Patricia J. Hayes, Psy. D. & Associates
351 Regency Ridge Dr. Centerville, OH 45459
Mailing Address: 206 Nicole Ct. Dayton, Oh 45420
Phone: 937-436-0700 Fax: 937-802-5199
pjhayes500@gmail.com

REGISTRATION

Date:_____

Name_____
First Middle Initial Last

Address_____

City_____State_____Zipcode_____

Home Phone_____May we leave a message?_____

Work Phone_____May we leave a message?_____

Cell Phone_____ May we leave a message?_____

May I text about appointment changes?_____

May I send a bill to the above address?_____

Alternate address for billing if needed_____

Social Security #_____ Date of Birth_____

Employer/School_____Full or Part time_____

Legal status: Single___Married___Divorced___ Partnered___

Will you be using insurance to help pay for your treatment?_____

Patient # or Medicare #_____Group #_____

Who is the carrier of this policy?_____
First Middle Initial Last
Address_____City_____St___Zip_____

Phone_____Sex_____Date of Birth_____

Relationship to you_____

PLEASE MAKE A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARDS IF YOU ARE USING MEDICARE OR TRICARE, AND RETURN THEM WITH THIS PAPERWORK.

How did you hear about our practice? Check all that apply:
_____Referral from another professional

Who?_____
Address_____City_____Zip_____
Phone _____Fax_____
Please sign here to give your therapist permission to send a thank you note

using your name_____
_____Referral from a friend
_____Referral from an insurance company
_____Website
_____Internet - _____CentervilleTherapy.com _____ Psychology.com _____EDReferral.com
_____Other

Send billing statement to:_____

Address_____City_____ST___Zip_____

Emergency Contact_____

Home Phone_____Work phone_____Cell phone_____

Primary Care Physician_____

Address_____City_____ST_____Zip_____

Phone_____ Fax_____

I, the undersigned, certify that I have insurance with_____
Name of insurance company
and assign directly to Dr. Patricia J. Hayes all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether paid by insurance or not.

_____Date_____
Client or Parent's Signature

I hereby authorize Dr. Hayes to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____Date_____
Client or Parent's Signature

HISTORY

Name_____Date_____

Reason for starting therapy_____

Problem areas:___Family___Work/school___Anger___Behavior___Depression___Relationships ____Anxiety___Alcohol/drugs____Eating___Other_____

What do you hope to accomplish in therapy?_____

_____

Physical health problems: Current_____

Past_____

Weight _____Height_____Weight change in last 6 months?_____

Appetite Change?_____Food or drug allergies_____

How would you describe the nutritional value and balance of your diet? Good___Fair___Poor__

Tobacco use: Current____ Past____Never used____ Packs per day_____Other use?_____

Sleep - How many hours per day?_____ Problems?_____

Sexual orientation: Straight__Gay/lesbian__Bisexual__Not sure___Transgendered___Other___

Describe any problems with sexual functioning_____

_____

Medication: Name of medication Prescribed By Dose How long? Results

Current: _____

_____

Past: _____

_____

Prior therapy or hospitalization for mental health issues:
Therapist/Hospital name When How long? Results

_____

What was the most helpful, and what was not particularly helpful or effective?

_____

_____

Other family members who have emotional, mental, or substance abuse problems?_____

_____

Have you ever had concerns about your use of pornography, masturbation, eating, gambling, internet use, spending, alcohol, prescription medications, or other drugs?

Yes___No____ Circle the ones above that you feel are problematic.

