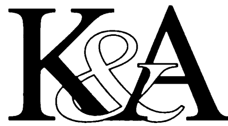


Kavalier & Associates, P.C.

Patient Information

Name: ____ Gender: M F DOB: ____________
(First Name, Middle Initial, Last Name)

Address: ______________________________ City: ________________ State: _____ Zip: ____________

Home Phone #: ______________ Work Phone # _________________ Cell Phone # _________________

Parent or Guardian Information if Patient is less than 18 years of age

Name: _________________________ DOB: ____________ Relationship to Patient: ________________

Address: ______________________________ City: ________________ State: _____ Zip: ____________

Home Phone #: ______________ Work Phone # _________________ Cell Phone # _________________

Name: _________________________ DOB: ____________ Relationship to Patient: ________________

Address: ______________________________ City: ________________ State: _____ Zip: ____________

Home Phone #: ______________ Work Phone # _________________ Cell Phone # _________________

Insurance Information

Primary Insurance	Secondary Insurance
Insurance Company: ______________________	Insurance Company: ______________________
Insurance ID Number: ______________________	Insurance ID Number: ______________________
Insurance Group Number: ______________________	Insurance Group Number: ______________________
Subscriber Name: ______________________	Subscriber Name: ______________________
Subscriber Date of Birth: ______________________	Subscriber Date of Birth: ______________________
Subscriber Employer: ______________________	Subscriber Employer: ______________________

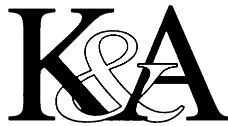
Appointment Reminders

An email reminder will be sent five days before your appointment. Three days before your appointment a text message will be sent asking for a confirmation. If the appointment is not confirmed from the text message, the system will call you two days before your appointment and will ask for a confirmation.

Email Address: ____

Email and text messages will be used for appointment reminders only.

☐ I do not want to receive appointment reminders.



Kavalier & Associates, P.C.

Medical/Psychiatric History

Reason for today's appointment: ______________________________

Who referred you to Kavalier & Associates? ______________________________

Medical Illnesses and Previous Surgeries: ______________________________

____

If patient has been seen by a counselor/therapist, please provide name, date and reason for seeking help:

____

____

If patient has been hospitalized in a psychiatric hospital, please list the hospital, date and reason:

____

____

List Current Medications and Dosage:

Medication	Dosage (example: 15mg)	Times per day

List Medication Allergies:

Medication	Reaction

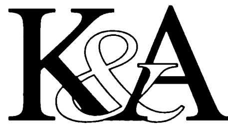
Informed Consent for Treatment

If patient is less than 18 years of age, the adult completing this paperwork shall assume financial responsibility for all services rendered.

I agree and consent to participate in behavioral health services provided by K&A for myself or the minor for whom I am responsible as legal parent or guardian.

______________________________ ______________________________

Patient/Parent or Guardian Signature Date



Kavalier & Associates, P.C.

Protected Health Information Consent

I understand that as part of my care, Kavalier & Associates, P.C. will originate and maintain paper and/or electronic records containing my Protected Health Information (PHI). Kavalier & Associates is required by the Health Insurance Portability & Accountability Act of 1996(HIPAA), to make sure that your PHI is kept private and also to inform you of our privacy practices.

I understand that my PHI can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and as further explained in Kavalier & Associates' Notice of Privacy Practices, I understand that I have certain rights to privacy regarding my PHI.

I understand that K&A has the right to change its Notice of Privacy Practices from time to time.

I understand that I may contact K&A, in regards to the Notice of Privacy Practices:

- To obtain a current copy of the Notice of Privacy Practices.
- For clarification of the content of the Notice of Privacy Practices.
- To address any special issues with regard to my PHI.

I understand that I may request in writing that you restrict how my private information is issued or disclosed to carry out treatment, payment or health care operations.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read K&A's Notice of Privacy Practices and K&A's Patient Rights and Responsibilities Statement which is posted in our waiting room and is available at the front desk.

I have been given the right to review K&A's Notice of Privacy Practices and K&A's Patient Rights and Responsibilities Statement prior to signing this consent.

____ ______________________________________

Patient/Parent or Guardian Signature Date

Phone Communication Consent

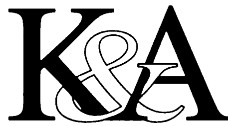
Kavalier & Associates may be required to contact you by phone. When no one is available, messages are sometimes left by our staff. Messages left with someone other than the patient or on an answering machine present the risk that unauthorized individuals are receiving information related to the patient's healthcare.

May we leave messages on an answering machine or voicemail? ☐Yes ☐No

If you have any other special requests regarding how we may contact you please list below:

____

____



Kavalier & Associates, P.C.

