P. O. Box 873
Bishop, CA 93515
760:873-6712

**CONFIDENTIAL PATIENT INFORMATION & REGISTRATION FORM**

Today's Date: ___________________________

Name: _________________________________________________ Date of Birth: ____________________

Mailing Address: _________________________________________________________________________

City: _____________________________________________ State: _______ Zip: ____________________

Phone 1: __________________________________ Phone 2: ____________________________________

Can a message be left at Phone 1? ___ Yes ___No Can a message be left at Phone 2? ___ Yes ____No

Email: ____________________________________________________________________________________

May the provider email you? ___ Yes ___ No

**OCCUPATION INFORMATION**

Occupation: _______________________________________________________________________________

**MEDICAL/EMERGENCY INFORMATION**

Primary Care Physician: _____________________________________ Phone: _____________________

Emergency Contact: __________________________________________ Phone: _____________________

AUTHORIZATION TO BILL CREDIT CARD

The undersigned patient hereby authorizes Dr. Andersen to charge the credit card provided for each visit and any late cancelled/missed appointments in accordance with the Office Policy. Dr. Andersen does not accept any form of insurance. Insurance billing shall be the obligation of the patient. Dr. Andersen will provide a Superbill after each visit for purposes of any insurance billing the patient may wish to pursue.

It is hereby agreed.

Dated: _________________________ Signature: ________________________________________

Print Name: ________________________________________

Credit Card Number: ________________________ Expiration Date: __/__ CVC ___

PSY 14114
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## OFFICE POLICY

**PAYMENT FOR SERVICE:** Patients are expected to pay for services at the time they are rendered. Patients understand Dr. Andersen will bill the credit card on file immediately following each visit or, in the event of a late cancellation or missed appointment, at the time of the scheduled visit. Patients are expected to update credit card information in the patient portal as necessary.

**INSURANCE REIMBURSEMENT:** Dr. Andersen does not take any insurance. Patients are responsible for seeking reimbursement from their insurance company. Dr. Andersen will provide patient a Superbill after each visit for use in any insurance claim the patient may wish to pursue.

**CANCELLATION:** Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24-hours notice is required to reschedule or cancel an appointment. There are no exceptions to this policy. ***The full fee of $100.00 will be charged for missed appointments without such notification. In the event Dr. Andersen cancels your appointment without a minimum of 24-hours notice he will reimburse you directly the sum of $100.00.***

Dr. Andersen

**CONFIDENTIALITY:** All information disclosed within sessions is confidential and may not be revealed to anyone without written permission except where disclosure is required by law. Additional exceptions include providing the results of treatment to your referring physician with your permission. Disclosure may be required in the following circumstances: Where there is a reasonable suspicion that the patient presents a danger of violence to others or where the patient is likely to harm him or herself unless protective measures are taken. Disclosure may also be required pursuant to a legal proceeding.

I have read and understand Dr. Andersen's office policies.

______________________________________ _______________
Print Patient Name Date

__________________________________________________________
Patient Signature (Parent Signature if patient is under 18 years of age)

KEITH J. ANDERSEN, Ph.D.
Clinical Psychology
PSY 14114
P.O. Box 873
Bishop, CA 93515
760:873-6712

# Patient Information and Consent for Teletherapy

## Introduction

Teletherapy is the delivery of mental and developmental health services using interactive audio and visual electronic systems where the provider and the Patient are not in the same physical location. The interactive electronic systems used in teletherapy incorporates network and software security protocols (encryption) to protect the confidentiality of Patient information and audio and visual data.

## Potential Benefits of teletherapy

- Increased accessibility to care
- Patient convenience

## Potential Risks with teletherapy

As with any healthcare service, there may be potential risks associated with the use of teletherapy. These risks include, but may not be limited to:

- Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate therapeutic
  decision making by provider.
- Providers may not be able to provide or arrange for emergency care that I may require.
- Delays in treatment may occur due to deficiencies or failures of the equipment.
- Security protocol can fail (although extremely unlikely) causing a breach of privacy or my confidential information.
- A lack of access to all the information that might be available in a face-to-face session but not in a teletherapy session may result in errors in therapeutic judgement.