Has anyone else ever expressed concerns about your use of any of the above? Yes___No____
Who?_____Concerns_____

Have you ever made a decision to cut down on or quit using any of these? Yes___No___

Have you experienced any of the following in connection with your use of any of the above?
Check any that apply:

___Financial problems	**___Relationship problems**	**_____Work problems**
___Increased use to obtain same effect	**___Physical problems**	**_____Emotional problems**
___Blackouts	**___Withdrawal problems**	**_____Cravings**

FAMILY: Who lives with you?_____

Any concerns about family members?_____
_____

Have you ever experienced:	**_____Physical abuse**	**_____Sexual abuse**
_____Emotional abuse	**_____Rape/sexual assault**	**_____Domestic violence**
_____Sexual harassment	**_____Other significant trauma**	**_____Bullying**

Please check which of the following is difficult for you, if any:		**_____Communication**
_____Budgeting	**_____Time Management**	**_____Stress Management**
_____Leisure	**_____Self Nurturing**	**_____Parenting**
_____Food choices		

Education_____

Current employment_____

Past employment_____

Any financial problems?_____
Any involvement with the legal system?_____
On probation or parole?_____Ever been in jail?_____

SS-77
HOW OFTEN HAVE YOU BEEN BOTHERED BY THESE SYMPTOMS IN THE PAST FEW WEEKS?

Please use the following guidelines to answer each question:

0 Not at all bothered
1 Slightly bothered
2 More occasionally bothered
3 Moderately bothered
4 Frequently bothered
5 Constantly bothered
6 Severely bothered

1. Pain in my shoulders..... 0 1 2 3 4 5 6
2. Headaches..... 0 1 2 3 4 5 6
3. Neck and chest pain.....0 1 2 3 4 5 6
4. Not knowing where I am..... 0 1 2 3 4 5 6
5. Troubling thoughts that repeat themselves..... 0 1 2 3 4 5 6

6. Feeling dizzy..... 0 1 2 3 4 5 6
7. Dry mouth..... 0 1 2 3 4 5 6
8. Feeling restless.....0 1 2 3 4 5 6
9. Less interest in things I used to enjoy..... 0 1 2 3 4 5 6
10. Feeling nervous..... 0 1 2 3 4 5 6

11. Problems from alcohol or taking drugs..... 0 1 2 3 4 5 6
12. A need to count unimportant items.....0 1 2 3 4 5 6
13. Feeling sick to my stomach.....0 1 2 3 4 5 6
14. My mind is going blank.....0 1 2 3 4 5 6
15. Feeling guilty about alcohol or drug use.....0 1 2 3 4 5 6

16. Increase in sleep walking.....0 1 2 3 4 5 6
17. Trying too hard to help others..... 0 1 2 3 4 5 6
18. Back pain.....0 1 2 3 4 5 6
19. Needing to block out impulsive thoughts.....0 1 2 3 4 5 6
20. Sudden fear of dying..... 0 1 2 3 4 5 6

21. Drinking or using drugs too often..... 0 1 2 3 4 5 6
22. Problems reading my own handwriting..... 0 1 2 3 4 5 6
23. Feeling helpless.....0 1 2 3 4 5 6
24. Nightmares about something bad that happened to me..... 0 1 2 3 4 5 6
25. Talking in my sleep more than usual.....0 1 2 3 4 5 6

26. Fears of going outside alone.....0 1 2 3 4 5 6
27. Feeling like I am having a heart attack.....0 1 2 3 4 5 6
28. Having to repeat certain things I do to avoid getting nervous.....0 1 2 3 4 5 6
29. Feeling sensitive about my faults.....0 1 2 3 4 5 6
30. Crying a lot.....0 1 2 3 4 5 6

31. Trouble thinking of the names of family members or close friends.....0 1 2 3 4 5 6
32. Shortness of breath..... 0 1 2 3 4 5 6
33. Feeling anxious.....0 1 2 3 4 5 6
34. Flashbacks of something bad that happened to me.....0 1 2 3 4 5 6
35. Needing to use alcohol or drugs to get high.....0 1 2 3 4 5 6

Name_____ Date_____

36. Being too unselfish for my own good..... 0 1 2 3 4 5 6
37. Feeling hopeless..... 0 1 2 3 4 5 6
38. Feeling terror..... 0 1 2 3 4 5 6
39. Fear of going crazy..... 0 1 2 3 4 5 6
40. Feeling detached from others..... 0 1 2 3 4 5 6

