PATIENT INFORMATION: (Please Print) Provider name ______________________________

Patient Name: ____
(Last) (First) (Middle Initial)

Home Address: ____ Apt # _______

____
City State Zip Code

Home Phone #: _____-_____-_______ Other Phone #: _____-_____-_____ Sex: ☐ Male ☐ Female

Date of Birth: _____/ _____/ _____ Social Security Number: ______-______-________
Month Day Year

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐ Partner
Occupation: ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Full Time Student ☐ Part Time Student

Name of Employer / School: ____

Previous Mental Health Treatment (within 2 yrs): ☐ Psychiatrist ☐ Psychologist ☐ LCSW-C ☐ Other
Mental Health Provider: Name: ____ Phone: ____-____-______

INSURANCE INFORMATION:

Primary Insurance Company: __________________ ID Policy #: _________________ Group #:_________

Claims Address: ____ Phone #: _____-______-______

Policy holder's Name: ____ Date of Birth: ____/____/______
Month Day Year

Social Security #: ___________________________ Effective Date of Insurance: ___ /____/____
Month Day Year

Policy Holder's Employer: ______________________________________ Phone #: _____- _____-_________
Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other
Person Responsible for Account: ☐ Patient ☐ Parent ☐ Other
_____________________________ Date of Birth: ____/_____/______ Phone # _____-______-______
Name (if different from patient)

Secondary Insurance (Medicare Patients only) _____________________ID Policy # ___________________

Policy Holder Name: ___________________________________ Date of birth:_______/_______/________

AUTHORIZATION TO BILL INSURANCE:

Patient or Authorized person's signature: I authorize ProPsych Billing Solutions to submit claims on my behalf. I authorize the release of any medical or other information necessary to process my claims.

Signed ____ Date______________

PATIENT INFORMATION

Please Print

Name:____ Date of Birth:_____/_____/_____

Address:____

City/State:____ Zip Code:____________

Home #:_____________________________ Work #:______________________________

Cell#:_______________________________

Is it okay to leave a message? (Circle all that apply): Home Work Cell

Employer:____

Social Security #:_____________________________________

Marital Status (Circle one): S M D W

Emergency Contact:

Name (Please list full name):____

Relationship to you:____

Phone#:____

Signed:____ Date:_______________________

Jin Nothmann, Psy.D.
66 Painter's Mill Road
Suite 204
Owings Mills, MD 21117
Phone: (443) 394-0768, ext. 5/ Fax: (443) 394-0345

OUTPATIENT SERVICES CONTRACT

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at our next meeting. 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 therapy to be most successful, you will have to work on things we discuss both during and between our sessions.

Psychotherapy can have benefits and risks. Because psychotherapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings such as sadness, guilt, anger, grief, frustration, loneliness, and helplessness. On the other hand, psychotherapy has been shown to have benefits for people who utilize it. Psychotherapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. However, there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial 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 in selecting a therapist for yourself. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to refer you to another mental health professional or provide you with resources for a second opinion.

APPOINTMENTS

I typically conduct an evaluation that will last from 1 to 3 sessions prior to beginning treatment. During this time, 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 or two 45 to 50-minute sessions per week at a time we agree upon.

CANCELLED/MISSED APPOINTMENTS

Once an appointment is scheduled, **you will be expected to pay for it unless you provide at least 24 hours advance notice of cancellation**. Please be aware that if insurance or Medicare reimburses for your therapy sessions, and you miss an appointment or cancel within **24** hours of your scheduled appointment, you will be responsible for paying the FULL fee (i.e., $160 for individual, $175 for marital/couples) yourself, as insurance/Medicare will not cover such costs. Keep in mind that a scheduled appointment means that time is reserved just for you. It is typically difficult for me to schedule another patient for the time that I have reserved for you unless I have advance notice.

