONSIBILITIES:
Your willingness to actively participate in treatment plays a crucial part in achieving treatment success. Therefore, you have the following responsibilities:

- The responsibility to provide accurate and complete information as needed for your treatment planning.
- The responsibility to update any changes in information needed for your treatment planning.
- The responsibility to make it known whether or not you understand your treatment plan.
- The responsibility to actively participate in your treatment.
- The responsibility to indicate when you are unwilling and/or unable to comply with your treatment plan.
- The responsibility for your actions if you refuse to comply with treatment plan recommendations.
- The responsibility to follow all rules and regulations established to maintain a safe treatment environment.
- The responsibility to respect the rights and confidentiality of others.

Patient's Signature: _____
Date:_____

Consent for Evaluation and Treatment

Clear and direct communication is important for effective psychiatric and psychological services. This handout is to provide you with clear information regarding practice policies. It is important that you understand this information so please ask any question you have about the information provided.

CONFIDENTIALITY: Information regarding treatment is controlled by the patient. There are exceptions to this rule:
1) By law therapists are to take whatever actions seem necessary to protect people from harm.

2) Therapists are required to contact the Department of Human Services if there is a reason to believe that someone is abusing or neglecting children, or a dependent adult.

3) If you have been referred to a therapist by court, you can assume that the court wishes to receive a report of the evaluation. In such instances, you have a right to tell the therapist only what you want me to know and be aware of the information that may be requested.

4) If you are involved in legal actions of any kind and inform the court of services that you receive from a therapist, you will be making your mental health an issue before the court. You may be waiving your right to keep your records confidential. You may wish to consult with your attorney regarding such matters before you disclose that you have received mental health treatment.

5) Most insurance companies, other payers, or manage care companies require the provider to release information regarding diagnosis, type and place of service, date of service, treatment plan, or other confidential information.

* Dr. Jasmine Bradley requires a formal, written, release form to be completed to release any information, verbal or written, unless required by law, or the release is needed to coordinate treatment with another healthcare professional, or for payment purposes, or for general health care operations. For more information, see Notice of Privacy Practices.

BENEFIT AND RISK OF THERAPY: Therapy is an interactive process between the patient and therapist. It is meant to promote change and understanding. Sometimes this process is very fulfilling but also can be emotionally difficult. You will be expected to contribute to decisions regarding interventions, including out of session tasks. You have the right to refuse or alter any intervention. You are encouraged to question the rationale of treatment if it is unclear to you. While I have every expectation of helping you determine and achieve personal therapeutic goals, any specific outcome cannot be guaranteed.

AFTER HOURS POLICY: In the event of an emergency, patients should call 911, or go to the closest emergency room.

CREDENTIALS: Doctorate in Clinical Psychology. License #PSY3178

BY SIGNING MY NAME BELOW I SHOW THAT I HAVE READ THE ABOVE INFORMATION AND IF NEEDED IT HAS BEEN EXPLAINED TO MY SATISFACTION. I HAVE HAD ALL MY QUESTIONS ABOUT FEES, CONFIDENTIALITY, INSURANCE OR OTHER MATTERS ANSWERED, AND HAVE RECEIVED A COPY OF THIS CONTRACT IF SO REQUESTED.

I,_____, HEREBY CONSENT TO EVALUATION AND TREATMENT.

Signature:_____Date:_____

Jasmine Bradley, Psy.D.

FINANCIAL AGREEMENT

I am committed to providing you with best possible care. In order to achieve this goal, I need your assistance and your understanding of your payment policy.

Payment is due at the time services are rendered. All charges are your responsibility from the date services are rendered.

If you are unable to keep an appointment, please notify me at 925-876-9356 as soon as possible. This will enable me to accommodate other patients and those on a waiting list. If you cancel 24 hours or less before your appointment time, or do not show for your reserved time, there will be a charge of $200.

Not all services are covered in session. There may be charges for questionnaires or letters that are not normally required for billing or treatment purposes, lengthy phone consults and emails, and medical record requests. For any legal depositions required, there will be a prepaid charge of $400 per hour, with a minimum of 2 hours and non-funded after scheduled.

In the event that the account becomes delinquent, the responsible party agrees to pay for attorney or collection fees that might occur. The account will become delinquent after it has matured to 121 days from the date of service. If the account goes to collections, there will be an added 33% to the account balance. The office of J. Bradley will determine the collection agency.

By signing below you have agreed to all the terms in this financial agreement.