41. Problems falling asleep or staying asleep..... 0 1 2 3 4 5 6
42. Stomach problems..... 0 1 2 3 4 5 6
43. A pounding or racing heart..... 0 1 2 3 4 5 6
44. Thoughts of hurting or killing myself..... 0 1 2 3 4 5 6
45. Thoughts about something bad that happened to me... 0 1 2 3 4 5 6

46. The need to keep things extra tidy..... 0 1 2 3 4 5 6
47. Not remembering where or when I was born..... 0 1 2 3 4 5 6
48. Problems remembering bad things in my life..... 0 1 2 3 4 5 6
49. Feeling that things aren't real..... 0 1 2 3 4 5 6
50. Needing to repeatedly wash hands..... 0 1 2 3 4 5 6

51. Stress at work (school) or at home..... 0 1 2 3 4 5 6
52. Arguments with family and friends about my alcohol or drug use..... 0 1 2 3 4 5 6
53. Feeling keyed up or "edgy"..... 0 1 2 3 4 5 6
54. Trying too hard..... 0 1 2 3 4 5 6
55. Feeling worthless..... 0 1 2 3 4 5 6

56. Sudden fear for no good reason..... 0 1 2 3 4 5 6
57. Fear of being in a crowded place..... 0 1 2 3 4 5 6
58. Sadness..... 0 1 2 3 4 5 6
59. Muscle and body soreness..... 0 1 2 3 4 5 6
60. Needing to retrace my steps..... 0 1 2 3 4 5 6

61. Being too honest for my own good..... 0 1 2 3 4 5 6
62. Using too much alcohol or drugs..... 0 1 2 3 4 5 6
63. Feeling self conscious..... 0 1 2 3 4 5 6
64. Feeling down or "blue"..... 0 1 2 3 4 5 6
65. Seeing things I know aren't real..... 0 1 2 3 4 5 6

66. Problems concentrating..... 0 1 2 3 4 5 6
67. Worry about the future..... 0 1 2 3 4 5 6
68. Hot or cold feelings in my body..... 0 1 2 3 4 5 6
69. Needing to drink or use drugs to feel better..... 0 1 2 3 4 5 6
70. Being too polite to other people..... 0 1 2 3 4 5 6

71. Feeling ashamed for using drugs or alcohol..... 0 1 2 3 4 5 6
72. Problems seeing things in color..... 0 1 2 3 4 5 6
73. Repeated checking of doors or window locks..... 0 1 2 3 4 5 6
74. Easily startling or feeling jumpy..... 0 1 2 3 4 5 6
75. Being reminded of something bad that happened to me..... 0 1 2 3 4 5 6

76. Having to do something many times to keep from getting nervous..... 0 1 2 3 4 5 6
77. Spending too much time reading or studying..... 0 1 2 3 4 5 6

Name_____ Date_____

Patricia J. Hayes, Psy. D.
Clinical Psychologist
351 Regency Ridge Dr. Centerville, OH 45459
(937) 436-0700 Fax (937)802-5199

PSYCHOTHERAPIST-CLIENT SERVICES AGREEMENT AND INFORMED CONSENT

Welcome to my practice. This document contains important information about my professional services, business policies, and HIPAA, the Health Insurance Portability and Accountability Act. When you sign this document, it will also represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and the client, and the particular problems you are experiencing. There are many different methods I may use to help you 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 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 needs. After that, I will be able to offer you some first impressions of what our work will include and a treatment plan to follow. You should evaluate this information along with your own opinion of whether you feel comfortable working with me. So that you have uninterrupted time, please turn off your cell phone before you come in for your session.

If you have questions about my procedures or are dissatisfied with anything that is happening in therapy, we should discuss it as soon as possible. Also, please discuss with me when you are feeling better and feel as if your problems have been resolved. When you feel you are ready to terminate therapy, please tell me at least two sessions before ending so we can discuss your feelings about ending and assess the progress and growth you have made.