If you are using insurance or Medicare to cover your sessions and you are more than **10** minutes late for your appointment, you will also be responsible for paying the FULL fee for your session. The reason for this is that if you are more than 10 minutes late for your session, I will not be able to submit a claim to your insurance company/Medicare for the session, as that constitutes insurance fraud. Finally, if you repeatedly cancel appointments outside of 24 hours but close to within 24 hours of your appointment, I may be unwilling to offer you additional appointments.

TERMINATION OF THERAPY

You always have the right to terminate therapy. Because significant feelings about the therapeutic relationship can develop during the course of therapy, I strongly suggest that we discuss the issue of termination before actually terminating our therapeutic relationship. Should you decide that you wish to continue therapy with someone else, I will gladly provide you with contact information or resources for other mental health professionals who may be helpful. It is *always* your right to request this.

PROFESSIONAL FEES

My current hourly fee is $190 for the initial one-hour session and $160 for each subsequent 45-50 minute session ($175 for each marital/couples session). Fees for sessions longer than 45-50 minutes (except the initial one-hour session) will be prorated accordingly. Please be advised that cost of living increases may lead to changes in this fee in the future. I will clearly discuss any change in fees with you prior to any such increase.

In addition to regularly scheduled appointments, I charge the same amount (i.e., $160) for other professional services you may need, although 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

time spent performing any other service you may request of me. Costs for such services will be made explicit prior to the provision of services.

LITIGATION CHARGES

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 $350 per hour for preparation and attendance at any legal proceeding. If I am required to attend a deposition, hearing, or other legal proceeding in the capacity of your current or past therapist, you will be billed at $350 per hour for my time, including preparation, telephone time, and travel time, as well as time spent at the legal proceeding.

BILLING AND PAYMENTS

You will be expected to pay for each session at the end of the session, unless other arrangements are made in advance or unless you have Medicare, which requires another arrangement. If you have a co-payment, you will be expected to pay the full amount of your co-payment at the time of each session. Payment schedules for other professional services will be agreed upon when they are requested. Please notify me if any problem arises during the course of your treatment regarding your ability to make timely payment.

INSUFFICIENT FUNDS FEES

If you make payment with a personal check while insufficient funds are available in your account, you will be expected to pay any and all related bank fees in full. If your check is returned by the bank more than twice during the course of your treatment, I reserve the right to refuse any future checks and an alternative method of payment will be required.

DELINQUENT ACCOUNTS

If your account becomes delinquent (past 30 days) and arrangements for payment have not been agreed upon, you will be charged eight percent (8%) of your balance as interest. In the case of a delinquent account, I have the option of using legal means to secure payment. I will first attempt to contact you directly. However, if your account remains delinquent, I may utilize the services of an outside collection agency, retain an attorney, or take small claims court action. If such legal action is necessary, the costs of such proceedings, including but not limited to, legal fees, collection agency fees, and court costs, will be included in the claim. Should this be the case, you will be required to pay an additional fee of fifteen percent (15%) of the balance due. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. You will be notified in writing prior to my undertaking this process.

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. However, you (not your insurance company) are ultimately 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. Unfortunately, due to the time involved in dealing with most insurance companies, I am not able to help you negotiate or advocate for your benefits directly with your insurance company.

Due to the rising cost 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 obtain authorization for additional sessions after a certain number of sessions. While a great deal can be accomplished in short-term therapy, some patients feel that they require additional services after insurance benefits end. Some managed-care plans will not allow me to provide services to you once your benefits end.

You should also be aware that most insurance companies require you to authorize me to provide them with a clinical diagnosis. Sometimes they require additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will then 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 your information once it is in their hands. In some cases, they may share the information with a national medical information databank.

Once we determine the benefits available to you through your insurance coverage, we will discuss what we can expect to accomplish with the benefits available, and what will happen if benefits run out before you feel ready to end treatment. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above.

ADDRESS CHANGES

Please advise me of any changes in your address, telephone number, place of employment, or insurance company or coverage.