## Alternatives to the use of teletherapy

- Traditional face to face sessions with a provider when available or possible
- Phone session with a provider

## Confidentiality Standard Required for Teletherapy

- During a teletherapy session, both locations shall be considered a Patient/provider office regardless of room's intended use.
- Both sites shall be appropriately chosen to provide audio and visual privacy.
- Rooms shall be designated private for the duration of the session with the provider and no unauthorized access shall be permitted.
- Both sites shall take every precaution to ensure the privacy of the session and the confidentiality of the Patient. All persons in the room at both sites shall be identified to all participants prior to the consultation and the Patient's permission shall be obtained for any visitors or clinicians to be present during the session.
- HIPAA confidentiality requirements apply the same for teletherapy as for face-to-face consultations.

Dr. Keith Andersen

**My Rights**

1. I understand that the laws that protect the privacy and confidentiality of therapeutic information also apply to teletherapy.
2. I understand that the video conferencing technology used is encrypted to prevent unauthorized access to my private information.
3. I have the right to withhold or withdraw my consent to the use of teletherapy during the course of my care or treatment.
4. I understand that the provider has a right to withhold or withdraw his/her consent for the use of teletherapy during the course of my care at any time.
5. I understand that all the rules and regulations which apply to the practice of mental health services in the State of California also apply to teletherapy.
6. I understand that the Patient and provider will not record any of our teletherapy sessions without prior written consent.

**Patient Consent to the use of teletherapy**

I have read and understand the information provided above regarding teletherapy, have discussed it with my provider and all of my questions have been answered to my satisfaction.
I hereby give my informed consent for the use of teletherapy in my psychotherapeutic care and authorize **Keith J. Andersen, Ph.D.** to use teletherapy in the course of my diagnosis and treatment.

**Print Patient Name: ____________________________________________**
**Signature of Patient: _____________________________________ Date: _______________**
**OR Verbal Consent Date: ___________________________________**
**(or consent of Parent/Guardian if Patient is under 18, unless minor is emancipated)**

**Provider: Keith J. Andersen, Ph.D.**
**Signature of Provider: _____________________________________ Date: _______________**

**My Responsibilities**

1. I will not record any teletherapy sessions without prior written consent from the provider.
2. I will inform the provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins.
3. I understand that third parties may be required to join in the meeting with my provider and me to provide technical support. I understand that I may be asked to interact with the technical support person on camera in order to fix the problem. I understand that if I decline this request and my equipment is rendered unusable for video conferencing, I may forfeit my option to use teletherapy.
4. I understand that I, not the provider, am responsible for the configuration of equipment on my computer which is used for teletherapy. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins. I understand that I may need to contact a designated third party (secure telehealth) or technical support to determine my computer's readiness for teletherapy prior to beginning teletherapy sessions with my provider.
5. I understand that if I need emergency mental health services, I should contact my local emergency provider at 911.

Dr. Keith Andersen

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# Medical Privacy Notice
# HIPAA
# Health Insurance Portability Accountability Act

In 1966, Congress passed a series of legislative acts designed to assure the security and confidentiality of medical records and information. This legislation is collectively known as HIPAA. All medical facilities and providers are required to comply with these requirements as of April 14, 2003.

## Permitted uses and disclosures of your medical information

1. Treatment, payment and healthcare operations
2. To communicate with your physicians and health care providers
3. To communicate with your insurance company for authorization and payment purposes
4. Under rare circumstances to comply with court orders, police or national security directives
5. To comply with public health directives laws and regulations

## Other disclosures or uses of your personal health information (PHI) require your written permission.

## You are entitled to

1. Inspect, copy or amend your medical information.
2. Restrict the use of your medical information by informing us in writing.
3. File a written complaint with the office if you feel your medical privacy rights have been violated

## We are additionally required to

- Post a copy of our policy in the waiting area
- Maintain a written privacy policy for the practice and provide you with a copy upon request
- Request that you read and sign a copy of this notice, which will be placed in your chart
- Provide you with the information required to file a privacy complaint with our office or with the federal Office of Civil Rights (OCR) on request

I acknowledge I have been given this form, offered a copy of the privacy policy and had the opportunity to ask any questions.

______________________________________________

Print Name and Signature                    Date