The terms of this contract are contingent on any contractual agreement made between the provider and your insurance company and any terms stated that violate the provider's contractual agreement are voided and/or non-applicable.

PATIENT/RESPONSIBLE PARTY **DATE**

VERIFICATION OF NOTICE OF PRIVACY POLICY

I, _____ agree that I have read Dr. Jasmine Bradley's Notice of Privacy Practices.

_____
_____Patient Signature of Guarantor
Date

_____
_____Witness Signature
Date

If signature was not given, please provide efforts in attempting to obtain signature.
_____
_____
_____
_____
_____
_____

****Complete this form only if the patient is a minor or an adult dependent****

AUTHORIZATION FOR EVALUATION AND TREATMENT OF MINORS AND ADULT DEPENDANTS

I certify that I am the parent or legal custodial guardian of _____ who is a minor or adult dependant.

Date _____ Signature _____

I authorize, Jasmine Bradley, Psy.D. to conduct an evaluation on _____. Such an evaluation may include, but is not limited to personal interviews, review of treatment records, and other generally accepted practices in the field of mental health.

AND/OR

I authorize, Jasmine Bradley, Psy.D. to provide mental health treatment to _____. Such treatment may include, but is not limited to individual psychotherapy, group treatment, family therapy, or specialized therapeutic procedures, which are generally accepted in the field of mental health.

Date_____ Signature _____

Patient:_____ Date of Birth_____

Primary Care Physician / Psychiatrist Communication Form

Communication between behavioral health providers and primary care physicians / psychiatrists is important to help ensure all patients receive comprehensive and quality health care. This information is not released without the patient's consent. This information may include diagnosis and treatment planning if necessary. Below please find the consent or refusal to release said information. The patient may revoke this consent at any point, in writing, except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified.

I agree to release the information and communication with:

___My Primary Care Physician ___My Psychiatrist

his/her name & address is: his/her name & address is:

_____
_____
_____
_____
_____
_____

I decline to release my information to:

___My Primary Care Physician ___My information to my psychiatrist

NA: ___I do not have a Psychiatrist ___I do not have a primary Care Physician

_____

(Completed by provider)

This pt was seen at my office for mental health treatment as a result of:

___Direct patient call to my office ___Post Psychiatric inpatient admission
___Referral from Psychiatrist ___Referral from insurance company.
___Referral from PCP
___Other_____

Treatment Plan:

This patient was last seen by me on _____

_____
Date

Jasmine Bradley, Psy.D.

CONFIDENTIAL CLIENT QUESTIONNAIRE

Name:_____
DOB:_____
Briefly describe your reason for seeking help and your goals for treatment:

Nervousness Depression Fear
Drug Use Alcohol Use FriendsAnger
Self-Control UnhappinessSleep
Stress WorkRelaxation
Headaches TirednessLegal Matters
Memory AmbitionEnergy
Insomnia Making DecisionsLoneliness
Inferiority Feelings ConcentrationEducation
Career Choices Health
ProblemsTemper Nightmares
MarriageChildren Appetite
Stomach Problems
Finances Being a Parent My Thoughts

Who suggested you seek treatment?

_____

If you are currently under the care of a psychiatrist, please state condition for which you are being treated, and list the psychiatrist's name and phone number:

_____

_____

_____

_____

Have you ever been admitted to a psychiatric hospital? ___No ___Yes If yes: list reason for and date of admission.

_____

_____

_____

Have you seen a mental health professional in the past? ___No ___Yes
If yes please list name of professional:

_____

Do you have psychiatric advanced directives? ___yes ___no

GENERAL HEALTH:

Do you have any medical problems? Please explain, and list doctor's name and

phone number:

_____
_____

_____
_____

Allergies: _____ ____ None Do you have any impairment? ___no ___yes; please list

Are you pregnant ___yes ___no

Do you smoke? Yes No If yes, how much?_____ For long?_____

Do you consume caffeine? __yes __no If yes, how much?_____

Please list any medications you take regularly.

Name of Medication Dose Frequency

_____
_____

_____
_____

_____
_____

Current or expected legal involvement? Yes No If yes, please explain: If yes, please explain:

_____
_____
_____

Your Occupation: _____ Highest degree completed:_____

Your leisure interests_____ Languages Spoken: _____

If you have a religion please list _____

Who do you live with_____
_____

Describe your support system:_____

Authorization to Use/Disclose Health Care Information

Jasmine Bradley, Psy.D.

