Appointment Reminders and Online Appointment Scheduling

You can schedule online at any time. Once your account is established, you simply visit our website at **www.RBpsych.com** and click on the patient portal link on the *Contact Us* page to view, schedule, or reschedule your appointments. As an alternative, you can also visit **www.therapyappointment.com** and click on *Find Your Therapist* in the upper right hand corner of the screen to manage your appointments. You may continue to schedule appointments in person or by telephone. 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) the day before your scheduled appointments. You will also be able to view your financial account, receive statement invoices or receipts for payment on your account, and send and receive confidential messages through the patient portal.

All Fields Below Must Be Completed

Your name: _____

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

Requested password: |__|__|__|__|__|__|__|__|__|__|
(letters AND numbers at least 8 long and NO special characters)
(This temporary password will be changed the first time you login)

Your home phone number: _____

Your cell phone number: _____

Where would you like to receive appointment reminders? **(check ONLY ONE)**

_____ Via a text message on my cell phone (normal text message rates will apply)

_____ Via an email message to the address listed below

_____ Via an automated telephone message to my home phone

_____ None of the above. I'll remember my appointments on my own.
(Missed appointment fees will still apply)

By providing my email address below, I hereby agree to allow Dr. Richard Barrett and/or staff to contact me by email, possibly conveying confidential information. I understand that my email will not be shared with any outside entities.

Your email address: _____

Appointment information is "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

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Signature Date

Richard H. Barrett, II, Ph.D.
Clinical Psychologist

5601 Duncan Rd
Fort Smith, AR 72903

Ph: (479) 561-3144 Fx: (866) 988-3317

211 North 34th St.
Rogers, AR 72756

Name _____ Date_____

Gender M F Birth Date _____

Address _____ City/State/Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Can you be contacted at work? Y N Best daytime contact number? Home Cell Work

Marital Status: Single Married Widowed Divorced No. of Children _____

Occupation of Client _____ Employer _____

Spouse Name _____ Phone _____

Occupation of Spouse _____ Employer _____

Referred By _____

If referred by a physician, a report will be mailed unless initialed here _____

Name of primary care physician _____ Phone _____

Name of person responsible for the account (and address if different from above):

_____

Signature of Responsible Party _____

Person to notify in case of emergency (name, address & phone number):

_____

INSURANCE INFORMATION

Primary Insurance Company_____ ID# _____

Insured Name_____ Birth Date_____Relationship to Patient _____

Insured's Address if different than above_____

Secondary Insurance Company_____ ID# _____

Insured Name_____Birth Date_____Relationship to Patient_____

Insured's Address if different than above _____

I, _____understand that I have contracted for services with DR. RICHARD BARRETT and that I alone am responsible for paying the amount that is billed for services. In particular, I understand that RICHARD H. BARRETT, II, PH.D. provides insurance filing as a courtesy and a convenience to me and/or will seek authorizations from my health care provider; however, these activities do not guarantee that my insurer will pay. I understand that at any time I am free to file my own insurance, in which case full payment of fees will be required at the time of service.

I understand that the business office will attempt to help me understand my insurance or managed care benefits and procedures, but that denial of benefits by my insurer means that I am fully responsible for the contracted amount.

I understand that I am responsible for meeting the requirements of my health insurer or managed care provider. In particular, I am responsible for:

- Obtaining the initial referral to the provider, if needed.
- Ensuring I have pre-certification of visits, if needed.
- Knowing limits regarding my deductible.
- Keeping track of benefits limits. Keeping track of my benefits entails knowing any limits on my policy and ensuring that I do not exceed those limits (e.g., some insurers set a maximum of 20 mental health sessions per year). If I exceed my limits and my insurer refuses to pay, I will be responsible for the amount refused. I understand that if I am also seeing a social worker or psychiatrist, those sessions may count against my mental health benefits. I also realize that while my managed care provider may authorize visits as appropriate for me, that does not mean that they will necessarily pay for those visits.

A fee of $50.00 will be charged if you do not give a **24** hour notice (during normal business hours) to cancel an appointment, with the exception of mutually agreed upon **emergencies**. We cannot bill insurance for this fee, as they will not pay for missed appointments.

I understand that if my policy changes or if I change insurance companies, I should inform the office immediately. If the office does not have the proper information and cannot collect payment from the insurer, I am responsible for the amount the insurance company will not pay.

I also understand that in the instance of my account being turned over to collections that I am responsible for the entire bill plus 100% of collection fees.

_____

Patient Name (Print)

_____

Patient Name (Signature)

_____

Responsible Party (Signature) if different than above

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PERMISSION TO LEAVE MESSAGE ON PHONE

May we leave a message with confidential information on your phone? Y N

If yes, which number? Home Cell Work

Patient Signature _____Date_____

****

RELEASE TO DISCUSS FINANCIAL INFORMATION
(complete only if applicable)

Patient Name: _____

I hereby authorize Dr. Richard Barrett and/or staff to disclose financial information regarding my bills with the following person(s):

Please list Name, Address, Phone Number, and Relationship of those we may speak with:

Name: _____

Address: _____

Phone: _____ Relationship: _____

Patient Signature _____Date_____

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NOTICE OF HIPAA PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

PURPOSE: This Notice of Privacy Practices describes how I may use and disclose your Protected Health Information to conduct treatment, obtain payment or carry out other healthcare operations and for other purposes permitted or required by law. "Protected Health Information" is information that may identify the client and that relates to the client's past, present or future physical or mental health, and may include name, address, and other identifying information.

I am required to give you this Notice and to maintain the privacy of your Protected Health Information. I must abide by this notice but I reserve the right to change the privacy practices described in it in response to changing legal requirements. You may request a copy of this notice at any time.

