NEW PATIENT INFORMATION

Name: _____ SSN: _____

Address: _____

City _____ State: _____ Zip: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Sex: __ M __ F

Marital Status: __ Single __ Married __ Separated __ Divorced __ Widowed

Spouse Name: _____ Spouse DOB: _____ Spouse Phone: _____

Parents Names (if minor patient): _____

FINANCIALLY RESPONSIBLE (OR INSURED) PARTY

Name: _____ SSN: _____

Address: _____

City _____ State: _____ Zip: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Relation to Patient: _____ Sex: __ M __ F

Employer: _____ City _____

Supervisor/Contact: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder Employer: _____ Phone: _____

Group: _____ Group Number: _____ ID Number: _____

Policy Holder Name: _____ DOB: _____

Patient's Relationship to Policy Holder: __ Self __ Spouse __ Child __ Other

Secondary Insurance: _____

Policy Holder Employer: _____ Phone: _____

Group: _____ Group Number: _____ ID Number: _____

Policy Holder Name: _____ DOB: _____

Patient's Relationship to Policy Holder: __ Self __ Spouse __ Child __ Other

EMERGENCY CONTACT INFORMATION

Contact Person: _____ Relationship: _____

Address: _____

City _____ State: _____ Zip: _____ Email: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Additional Contact Person (not living in your home): _____

Address: _____ Home: _____

SYMPTOM CHECKLIST

Please mark all of the following symptoms you are now experiencing with a N. Please mark all of the follow symptoms that you have experienced in the past, but are no longer currently experiencing with a P.

__ Sadness
__ Feeling empty
__ Tearfulness
__ Irritability
__ Guilt
__ Headaches
__ Stomach aches
__ Fatigue/exhaustion
__ Restlessness
__ Social withdrawal
__ Indecisiveness
__ Low self-esteem
__ Feeling worthless
__ Self-blame
__ Restless sleep
__ Not sleeping enough
__ Waking too early
__ Sleeping too much
__ Suicidal thoughts
__ Difficulty thinking
__ I wish I didn't exist
__ Loss or reduction of energy
__ Weight loss (_____ lbs.)
__ Weight gain (_____ lbs.)
__ General aches/pains
__ Things aren't fun anymore
__ Loss of interest in things/life
__ Difficulty concentrating

__ Worrying/brooding
__ Avoid social situations
__ Compulsions
__ Feeling stressed out
__ Restless/on edge
__ Mind goes blank
__ Muscle tension
__ Unresolved trauma
__ Easily fatigued
__ Irritability
__ Obsessive thoughts
__ Fear of leaving home
__ Intense or irrational fears
__ Decreased concentration
Decreased concentration

__ Panic
__ Shortened breath
__ Nausea
__ Fear of dying
__ Palpitations
__ Hyperventilating
__ Dizziness
__ Tingling sensations
__ Sweating
__ Choking
__ Things seem unreal
__ Chills/hot flashes
__ Trembling
__ Chest pain
__ Fear of losing control
__ other

__ Poor attention to detail
__ Difficulty listening
__ Difficulty organizing things
__ Excessively fidgety
__ Frequent, careless mistakes
__ Difficulty following instructions
__ Hyperactive
__ Talks excessively
__ Difficulty paying attention
__ Difficulty finishing tasks
__ Impulsive
__ Forgetful

__ Lose temper easily
__ Deliberately annoying
__ Angry
__ Bullies others
__ Legal problems
__ Argumentative
__ Easily annoyed
__ Spiteful/vindictive
__ Initiates physical fights
__ Starts fires
__ Defiant/noncompliant
__ Excessively "touchy"
__ Cruel to animals
__ Destroys property
__ Robbery
__ Blames others
__ Aggressive
__ Cruel to others
__ Theft/stealing

__ Grossly inflated self-esteem
__ Very rapid, "pressured" talking
__ Excessive increase in productivity
__ Reckless decision making
__ Decreased need for sleep
__ Ideas racing through mind
__ High risk or hypersexual
__ Excessive energy
__ Far more talkative than usual
__ Excessively distractible
__ Running away from home
__ Spending far too much

__ Sig. reduction of calories
__ Dissatisfaction with body
__ Sig. weight loss
__ Excessive exercise
__ Loss of menses
__ Obsession with food
__ Laxative abuse
__ Binging
__ Intense fear of weight
__ Purging

ADULT DBT CONTRACT

I have read and reviewed the above and have discussed with Dr. Hancock those items which were unclear or of concern to me. I understand and agree to the above as written as verified by initials and signature (as indicated). My signature also verifies that I have been provided a printed and/or electronic copy of the information and agreement.

