LIVE OAK
PSYCHOLOGICAL ASSOCIATES, P.A.

1151 North State Street, Suite 212
Jackson, Mississippi 39202
601-352-7398

Today's Date_____

Patient Name

_____
Last First Middle

Date of Birth_____ Age_____ Social Security#_____

Address_____
Street City State Zip

Mailing Address (If different from above)

_____
Street City State Zip

Email address_____
(Parent's email if patient is a minor)

Home Phone_____ Work Phone_____ Cell_____

Marital Status_____ Spouse's Name_____

Employer (or School)_____

Referred By_____

Insurance (Fill out ONLY if you have Blue Cross Blue Shield.)

We accept Blue Cross Blue Shield Insurance. ID #_____

Name of Insured (Subscriber) _____D.O.B._____

If patient is a minor, please provide names and phone numbers of both parents:

Father _____Cell_____

Mother _____Cell_____

Person responsible for payment_____

Address_____
(If different from above)
Person to contact in an emergency _____Phone_____

Previous Psychological treatment_____

Briefly describe the nature of this visit _____

Practice Policies

The following are our general policies and office procedures. Please read them carefully and sign the bottom of this sheet. Thank you.

Scheduling

Our sessions at Live Oak Psychological Associates are 50 minutes in duration, and are set up in advance with our office personnel. Since your appointment is set aside for you alone it is important to give us a 24 hour advance notice if you need to cancel your session. This notice allows us time to reorganize our schedule to fill an open time slot. Except in the case of emergencies, failure to give us this notice will result in our charging you for the missed session.

Any contact with doctors should be directed through the office at 601-352-7398. An answering service is provided if the doctors need to be reached after hours or on weekends, however, after hours contact is limited to emergency situations only.

Confidentiality

We maintain absolute confidentiality with regard to our patients' identities and the content of their therapy. However, Mississippi law requires a potential breach of this privacy in some limited situations such as danger to self or others or abusive situations involving a minor. If you have any concerns whatsoever regarding the confidentiality policies of this office, please feel free to discuss them with your doctor.

Financial Considerations

We ask that you be prepared to pay for your visits with our doctor at the time of service. Our office personnel will file Blue Cross Blue Shield insurance for you, but we must hold our patients ultimately responsible for all fees. If you have any concerns about payment issues, please address them with your doctor.

Agreement:

I have read, understood and accepted the above policies, procedures and conditions.

_____

(Signature of patient or legal representative)

_____

(Date)

Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

: a basis for planning my care and treatment
: a means of communication among the many health professionals who contribute to my care
: a source of information for applying my diagnosis and surgical information to my bill
: a means by which a third-party payer can verify that services billed were actually provided
: and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a ***Notice of Information Practices*** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address. I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information.

_____

_____

_____

Signature of Patient or Legal Representative

*Date*_____