Authorization for Disclosure of Protected Health Information to Insurance

I authorize Kavalier & Associates, P.C. (K&A) to release mental health and/or substance abuse information to the full extent specified by federal and Iowa state law to my insurance company or to any organization contracting with my insurance company for claim processing, case management, coordination of treatment, quality assurance, and/or utilization review purposes.
I understand that I may revoke this authorization at any time by providing a written revocation letter to K&A. In the event that I revoke this authorization, I agree to accept financial responsibility for the mental health care service provided, if my insurance company or its payment agency refuses to pay for the services provided by K&A because the records could not be released.

Payment Authorization from Insurance

I authorize my insurance company to make payments directly to K&A for the medical services received. I also understand that I am personally responsible for all balances that are not covered by my health insurance plan.

The above authorizations will remain valid for all records relating to services provided to me or the above named patient from today until treatment ceases.

____ __________________________________

Patient/Parent or Guardian Signature Date

Authorization for Disclosure of Protected Health Information to Primary Care Practitioner

☐ I authorize K&A to release mental health and/or substance abuse information to my primary care physician listed below. The purpose of this disclosure is to facilitate continuity and coordination of treatment. This disclosure may include diagnostic impressions, medication information, and treatment recommendations. I understand that I may revoke this authorization at any time by providing a written revocation letter to K&A. I understand that K&A may have already released records according to this authorization, prior to receiving my written notice to cancel. Unless cancelled, this authorization expires one year from the date signed.

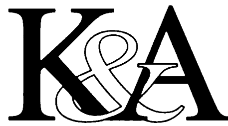
Physician Name ______________________________Phone Number ______________________________

Address: ___________________________________City:________________State: ____ Zip: __________

☐ I do **NOT** authorize K&A to release mental health and/or substance abuse information to my primary care physician.

____ __________________________________

Patient/Parent or Guardian Signature Date



Kavalier & Associates, P.C.

Billing and Office Policies

Payments & Interest: Payments for services rendered are the responsibility of the Patient (or legal guardian of the Patient) and are due at the time of service. We accept cash, check, Visa or MasterCard. A service charge will be assessed for each dishonored check in addition to any bank charges which are incurred for insufficient funds. We do not make payment plans for past due accounts. Interest will be charged at the rate of 1.5% per month on all "past due" accounts. "Past due" accounts are those which are not paid in full within thirty (30) days of the date of original invoice. K&A reserves the right to deny service to Patients with past due account balances.

Costs & Fees For Collection: Past due accounts of more than thirty (30) days will receive a letter stating that you have thirty (30) days to pay the past due amount in full. Past due accounts of more than sixty (60) days may be referred by K&A to a collection agency. In the event a patient account is referred to a collection agency and/or attorney for collection, Patient shall be responsible for the reasonable costs, fees and expenses incurred to collect on the past due account. Any account that is sent to a collection agency will result in termination of services.

Insurance Claims: K&A will file claims with your insurance company. However, Patient is ultimately responsible for payment for services rendered by K&A. In order for K&A to file your claim, you must provide us with accurate, up-to-date evidence of insurance coverage at the time of each visit. If K&A has a contract with your insurance company, you will be required to pay all applicable co-payments, co-insurance or deductibles at the time of service. If K&A does not contract with your insurance carrier, the claim may be submitted, however, you will be required to make payment in full at the time of service.

By having K&A file your claim; you are granting us permission to discuss your account information with both the Insurance Company and the Policy Holder. Please note that insurance company communication will likely be with the Policy Holder – not necessarily the Patient or Guarantor. Patient is ultimately responsible for payment. In order to insure that K&A services will be covered by your insurance, you should contact your insurance carrier about your benefits BEFORE we render services. You may wish to note the name of the representative, time and date that coverage is approved.

Office Hours: Monday through Friday 8:00 a.m. to 5:00 p.m.

After Hour Emergencies: Dr. Kavalier or a substitute is available to all patients after normal office hours for emergencies. Use the regular office phone number (267-1003) and leave a brief message that includes your name and phone number. **If the emergency is such that you cannot wait for a return call, you should go to the hospital.**

No Shows and Cancellations: A fee of $75.00 will be charged if you fail to show up for a scheduled appointment or cancel a scheduled appointment less than 24 business hours before the scheduled appointment time. Insurance plans will not cover these fees. Understand that when scheduling an appointment, you are reserving professional time in advance and that it is the Patient's responsibility to appear for scheduled appointments. Reminder calls are a courtesy. Repeated missed appointments and late cancellations will result in termination of services.

Parent Supervision: Parents/guardians are required to accompany their children to the office and to supervise them at all times.

Please Do Not Eat or Drink In the Waiting Room.

I have read and understand the K&A Billing and Office Policies set out above.

_______________________________________ _______________________________

Patient/Parent or Guardian Signature Date