WILLOW MEDICAL
& wellness

Patient Registration Packet for PSYCHOLOGICAL TESTING

Date: _____ **Name:** _____
(Last) **(First)** **(Middle)**

DOB_____ Age_____ _____Male _____ Female_____Other:_____

Mailing Address _____
Address (City) (State) (Zip Code)

Physical Address_____
(if different than above) Address (City) (State) (Zip Code)

Home phone _____ Work phone _____ Cell _____

Email address_____ Social SecurityNumber_____

Patient Employer _____ Insured's Employer _____

Insured's Name _____ Insured's Birth Date _____

Secondary Insured's Name _____ Secondary insured's Birth date _____

Additional family members who have permission to contact us regarding appointments

_____

Phone number we may use to contact you and leave messages : _____

Preferred method of appointment reminder (please check): **Call**_____ **Text**_____ **or Email**_____

*Appointments not confirmed **may** receive a **courtesy** reminder call the day before appointment. Please do not rely on this as your only reminder.*

Emergency contact people that we may call **without a release of information** should you require emergency care or intervention regarding your safety.

_____ _____
(Name) (Contact Number)

INSURANCE BILLING IS PROVIDED AS A COURTESY. PLEASE BE SURE YOU HAVE CONTACTED YOUR INSURANCE FOR ANY PREAUTHORIZATION REQUIREMENTS AND TO DETERMINE YOUR BENEFITS.

YOU ARE REQUIRED TO KEEP OUR OFFICE UP TO DATE WITH YOUR CURRENT INSURANCE. IF YOUR POLICY CHANGES OR YOU ADD ADDITIONAL INSURANCE WE MUST BE NOTIFIED. WE WILL NOT BILL FOR CHANGES OVER 90 DAYS OLD.

Insurance information

Please provide a copy of your medical insurance card (front and back) and a photo ID to our front staff. To send electronically, you may use our UPLOAD link to send this information directly and securely to our office.

Primary Insurance Information:

Insurance Company _____ Policy Holder Name _____

Policy I.D. # _____ Group I.D. # _____

Policy Holder SS # _____ DOB _____

Relationship to client _____

Secondary Insurance Information:

Insurance Company _____ Policy Holder Name _____

Policy I.D. # _____ Group I.D. # _____

Policy Holder SS # _____ DOB _____

Relationship to client _____

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Medical Practice Commitments and Expectations for PSYCHOLOGICAL TESTING

Welcome to Willow Medical & Wellness. Our primary goal is to provide all of our patients with the best care possible in an effective and efficient fashion. Establishing commitments and expectations at the start of our work together will ensure a mutually satisfying treatment relationship. Please review the following items and sign at the end of the document to indicate your agreement with the terms. If you have any questions or concerns, please let us know so that we may address them.

_____ (Initial please) Keeping Appointment

Keeping your appointment is integral to the assessment process. We recognize that things can come up and sometimes make it difficult to keep your appointment. Please let us know as quickly as possible so that we can reschedule your appointment and offer that time to another patient. We do ask for 72 hours notice for a cancellation or rescheduling. (For example, if your appointment is Thursday at 1:30 pm we request that you call by Monday at 1:30 pm.) We consider a late cancelled appointment to be the same as a missed appointment. Reminder calls are made as a *courtesy* and are not guaranteed. The fee for a missed appointment or late cancellation is **$500** (credit card deposit required to schedule appointment). Insurance will not cover "No Show" fees and must be paid prior to rescheduling. It is our clinic policy to refer patients to other qualified provers when there have been two missed appointments or late cancellations. Should this occur, Willow Medical & Wellness will be happy to provide referral names and contact numbers of alternative providers who may better suit your needs

_____ (Initial please) Payment for Services

We require payment of the portion of your bill not covered by your insurance at the time of service. Legal means to secure payment will be considered if necessary. This may involve hiring a collection agency, although we prefer not to use this option. All fees associated with this will be charged to the client. If your account is sent to collections we will no longer be able to continue treatment.

_____ (Initial please) Purpose of Treatment/Testing

I understand that the purpose of my psychological testing is for my personal emotional/ physical health & wellbeing. Treatment goals/recommendations will be between myself, my referring provider, and Dr. Stephanie Richardson as a result of the intake, testing and assessment process. My treatment is not intended to be used for litigation purposes. I agree not to request that my provider release my medical records for litigation purposes and I agree not to call her to serve as a witness in any litigation I am currently involved in or any litigation I become involved in.

_____ (Initial please) Collaboration of Care

Your providers may collaborate care between each other and with other providers in the office. The administrative staff may also be asked to coordinate care between clinicians in the office or outside of the office depending on what is needed, this may be calling other clinics for availability, sending referrals or requesting records as needed. No protected health information will be shared with outside providers without a signed ROI.

_____ (Initial please) Clinic Property

Willow Medical and Wellness is a smoke free property. Please refrain from smoking on the property. We also respectfully request that you refrain from bringing in any weapons onto the clinic premises as we do see children, adolescents, and many of our adult clients have significant trauma issues. If you have questions about this request, please bring this to the attention of your treating provider. We appreciate your cooperation.

_____ (Initial please) Contacting the Clinic

You may reach us during business hours at (907) 222-0753. Our fax number is (907) 222-0754. Our hours of operation are Monday – Thursday 9:00 AM to 6:00 PM and Friday 9:00 AM to 5:00 PM. If we do not answer the phone during our regular office hours we are either on the phone or away from the desk momentarily. Please feel free to leave a message and we will get back to you as soon as possible.

If you are calling after hours, please leave a message and we will get back to you the next business day. Please note that we are closed all major holidays and are often closed the day prior or the day after depending on what day of the week the holiday falls on.