My mobile phone number is: (_____) _____ - _____. I authorize the use of my mobile phone number (listed above) to receive scheduling and billing messages. I agree to update this office if my mobile number changes. _____ (Please initial)

I specifically elect to follow the billing practices identified below (initial one):

_____ (initial) I will pay $40 for each individual group, due at the beginning of each group.

_____ (initial) I would like my insurance to be billed for each group. I understand that I will be responsible for deductible charges for both my child and myself. I understand that co-pay and co-insurance charges are separate from deductible charges.

Patient's Name (printed)	Today's Date
Signature of Financially Responsible Person	Name of Financial Guarantor

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

I, the undersigned, hereby authorize Kyle Max Hancock, PhD, PC and its affiliates the release of medical/health/psychological information of:

Name (print): _____ **Birthdate:** _____

Address: _____ **City, State, Zip:** _____

Home Phone: _____

Initial One:

__ To release information to:

__ To receive information from:

__ To exchange information with:

Professional/Clinic/Person: _____

Address: _____

City, State Zip: _____

Phone: _____

Fax: _____

Please provide any information available whether written or verbal with respect to any psychological testing, reports, academic information, medical history, physical examinations/evaluations, consultation reports, and any treatment or programs prescribed.

With the following limitations or exclusions:

Important:

- You may revoke this authorization at any time by written request. Obviously, the revocation can't apply to information already released.
- There may be charges associated with services rendered to fulfill this release of information request.
- Your treatment is not conditional on signing this authorization.
- You are entitled to a copy of this authorization upon request.
- This authorization will expire one year from the date of your signature below.

Person Authorized to Consent: _____ **Date:** _____

Signature of Authorized Person: _____ **Date:** _____

OUTSTANDING PAYMENT AUTHORIZATION

In an effort to optimize efficiency and reduce collections services (which are extremely expensive), Kyle Max Hancock PhD, PC requires each financial guarantor to consent to an outstanding payment authorization agreement. With your signature, you authorize Kyle Max Hancock, PhD, PC to charge your credit/debit card (identified below) for the total amount of any unpaid balance after it is a minimum of 60 days past due. All financial guarantors will be provided at least two separate notices of any past due balance prior to charging the card on file. If you dispute any charges billed, a written notice of dispute must be provided to Kyle Max Hancock, PhD, PC a minimum of five business days prior to the 60-day limit. All reasonable and appropriate efforts will be made to resolve any identified dispute before charging the card on file. However, Kyle Max Hancock PhD, PC reserves the right to submit charges to the card on file for any services rendered consistent with the authorized rates and charges identified in the signed contract between any financial guarantor and Kyle Max Hancock, PhD, PC provided that sufficient reasonable evidence exists that services have, indeed, been rendered for each applicable charge (e.g., patient signature on applied date of service). No other charges will be placed upon the card on file without the express consent of the responsible party. All credit card information will be stored using encryption consistent with both HIPPA and PCI DSS. This agreement does not preclude any account being submitted to collections as outlined in the signed contract. Additionally, if, consistent with this agreement, an attempt to charge the card/account identified below is unsuccessful or denied for any reason, the financial guarantor on this account will be assessed a service fee of $100 in addition to all other outstanding charges and the account may be submitted to collections as detailed in the signed contract. Finally, with your signature, you guarantee that if, at any time, you terminate the card on file, you will provide Kyle Max Hancock, PhD, PC with a replacement card.

With your signature, you certify that you are an authorized user of the identified credit card/account and that you will not dispute these transactions with your bank or credit card company, so long as the transactions correspond to the terms indicated in this authorization form.

Please complete the information below:

___ Visa ___ MasterCard ___ Discover

Cardholder Name: _____ Card Number: _____

Expiration Date: _____

Billing Address: _____ Phone: _____

City, State, Zip: _____ Email: _____

Name of Patient: _____

Name of Responsible Party: _____ Date: _____

Signature of Responsible Party: _____ Date: _____

APPOINTMENT REMINDERS & PATIENT PORTAL

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a voice message) before your scheduled appointments.