CONTACTING ME

I am often not immediately available by telephone. While I am usually in my office during typical working hours (i.e., 9AM to 5PM), I will not answer the phone when I am with a patient. When I am unavailable, you have the option of leaving me a message in my confidential voice mailbox. As much of my time is also taken up with paperwork or other responsibilities, it sometimes may take me awhile to return non-emergency phone calls. However, I will make every effort to return your call as soon as possible in cases of emergencies, which I will clearly define for you. If you are unable to reach me and feel that you can not wait for me to return your call, contact your family physician or the nearest emergency room, or call 911 and ask for the mental health specialist on call. I will give you advance notice if I will be unavailable for an extended period of time.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep treatment records. You are entitled to receive a copy of the records unless I believe that seeing them would be emotionally damaging, in which case I will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. 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 time spent in preparing information requests.

CONFIDENTIALITY

In general, the privacy of all communications between a patient and a psychologist is protected under Maryland law, and I can only release information about our work to others with your written permission. However, the following are a few exceptions to this confidentiality.

There are some situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about your treatment. For example, if I have reason to suspect that a child, elderly person, or disabled person is being neglected or abused, the law mandates that I file a report with the appropriate authorities.

If I have reason to suspect that you represent a threat to yourself, I may be obligated to seek hospitalization for you, or to contact family members or others who can help provide protection. If I believe that you are threatening serious bodily harm to another, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for you.

In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings however (e.g., cases involving child custody, cases in which your emotional condition is an important issue), a judge may order my testimony if he/she determines that the issues demand it. If a court of law orders me to testify, I can be required to do so without your authorization. If you do authorize me to testify in a court case, I may be compelled to testify on any issues discussed in therapy, beyond what you wish to have discussed in court.

In the case of marital or couples therapy, authorization to release information is required from both parties. However, it is possible during legal proceeding that the court will compel me to testify when one party subpoenas the treatment records without the other party's authorization. In the event that this occurs, I will make every effort to discuss confidentiality issues with the court; however, the court can ultimately compel me to comply with the judge's ruling.

These situations have rarely occurred in my practice. If a similar situation occurs, I will make every effort to fully discuss it with you prior to taking any action.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting. I will be happy to discuss these issues with you if you need specific advice; however, formal legal advice may be required as the laws governing confidentiality are quite complex, and I am not an attorney. I will be happy to provide you with relevant portions or summaries of the State laws regarding these issues upon your request.

CONSULTATION

I may occasionally find it helpful to consult with other professionals about your treatment. During consultation, I make every effort to keep any identifying information regarding my patients confidential. The consultant is also legally bound to keep the information confidential. If you do not object, I will not tell you about these consultations unless I feel that it is relevant or important for our work together.

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

I HAVE READ AND UNDERSTAND THESE POLICIES.

____ ________________________
Patient Signature Date

CONSENT FOR TREATMENT

I, ____, authorize and request that Jin Nothmann, Psy.D., provide psychological services including psychological assessments, interventions, and/or diagnostic procedures that now or during the course of my care as a patient are advisable. The frequency and type of assessment and/or interventions will be decided between Dr. Nothmann and myself.

I understand that the purpose of these procedures will be explained to me and be subject to my agreement.

I understand that there is an expectation that I will benefit from these assessments and/or interventions, but there is no guarantee that this will occur.

I understand that maximum benefit will occur with consistent attendance, and that at times I may feel conflicted about my therapy as the process can sometimes be uncomfortable.

I have read and fully understand this Consent for Treatment form.

____
Patient Name

____
Patient Signature

____
Date

Please take a moment to let me know now you heard about me (Check One):

____American Psychological Association (APA)
____Maryland Psychological Association (MPA)
____Psychology Today
____Internet/Website
____Physician (Name):______________________________________
____Word of Mouth (Please Specify):_______________________________________
____Other:____

Once again, welcome to my practice. I look forward to a productive working relationship with you!

Jin Nothmann, Psy.D.
66 Painter's Mill Road
Suite 204
Owings Mills, MD 21117
Phone: (443) 394-0768, ext. 5/Fax: (443) 394-0345

FINANCIAL AGREEMENT

Please understand that you are financially responsible for your treatment and that payment is expected when services are rendered.