Patient Name:_____ **Birth Date**:_____
Maiden or other name (if applicable)_____
I request and authorize Jasmine Bradley, Psy.D. to exchange and release health care information described below with:

Name:_____ at _____
Address:_____
_____
City_____**State**_____**Zip**__
_____

Please initial to specifically authorize the use and/or disclosure of the following psychiatric records:

___Initial Psychiatric Evaluation ___Out-Patient Progress Not
___Discharge Summary
___Other_____
___Verbal Discussion of Case
_____

The requested records or information is about health care provided during the following approximate time frame:

Purpose(s) of this use/disclosure:_____

Authorization expires:_____, or if unspecified 6 months from the date of the
(Date)
signature below.

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Jasmine Bradley, Psy.D. .

I understand that Jasmine Bradley, Psy.D. may not condition treatment, payment, or enrollment or eligibility of benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research.

I understand that information disclosed based on this authorization may be subject to redisclosure by the recipient, and no longer protected by federal privacy regulations.

I understand that my express consent is required to release any health care information related to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/ mental health or drug/alcohol treatment or use.

Signature (patient or authorized representative)_____

Date_____
Relationship if signed by authorized representative:
_____

Jasmine Bradley, Psy.D.

Cancellation policy:

Cancellations for appointments should be made 24 hours in advance, when possible.
Anything less than 24 hours makes it difficult to reschedule anyone else for that empty
time slot. Because short notice cancellations result in revenue loss for the clinician,
Dr. Bradley has requested that clients submit a credit/debit card number to keep
on file. If you cancel with less than 24 hours notice, your card will be debited for $200, and you will be notified of this charge. If you have a need to cancel your appointment for emergency purposes, the nature of the emergency will be considered before exacting a cancellation fee.

Sincerely,
Dr. Jasmine Bradley

_____ _____
_____ _____
Type of cardCredit/Debit card account number Expiration date Security Code

Billing Zip code:

Jasmine Bradley, Psy.D.
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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship. You will find Jasmine Bradley, Psy.D. will do all she can to protect the privacy of your mental health records.

As required by "HIPAA", this explanation was prepared to explain how therapists are required to maintain the privacy of your health information and how Jasmine Bradley, Psy.D. may use and disclose your health information.

The mental health licensing law provides extremely strong privileged communication protections for conversations between your mental health provider and you. There is a difference between privileged conversations and documentation in your mental health records. Records are kept, documenting your care, as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "designated medical record" as well as some material, known as "Psychotherapy Notes" which is not accessible without your authorization to insurance companies and other third-party reviewers.

HIPAA provides privacy protections about your personal health information. We may use and disclose your medical and mental health records *without authorization* for each of the following: treatment, payment and health care. These functions require release of "protected health information" (PHI). Below, we have defined these three (3) functions: *treatment, payment, and health care operations*.

- **Treatment Purposes** refers to J. Bradley, Psy.D. coordinating or managing your mental health care treatment. Examples of this would a counseling session in which the healthcare provider records information in the health record. Or during the course of your treatment, the treating provider determines she will need to

consult with another specialist in the area. She may share the information with such specialist to obtain his/her input. Also, this includes communication between Jasmine Bradley, Psy.D. and any other treating provider for the purpose of providing health care to you. While this is permitted by HIPPA, Jasmine Bradley's standard practice is to require written releases for this information in many situations.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. Examples of this would be sending a bill for your visit to your insurance company for payment or the health insurance company or a business associate helping us obtain payment, and them requesting information from us regarding your medical care. She will provide information to them about you and the care given.
- **Health care operations** include the business aspects of running her practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. She will share information about you only if it is necessary to obtain and continue your services.

Routine Uses and Disclosures

The use of your protected health information is necessary to perform routine activities at our office such as filing insurance claims, scheduling appointments, keeping records and other tasks. You will not need a written authorization to allow us to perform these duties for you.

She may contact you via telephone (a message may be left) or mail to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. She will not require your authorization.

She may also create and distribute de-identified health information by removing all references to individually identifiable information for marketing or research. She will not require your authorization.

Unless required by law, most other uses and disclosures will be made only with your written authorization. You may revoke such authorizations in writing, except to the extent that we have already taken actions relying on your authorization; we refer to this as "Authorized Non-Routine Disclosures".

Uses and Disclosures of Protected Health Information Requiring Authorization, Authorized Non-Routine Disclosures

Tennessee requires the provider to get authorization and consent for treatment, a release of payment and to conduct healthcare operations. HIPAA does nothing to change this requirement by law in Tennessee. She may disclose Protected Health Information (PHI) for the purposes of treatment, payment, and healthcare operations without your consent.