You can also enjoy the convenience of viewing your scheduled appointments, account balance, and other tools located in our secure patient portal. This is also the method we will use to send your bill to you. Simply visit www.therapyappointment.com to find your healthcare provider and set up your patient portal. Once established, you can access your patient portal by going to www.schedule.care.

Patient name: _____

Requested login name: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
(letters and/or numbers only)

Requested temporary password: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|
(must be at least 8 characters and contain both letters and numbers)

(After you log in, you will be asked to change this to a permanent password)

Your email address: _____

Your home phone number: _____

Your cell phone number: _____

How would you like to receive appointment reminders? (initial one)

_____ via a text message to my cell phone (normal text message rates will apply)

_____ via an email message to the email address listed above

_____ via an automated voice message to my home phone number listed above

_____ Do not send reminders. I'll remember my appointments on my own.

NOTES: (1) If requested, appointment reminders are sent as a courtesy. Missed appointment fees still apply if, for any reason, the reminders cannot be delivered. (2) Appointment information may be classified as "Protected Health Information." By my signature, I am requesting that reminders be handled as I have noted above.

Signature _____ Date _____

INFORMATION & AGREEMENT

This document contains important information about the professional services and business policies of Kyle Max Hancock, PhD, PC. Please read it carefully and note any questions you might have so we can discuss them. Your signature verifies this document as a legal and binding agreement between us.

SKILLS TRAINING CLASS

As a group member, you have rights, benefits, and duties; you understand that some of them are described in this agreement.

This class will be called the DBT Class for Adults and will meet on Wednesdays from 5:00 – 6:00. You agree to pay the full fee if you do not show up for group or if you cancel without 24 hours notice, except in the case of emergency or illness. Payment is due in full at each group session. The total cost of this group is $40 per class, if clients pay for the class without billing their insurance company. If you prefer to bill your insurance company, Dr. Hancock has agreements with various insurance companies and additional information can be provided upon request. Please note that the insurance company will be billed for any person who attends the class unless specific accommodations or agreements are made in writing between the participants and Dr. Hancock.

PURPOSE OF DBT CLASS

The primary aim of this program is to provide training using standardized assessments and therapies with demonstrated effectiveness. In order to be able to determine whether a treatment we are providing is effective, we measure our clients' improvement over time. For this reason, we make use of various assessments approaches (e.g., self report and clinical interviews) in our practice.

To make DBT skills and therapy groups successful experiences, it is essential that the client be under the care of a primary mental health treatment provider (a primary therapist who sees you regularly) while participating in the program. DBT skills/therapy groups and phone coaching are not a substitute for the treatment provider for each client's primary provider. It is also very important that each treatment provider for each client understands and agrees to the client's participation in the DBT skills training and therapy groups. Each client has responsibilities, described below, that must be met if DBT is to be successful.

TREATMENT AGREEMENT

The treatment consists of weekly class skills training and regular individual therapy to help with applying new skills to everyday life. Five sets of skills will be covered: how to stay in the moment, how to regulate intense emotions, interact effectively with others, tolerate distress, and walk the middle path in ways that are not harmful to oneself or others; classes are taught in five separate modules.

You are voluntarily requesting to participate in the Dialectical Behavior Therapy Program. The guidelines of the program and its foundation are contained in Marsha Linehan's Cognitive Behavioral Treatment for Borderline Personality Disorder (Guilford Press, 1993). You understand that this program includes identifying patterns of reinforcement for behaviors that you want to change and that you do not need to have borderline personality disorder in order to benefit from this treatment. You also recognize that you must also take responsibility for my actions. There will be times when you will not get the response from therapists that you

might have expected in the past and this might increase my distress temporarily or put greater burden on others concerned about me.

You give the staff of the Dialectical Behavior Therapy Program permission to contract my treatment team member(s) (including my therapist, psychiatrist, family members, and therapist involved in my treatment), but you understand that you are personally responsible for conveying any essential information.

You will not assume that professionals involved in my treatment will pass important information along to others, but you understand that they may do so when they feel it is necessary for their own supervision/consultation or my treatment.

You understand that if you miss 2 out of 5 sessions of DBT skills training class for any reason, you will have voluntarily dropped out of DBT. You also understand that you must maintain individual therapy with a primary therapist and if you do not, you will no longer be able to participate in the DBT program.

You understand that you can request further clarification when you have a question regarding specific application of any parts of this authorization. You understand that you may speak with Dr. Hancock if you have any concerns.