You will be provided with a receipt or invoice to obtain reimbursement from your managed care or insurance company if necessary.

NOTE: Your insurance will *not* reimburse for missed appointments or cancellations without 24 hours notice.

I authorize Jin Nothmann, Psy.D. to use my credit card for payment of ongoing sessions, including missed appointments and cancellations without 24 hours notice, and unpaid balances, until termination of treatment or my explicit request to stop billing.

In the event that there is a missed appointment or a cancellation without 24 hours notice, or an unpaid balance, I authorize Jin Nothmann, Psy.D. to use the credit card below for payment.

Please circle one: Visa MasterCard

Card #: ____ Exp. Date: ____________

____ ____________________________
Signature Date

I have read and agree to all above-mentioned conditions.

____ ____________________________
Signature Date

NOTICE OF PRIVACY PRACTICES

Notice of Policies and Practices to Protect the Privacy of Your Patient Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *written authorization*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- "*Treatment, Payment, and Health Care Operations*"
  – *Treatment* is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  – *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  – *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my office/practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my office/practice such as releasing, transferring, or providing access to information about you to other parties.
- "*Authorization*" is your written permission to disclose confidential mental health information. All authorizations to disclose must be on a specific legally required form.

II. Other Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes I have made about our conversation during a private, joint, or group counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage; law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures without Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Neglect/Abuse* – If I have reason to suspect that a child has been subjected to abuse or neglect, I must report this to the appropriate authorities.

- *Elder Abuse/Abuse of Disabled Individuals* – If I have reason to suspect that an elderly or disabled individual has been subjected to abuse or neglect, I must report this to the appropriate authorities.

- *Adult and Domestic Abuse* – If I have reason to believe that you are a victim of abuse, neglect, self-neglect, or exploitation.

- *Health Oversight Activities* – If I receive a subpoena from the Maryland Board of Examiners of Psychologists because they are investigating my practice, I must disclose any PHI requested by the Board.

- *Judicial and Administrative Proceedings* – If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and I will not release information without your written authorization or a court order. The privilege does not apply when you are being evaluated by a third party, or where the evaluation is court ordered. You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety* – If you communicate to me a specific threat of imminent harm against another individual or if I believe that there is clear, imminent risk of physical or mental injury being inflicted against another individual, I may make disclosures that I believe are necessary to protect that individual from harm. If I believe that you present an imminent, serious risk of physical or mental injury or death to yourself, I may make disclosures I consider necessary to protect you from harm.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You have the right to inspect or obtain a copy (or both) of Psychotherapy

Notes unless I believe the disclosure of the record will be injurious to your health.
Upon your request, I will discuss with you the details of the request and denial process for both PHI and Psychotherapy Notes.

• *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. Upon your request, I will discuss with you the details of the amendment process.

• *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.

• *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

• I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.

• I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

• If I revise my policies and procedures, I will notify you by mail and/or in person during the next session.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact Jin Nothmann, Psy.D. at 443-394-0768, ext. 5.

If you believe that your privacy rights have been violated and wish to file a complaint with me, you may send your written complaint to Jin Nothmann, Psy.D., 66 Painter's Mill Road, Suite 204, Owings Mills, MD 21117.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect on April 14, 2003. I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. I will provide you with a revised notice by mail and/or in person.

Acknowledgement of Receipt of Notice of Privacy Practices

Name: ____ Date of Birth: _____________________

By signing below, I hereby acknowledge receipt of the Notice of Privacy Practices.

____ ________________________________

Signature Date

For Therapist use only:

Date: ___________________________________

Jin Nothmann, Psy.D. has made good faith efforts to obtain written acknowledgement of receipt of the Notice of Privacy Practices, but has been unable to obtain it. The following efforts were made:

The written acknowledgement was unable to be obtained for the following reason.

____________________________________ ______________________________

Signature Date