Additionally, if you ever want Jasmine Bradley's office to send any of your protected health information of any sort to anyone outside our office, you will always first sign a specific authorization to release information to this outside party unless stated otherwise in the PHI section of this Notice. The release is available upon request.

There is a third, special authorization provision potentially relevant to the privacy of your records: Psychotherapy Notes. In recognition of the importance of the confidentiality of conversation between mental health providers and patients in treatment setting, HIPAA permits keeping separate "Psychotherapy Notes" separate from the overall "designated medical record". Insurance companies cannot secure "Psychotherapy Notes" without your written authorization. "Psychotherapy Notes" are the notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and that are separated from the rest of the individual's "designated medical record." A patient's authorization is required for the use and disclosure of psychotherapy notes except for use by the originator of the notes for treatment, or for use of disclosure by the covered entity for its own mental health training programs, or use or disclosure by the covered entity to defend itself in a legal action or other proceedings brought by the patient or guarantor; and/or when required by law.

"Psychotherapy Notes" are necessarily more private and contain much more personal information about you, hence the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information about your care each time you have an appointment at our office: medication prescriptions and monitoring, assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical test, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

USES AND DISCLOSURES NOT REQUIRING CONSENT OR AUTHORIZATION

By law, the following protected health information may be released without your consent or authorization:

- Child abuse
- Suspected sexual abuse of a child
- Adult and Domestic Abuse
- Health Oversight Activities (i.e., licensing boards for mental health providers in Tennessee)
- Judicial or administrative proceedings (i.e., if you are ordered here by the court for an independent child custody evaluation in a divorce)
- Serious Threat to Health or Safety (i.e., our "Duty to Warn" Law, national security threats)
- Workers Compensation Claims (if you seek to have your care reimbursed under workers compensation, all of your care is automatically subject to review by your employer and/or insurer(s), except Psychotherapy Notes. If requested, we will obtain your written authorization before releasing any Psychotherapy Notes, unless required by law.
- Disclosures to coroners, medical examiners, and funeral directors
- Disclosures to organ procurement organizations

Your Health Information Rights

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to Jasmine Bradley – She is not required to grant the request but she will respond to any request;
- Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information ("Notice");
- Right to inspect and copy your records in the designated mental health record set and billing record – you may exercise this right by delivering the request in writing to our office using the form we provide to you upon request; or you have the right to appeal a denial of access to your protected health information except in certain circumstances;
- Right to request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office using the form we provide to you upon request. (The physician or other health care provider is not required to make such amendments); you may file a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Right to receive an accounting of non-authorized disclosures of your health information as required to be maintained by law by delivering a written request to her office using the form she provide to you upon request. An accounting will not include internal uses of information from treatment, payment, or operations, disclosures made to you or made at your request, or non-medical records (clinical information) disclosures made to family members or friends in the course of providing care;
- Right to confidential communication by requesting that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to her office using the form she gives you upon request; Example would be you may not want your bills sent to your home address so you may request them to be sent to another location of your choosing;
- Right to revoke your authorization of your protected health information except to the extent that action has already been taken; and,

If you want to exercise any of the above rights, please contact Jasmine Bradley (901) 755-1396, 1088 Rogers Road, Cordova, TN 38018, in person or in writing. She will provide you with assistance on the steps to take to exercise your rights.

Jasmine Bradley's Responsibilities

The office is required to:

- Maintain the privacy of your health information as required by the state and federal law;

- Provide you with a notice of her duties and privacy practices;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request;
- Accommodate your reasonable requests regarding methods to communicate health information with you; and
- Accommodate your request for an accounting of non-authorized disclosures

She appointed herself as a "Privacy Officer" for her practice per HIPAA regulations. If you have any concerns of any sort that her office may have somehow compromised your privacy rights, please do not hesitate to contact Jasmine Bradley, the "Privacy-Complaint Officer" immediately about this matter. You will find she is always willing to talk to you about preserving the privacy of your protected mental health information.

Jasmine Bradley reserves the right to amend, change, or eliminate provisions in her privacy practices and access practices and to enact new provisions regarding the protected health information she maintains. If her information practices change, she will amend her Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy or by visiting her office and picking up a copy.

Please contact us for more information by asking to speak to our Privacy Officer or for written enquiries, note "Attention Privacy Officer".

For more information about HIPAA or to file a complaint, contact:

The U.S. Department of Health and Human Services
Office of Civil Rights