You understand that payment for services is due at the time of service. Each class costs $40. You acknowledge that there will be no refunds for missed classes (with the exception of illness, emergency, etc.).

By your signature, you agree to the following:

1. To attend the skills class on a regular basis.
2. To work in this group. This means openly talking about my thoughts and feelings, honestly reporting my behaviors, keeping my promises, and exchanging helpful feedback with other members of the group when appropriate.
3. To attend all meetings of the group from start to finish, even if you do not always feel like it. If you cannot attend, you will tell the group a week in advance (at the beginning of that meeting), or, if it is an emergency, call one of the leaders as soon as you know you cannot attend.
4. You understand that the leaders are required by law to report any suspected child or elder abuse, or serious threats of harm to myself or another person, to the proper authorities.
5. To avoid coming to group under the influence of drugs or alcohol.
6. To not discuss past (even if immediate) suicidal, self-harm behaviors, drug use, or other impulsive behaviors with other clients in or outside of group.
7. To keep information obtained during sessions, as well as the names of clients, strictly confidential.
8. To call the group leaders ahead of time if you will arrive late.
9. To provide 24 hours notice prior to missing any group.
10. To maintain appropriate relationships with other group members.
11. To pay my bill on time and in full.
12. Not to come to sessions under the influence (or appearing to be) of alcohol or illicit drugs.

CLASS RULES

1. Clients who drop out of DBT are out of DBT. "Dropping out" means missing 2 sessions out of 5 consecutive skills training sessions.
2. Each client must be in ongoing psychotherapy and have authorized communication between therapists.
3. Clients are not to discuss past (even if immediate) para-suicidal behaviors with other clients outside the group.
4. Clients who call one another for help when in need must be willing to accept help from the person called.
5. Information obtained during sessions, as well as the names of clients, must remain confidential.
6. Clients who are going to be late or miss a session must call 24 hours in advance.
7. Clients may not form "private" (that is "secret") relationships with one another outside of groups. If it cannot be discussed in the group, don't say or do it.
8. Sexual partners may not be in DBT groups together.
9. Physical violence, intimidation, or destructive comments are unacceptable.
10. Skills training group or therapy group therapists may be telephoned when there is need for "coaching" to use DBT skills and the primary therapist is unavailable. Skills coaching are not a crisis call and are limited to 5 minutes. Clients are expected to have tried practicing skills before calling for skills coaching. Skill coaching availability is based on the therapist's limits, which may vary between therapists.

CONFIDENTIALITY

In general, law protects the privacy of all communications between a patient and a psychologist; we can only release information about our work to others with your permission, but there are a few exceptions, outlined below:

1. The nature of the skills training class is such that we cannot control the release of information from any group member outside of the group; consequently, although we will remind all group members of the requirements and regulations of the need for confidentiality on a regular basis, we cannot guarantee the maintenance of confidentiality of any individual member of the group by another group member. However, we will consistently maintain the confidentiality of each individual group member at all times—including during individual therapy. This means that we will not discuss any individual group member's group participation with any other member of the group during individual therapy.

2. There are some situations in which we are legally obligated to take action to protect others from harm (such as reporting to appropriate agencies when someone has threatened serious bodily harm, a life is at risk, or when abuse or neglect is suspected). These actions may include notifying the potential victim, contacting family members or others that can help provide protection, contacting the police or seeking hospitalization for the patient. Such situations often require that we reveal some information about a patient's treatment.

3. When a child's welfare is involved or where a patient's emotional condition is a critically important issue, a judge may order our testimony if he/she determines that the issues demand it. Such an order has been exceptionally rare in our experience.

4. We associate with and collaborate with four other behavioral health providers, all of whom are members of Mt. Logan Clinic, LLC. We are each independent of one another, yet we

share office space, certain expenses, and administrative functions. It is important that you understand that we are completely independent in providing you with clinical services and we alone are fully responsible for those services. My professional records are separately maintained and no member of the group can have access to them without your specific, written permission.

5. My support staff may have access to your medical chart and may occasionally send or receive privileged information such as psychotherapy notes, evaluations, and other written and/or verbal communications. All persons affiliated with Kyle Max Hancock, PhD, PC abides by the same limits and laws of confidentiality.

We are willing to discuss any questions you may have about confidentiality. You may also want to obtain formal legal advice because the laws governing confidentiality are quite complex and we are not attorneys.

BILLING & PAYMENT

1. Class fees and/or insurance copays must be paid for at the beginning of each class. There is a $10 service fee charged if patients choose to not pay the class fee at the time of service.