CANCELLATION POLICY

Most therapy clients have a standing appointment at the same time every week or every other week. This time is reserved for you. **PLEASE HAVE YOUR CHECK READY AT THE BEGINNING OF THE SESSION IN ORDER TO SAVE TIME AT THE END.** Although emergencies come up from time to time for both me and you, it is expected that you will not cancel unless it is an extreme emergency. **Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. It is important to note that insurance companies do not provide reimbursement for cancelled sessions, so under most circumstances, you will need to pay the cancellation fee yourself.** However, in order to balance your needs and mine, the 1st Late Cancellation or No Show (for any reason) will be free. For every late cancelled or missed session thereafter, no matter the reason (work, illness, emergency, etc.), the fee will be $75.00.

PROFESSIONAL FEES

Fees are as follows:

First session (assessment)	55-60 minutes	$150
Individual Psychotherapy	30 minutes	$ 75
Individual Psychotherapy	55-60 minutes	$150
Family Therapy	55-60 minutes	$150
Testing or professional time	55-60 minutes	$150
Legal proceedings	55-60 minutes	$225

For sessions that go beyond the scheduled amount of time, the charge will be $30 per 10 minutes. In addition to weekly appointments, I charge these same amounts 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, 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 us. 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. Because of the difficulty of legal

involvement, I charge $225 per hour for preparation and attendance at any legal proceeding, including travel time. Fees may be raised during the course of therapy. You will be notified in advance if this occurs.

BILLING AND PAYMENTS

You will be expected to pay for each session at the beginning of the session, 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. Depending on your insurance company, you can begin paying only your co-pay amount after I have verified your coverage with your insurance company. You may pay with cash or check. If you bounce a check there is a $30.00 fee to cover my expenses.

There is a re-billing fee of $10.00 per month for all accounts not paid after the 1st bill, unless you have made arrangements with me. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment (collection agency or court). In most collection situations, the information released regarding a patient's treatment is his/her name, the nature of services provided, any identifying and contact information, and the amount due. If such legal action is necessary, you will be billed for these. Your signature at the end of this agreement indicates that you agree to reimburse me the fees of any collection agency, which may be based on a percentage at a maximum of 32% of the debt, and all costs and expenses, including reasonable attorney's fees that are incurred in such collection efforts.

INSURANCE REIMBURSEMENT

At this time, the only insurance company with which I am contracted is Medicare. You will need to pay your deductible and copay (20%) unless you have supplementary coverage. I will also bill Tricare. Although I am not in network with them, most policies cover my services. You will be responsible for your deductible and your copay.

If you have other insurance coverage, I am considered an out of network provider. I do not bill these companies, so you will be responsible for the entire fee at the time of service. I will give you a superbill with all the information needed by your insurance company, so you can send it to them directly.

Generally, you (not your insurance company) are responsible for full payment of fees. If there is a problem with your insurance company paying, I will try to work it out with them first. After that, I require that you pay your outstanding balance and that you take on the responsibility of collecting from your insurance company if that is allowable.

You should also be aware that your contract with your health insurance company requires me to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. 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. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your insurance carrier.

CONTACTING ME

I am not often available by telephone. If you call, please leave a voice mail. My assistant occasionally listens to the voice mail and gives me the message. I use texting occasionally to cancel or reschedule appointments. Your signature below gives me permission to text or call you. You may text me about cancelling or scheduling if you wish. If I have not called you back and it is an emergency, please call your family physician or Crisis Care at (937) 224-4646, or go to the hospital emergency room. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, 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 situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult with other health and mental health professionals. During a consultation, I make every effort to avoid revealing the identity of my client. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.
- My assistant handles many phone calls. She has been given training about protecting your privacy and has agreed not to release any information outside of the practice.