If you believe your privacy rights have been violated, you may complain to me or to the U. S. Secretary of Health and Human Services. To file a complaint with me, you may send a letter describing the violation to the address above. There will be no retaliation, effect on the services provided to you or other negative effect for filing a complaint.

ACKNOWLEDGMENT: You will be asked to sign an ACKNOWLEDGMENT of receipt of this Notice.

Your Privacy Rights. You have the following rights relating to your Protected Health Information and may:

Obtain a current copy of this Notice.

Inspect or obtain a copy of your records. Your request to obtain a copy of your records must be made in writing.

Request that I amend your record if you feel the information is incomplete or incorrect.

Make a reasonable request to have confidential communications of your Protected Health Information sent to you by alternative means or at alternative locations.

I will obtain your written permission for uses and disclosures of your Protected Health Information that are not covered by the Notice or permitted by law. Except to the extent that the use or disclosure has already occurred, you may cancel this permission. This request to cancel must be put in writing.

My Responsibilities.
I am required to protect the privacy of your Protected Health Information, abide by the terms of the Notice and make the Notice available to you.

Examples of Uses and Disclosures.

Law Enforcement: I must disclose your Protected Health Information for law enforcement purposes as required by law.

As Required by Law: I must disclose your Protected Health Information when required by federal, state or local law.

Abuse or Neglect: I must disclose your Protected Health Information to government authorities that are authorized by law to receive reports of suspected abuse or neglect.

Legal Proceedings: I may disclose your Protected Health Information in the course of any judicial or administrative proceeding or in response to a court order, subpoena, discovery request or other lawful process.

To Avoid Harm: I may disclose information about you when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person.

By your signature below, you indicate that you have received and read and agreed to this document. Please feel free to keep a copy of this form for yourself.

Patient Signature _____Date_____

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OUTPATIENT SERVICES CONTRACT AND CONSENT TO TREATMENT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and ask any questions you might have so that we can discuss them. When you sign this document, it will 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 patient, and the particular problems you bring forward. There are many different methods 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 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 significant benefits for most people who go through it. 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 session or two will involve an evaluation of your 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 along with 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.

MEETINGS

During the evaluation meeting(s), we can both decide if I am the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, I will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent. Once an appointment hour is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation unless we both agree that you were unable to attend due to circumstances beyond your control.

PROFESSIONAL FEES

My fee for a 50-minute session is $150. I charge $185 for a full 60-minute hour or 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 10 minutes, attendance at meetings with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

If you become involved in legal proceedings that require my participation, you will be expected to pay for my professional time even if I am called to testify by another party. Because of the difficulty of legal involvement, I charge $400 per hour for preparation and attendance at any legal proceeding. Further information on my fees is available at https://www.rbpsych.com.

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 which requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. [In circumstances of unusual financial hardship, I 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, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. [If such legal action is necessary, its costs will be included in the claim.] In most collection situations, the only information I would release regarding a patient's treatment would be his/her name, the nature of services provided, and the amount due. Happily, I have never needed to do this and hope that continues to be true.

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 will fill out forms and submit claims for you, as well as provide you with whatever assistance I can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers.

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. If it is necessary to clear confusion, I will be willing to call the company on your behalf.

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 a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. [Some managed-care plans will not allow me to provide services to you once your benefits end. If this is the case, I will do my best to find another provider who will help you continue your psychotherapy.]

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes I have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). 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.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above [unless prohibited by contract].

CONTACTING ME

I am often not immediately available by telephone. While I am usually in my office between 8 AM and 5 PM, I probably will not answer the phone when I am with a patient. When I am unavailable, my telephone is answered by my office manager who knows where to reach me. 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 can't wait for me to return your call, contact your family physician or the nearest 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.

BOUNDARIES

Appropriate boundaries are an essential aspect of psychotherapy. In order to maintain the emotional safety of the patient, professional objectivity, competence, and effectiveness and to avoid any potential risk of exploitation or harm to you, I will not engage in extra-therapeutic discussions with you in the course of psychotherapy, nor will I agree to meet with you outside of the office or engage in telephone conversations not focused on professional or therapeutic topics. Because my practice is not located in a large metropolitan area, there is a greater potential that we may find ourselves in an unexpected encounter in public settings. If this occurs, I will not initiate any interaction with you but will, of course, briefly respond appropriately should you initiate an interaction with me. Please refer to http://www.apa.org/ethics/code/principles.pdf for further information regarding this topic and other ethical principles by which I am bound.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of your records, or I can prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, I recommend that you review them in my presence so that we can discuss the contents. Patients will be charged an appropriate fee for any professional time spent in responding to information requests.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected by law, and I can only release information about our work to others with your written permission. But there are a few exceptions. Please refer to our HIPAA Agreement for a full outline of our privacy policy.

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

Patient Signature _____Date_____

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PERMISSION FOR CREDIT CARD ON FILE

Date: _____

Patient Name: _____ DOB: _____

Cardholder Name:
_____

Cardholder Address:
_____

_____

Card #: _____ -_____ - _____ - _____ Exp Date: _____ / _____ CVV_____

Visa Mastercard Discover AMEX Debit Card

My signature below indicates that, as the cardholder, I agree to: authorize payment for services rendered by the service provider. By signing, I agree to accept total responsibility of the bill, in which total amounts may reflect the 1.) Full amount owed for service, 2.) Copayment of insurance benefits, 3.) No show fee for failure to attend scheduled appointment or notify Dr. Barrett and/or staff of inability to attend said appointment with 24 hours notice, or 4.) Other payment arrangements agreed upon by the patient, cardholder, and/or service provider.

Cardholder Signature: _____Date: _____