2. No-Show Fees: when patients fail to present for group without calling to cancel a minimum of 24 hours prior to their scheduled appointment (unless in cases of sudden illness or emergency), they will be charged a fee of $25. Patients may speak with me if they feel circumstances warrant a discount or waiving of the fee. Number and frequency of no-shows, ratio of no-shows to shows, as well as unique circumstances may be taken into consideration.

3. Outstanding balances: interest is charged on outstanding balances at a rate of 1.5% per month, 18% per year. Patients will be informed of their total balance at each scheduled session; each person will also have the opportunity make payments toward their balance. Patients owing a balance will also be sent monthly statements reflecting the portion they owe for services provided. Statements can be confusing to read (e.g., our billing software system automatically applies payments to the oldest outstanding charge in order to reduce patients' interest charges; it may therefore appear that a co-pay paid wasn't credited to the account when it was, but it was applied to an older charge). If patients have questions about their statement or amount owed, they are encouraged to contact Carolyn or speak with Dr. Hancock. *Patients whose balances (patient portion) exceed $300 will be given one month from the statement date indicating an outstanding payment balance exceeding $300 to return their balances under $300. If that does not occur, patients will be contacted to make a payment or payment arrangements. Payment arrangements must be made (and followed) in order to schedule further appointments and/or to retain existing appointments.* Patients will be sent a letter indicating the amount of their outstanding bills. Patients will be sent a second letter of outstanding balance with an appraisal that payments are necessary to avoid having the balance sent to collections. Although we will make every effort to work with patients on payment plans in cases of financial hardship, patients who refuse to make payment arrangements or adhere to them will be sent to collections. Thus, when reasonable efforts to collect an outstanding balance have failed, the account will be turned over to a collections agency or a claim will be made in small claims court. Should your account be submitted to a collections agency, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, all associated attorney's fees, all associated court fees, and all associated collection fees in the amount of 40% of the initial balance. The obligation to

pay all collection fees shall be imposed at the time of the assignment of the debt to a third party debt collection agency. State law requires us to inform you that a negative credit report is submitted to a credit-reporting agency if you fail to fulfill your financial oblations.

4. Monthly statements will be sent to you showing charges and your payments. If there is an error on your statement, please bring it to our attention so we can promptly resolve the problem. Payment is due within ten days of receipt of your statement. A finance charge of 1.5% per month (18% per annum, $5.00 minimum charge) is assessed on any unpaid balance over 60 days old. Returned checks result in a $20 service charge in addition to any bank service charges.

5. When reasonable efforts to collect an amount owed fail, the account is turned over to a collection agency or a claim is made in small claims court. If such action is necessary, 40% of the outstanding amount is added to the bill as a "collection fee". This charge is included in the claim. In most collection situations, the only information we release is the name of the patient and responsible party, the dates and nature of services provided, and the amounts due. State law requires me to inform you that a negative credit report is submitted to a credit reporting agency when a person fails to fulfill contracted financial obligations.

6. Any and all agreed-upon changes to the above billing policy must be made and maintained in writing.

7. With your signature, you are authorizing payment of medical benefits to Kyle Max Hancock, PhD, PC. Additionally, you are authorizing Kyle Max Hancock, PhD, PC and/or its affiliated office and billing personnel to contact you for billing purposes.

APPOINTMENTS

Skills training classes are approximately 75 minutes long. This time is reserved specifically for the class meeting. Because your class is a substantial portion of our day's schedule, it is important that you keep track of your appointments. Reminder calls are a courtesy only, are not guaranteed, and should not be relied upon as a way of keeping track of your appointments. Do not leave appointment cancellations on the voicemail of Dr. Hancock.

Effective skills training commonly requires full attention. As such, please make arrangements for childcare because we cannot provide it. Children should not be left in the waiting room unsupervised. Should a problem arise due to inadequate supervision, your therapy session would be cut short that day.

PROFESSIONAL RECORDS

The laws and standards of our profession require that we keep treatment records. As required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we keep two sets of records–the medical record and our psychotherapy notes. The medical record includes the dates and times of sessions, the type of therapy provided, the results of any psychological testing, and any summaries of symptoms, diagnosis, treatment plan, and treatment progress. **The medical record is available for your review**. Psychotherapy notes and personal notes, on the other hand, are protected by HIPAA law and state law and are considered the property of the health care provider who created them.