- I also have contracts with electronic billing and collection services. As required by HIPAA, I have a formal business associate contract with these businesses, in which they promise 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.

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 evaluation, diagnosis or treatment, such information is generally protected by the psychologist-patient privilege law. I cannot provide any information without your (or your personal or legal representative's) written authorization, or a court order. 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 (for example, the Ohio Board of Psychology), 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, the patient must execute a release so that I may release the information, records or reports relevant to the claim.
-

There are some situations in which I am legally obligated or permitted 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. These situations are unusual in my practice.

- Generally, if I know or have reason to suspect that a child under 18 years of age or a mentally retarded, developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child, the law requires that I file a report with the appropriate government agency, usually the Children Services Board. Once such a report is filed, I may be required to provide additional information.
- If I have reasonable cause to believe that an elderly or vulnerable adult is being abused, neglected, or exploited, or is in a condition which is the result of abuse, neglect, or exploitation, the law requires that I report such belief to the county Department of Job and Family Services or other appropriate agency. Once such a report is filed, I may be required to provide additional information.
- If I know or have reasonable cause to believe that a client has been the victim of domestic violence, I must note that knowledge or belief and the basis for it in the client's records.
- If I believe that a client presents a clear and substantial risk of imminent serious harm to him/herself or someone else and I believe that disclosure of certain information may serve to protect that individual, then I may disclose that information to appropriate public authorities, and/or the potential victim, and/or professional workers, and/or the family of the client.

If such a situation arises, I will, depending on the circumstances, make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, I keep Protected Health Information about you in your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that I receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances, you may examine and/or receive a copy of your Clinical Record if you request it in writing and the request is signed by you and dated not more than 60 days from the date it is submitted. 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, there are copying fees set by Ohio law which are adjusted yearly. If I refuse your request for access to your Clinical Record, you have a right of review, which I will discuss with you upon request.

In addition, I occasionally also keep a set of Psychotherapy Notes. These Notes are for my own use and are designed to assist me in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to me that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without a separate signed written Authorization. Insurance companies cannot require your Authorization as a condition of coverage

nor penalize you in any way for your refusal. You may generally examine and/or receive a copy of your Psychotherapy Notes under Ohio law.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized or that are not for treatment, payment, or health care operations; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records. The Notice Form of my Policies and Practices to protect the privacy of your health information is printed on my website at **www.centervilletherapy.com,** and is on the shelf in my waiting room. You have the right to request a paper copy if you wish. I am happy to discuss any of these rights with you.

PROFESSION WILL

In the case of my death or incapacity, I have made a professional will which specifies a Psychologist who is in charge of my records and will keep them confidential.

You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have taken action already; 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.

_____By initializing this section you agree to allow me, if you are incapacitated, in an emergency situation, or are not available after multiple attempts, to contact your emergency contact. This can be a family member, a relative, a close friend, or any other person you identify on the registration form. I would only disclose information directly related to the issue at hand. This information will only be disclosed as necessary if I determine it is in your best interest based on my professional judgement.

If you want to use electronic communication (phone, text, email), please know there are confidentiality risks inherent in these forms of communication if they are unencrypted. I will follow your wished indicated on the first page of the Registration form.

_____By initializing this section you agree that you understand the risks involved in unencrypted electronic communication and agree to accept such risks in communication from either me to you or you to me that involve either scheduling and/or therapy.

CONSENT FOR TREATMENT

I have read this agreement and I agree to its terms. I acknowledge that I can ask to receive a paper copy of the HIPAA Notice Form that is on the website at www.centervilletherapy.com. I acknowledge that I can receive a copy of this Psychotherapist-Client Services Agreement by asking Dr. Hayes or on my website. I understand that I have the right to an explanation of the risks and benefits of each proposed treatment, of alternative treatments, and of no treatment. I understand that I can refuse treatment at any time and that I have the right to have alternative treatment approaches planned with me.

_____ _____

Signature Date