If you are experiencing a life-threatening emergency please call the local Community Crisis Line, at (907) 563-3200, call 911 or proceed to the nearest emergency room. Help is also available dialing the **988** Suicide and Crisis Lifeline.

_____ (Initial please) No Surprises Act

OMB Control Number [0938-1401]

Expiration Date [05/31/2025]

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the law, health care providers need to give patients ***who don't have insurance or who are not using insurance*** an estimate of the bill for medical items and services.

You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.

Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service. If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill. Make sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call [907-222-0753]

_____ (Initial please) HIPAA Notice of Privacy Practices

I hereby acknowledge receipt of Willow Medical & Wellness Notice of Privacy Practices. (Client Form #11 on website). You may request a printed copy. I understand that the Notice describes how my personal protected health information may be used and disclosed, as well as how I may gain access to my protected health information.

I HAVE REVIEWED THE COMMITMENTS AND EXPECTATIONS DOCUMENT AND AGREE TO ABIDE BY THEM WHILE I AM WORKING WITH WILLOW MEDICAL & WELLNESS.

_____

Patient Signature Date

920 E 72nd Avenue Anchorage, Alaska 99518 ● Phone: 907.222.0753 ● Fax: 907.222.0754

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CONSENT FOR PSYCHOLOGICAL TESTING ASSESSMENT

Please read this document carefully as your initials/signature will represent an agreement between you and Willow Medical & Wellness.

The Appointment: *Please allow 4-6 hours with a one hour lunch break on the appointment day. You are welcome to bring water and/or snacks. You can take breaks as needed during the testing process (in addition to the lunch break)*

- **The Morning Session:** 9:00am-12:00pm
  The appointment starts with a meeting with Dr. Richardson to talk about what led you to seek this assessment, and how you hope it will be helpful. She will also ask you some questions about your medical, psychological, and social history. You are welcome to have a family member, significant other or referring medical provider present during this part of the assessment to help provide information and to offer support.

  The second part of the appointment is participation in specific activities to examine your mental and emotional experiences. During this part of the assessment, others may not be present. Dr. Richardson will introduce various activities and standardized tests. You do not need to study ahead for this. You cannot fail the activities or testing. All you need to do is give your best effort. The goal is for the assessment outcome to reflect your life experiences and functioning on a daily basis.

- **Lunch Break:** 12:00pm to 1:00pm
  Please utilize this time to rest, nourish, and relax to allow for a physical and mental break from testing day.

- **The Afternoon Session**: 1:00pm –3:00pm
  The final part of the appointment will be used to complete any remaining assessment activities or tests.

- **The Feedback Session:** 60 min (2 weeks after first appointment).
  After the assessment, you will have a 2-week follow-up appointment with Dr. Richardson to review the results. Please feel free to invite your family member, significant other and/or referring medical provider to this appointment. Dr. Richardson will discuss the patterns identified during the assessment, information regarding any DSM-V-TR/ICD-10 diagnosis, and provide recommendations about how this information can be used to improve your quality of life. You will receive a written report regarding the assessment.

_____**(Initial)** A $500 non-refundable deposit is required when the assessment appointment is scheduled. With the completion of the appointment, the deposit will be applied to insurance deductible, co-pay, or coinsurance. Any remaining funds will be refunded to you.

_____**(Initial)** All communication is confidential *unless* there is a high, immediate risk of suicide or homicide; or if suspected abuse, neglect, or exploitation of a child or vulnerable adult is reported. Alaska state law requires Dr. Richardson to report these situations. Recording devices are not allowed during any part of the appointment.

_____ **(Initial)** I understand that I have the right to end the evaluation whenever I wish. I understand that Dr. Richardson also has the right to end the assessment at any point if there are immediate safety concerns, or if she should become aware of any pending litigation. (i.e., open custody/divorce cases, contested guardianship, worker's compensation case, etc). *This assessment is for diagnostic and treatment planning purposes only*, *not for past, current or future legal claims or forensic evaluations.*

_____ **(Initial)** I understand that if the assessment process is not completed (due to my decision or Dr. Richardson's decision), Dr. Richardson will be unable to provide an assessment report, any diagnoses, or treatment recommendations. I understand that I will be responsible for the time/ services provided and that my insurance will not be billed.

I, _____ (Full Name), have reviewed the consent information above. I understand that I will have an opportunity to ask further questions regarding this process/consent with Dr. Richardson at the first appointment. My signature below represents, with my full authority, voluntary consent to the Psychological Testing Assessment.

_____

Patient Signature **Date**

RELEASE OF INFORMATION

WILLOW MEDICAL
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CLIENTS NAME:_____Date of Birth:_____
First Name Last Name

Today's Date: _____

Requesting Entity:	Releasing Entity:_____
Willow Medical & Wellness 920 East 72nd Avenue Anchorage AK 99518 Tel: 907.222.0753 Fax: 907.222.0754	_____ Street Address _____ City / State / Zip _____/_____ Fax Phone

_____(initial) I authorize this release to be reciprocal between the two parties.

INFORMATION AUTHORIZED FOR RELEASE

- ☐ Psychological Evaluations/Reports
- ☐ Psychiatric Evaluations/Reports
- ☐ Physical / Medical Records / Med. List
- ☐ Lab Results
- ☐ Radiology Reports (CT/MRI)
- ☐ Emergency Reports
- ☐ Psychotherapy Notes
- ☐ Social History
- ☐ Vocational/ Work Information
- ☐ Discharge Summary (ies)
- ☐ Verbal Information
- ☐ Any documents which may include information regarding **HIV status**.
- ☐ Any documents which may include information regarding **chemical dependency.**
- ☐ Other _____

I hereby authorize the above information to be released to the party I have indication for the purpose of:
☐ continuity of care ☐ other:_____
I retain the right to revoke this authorization in writing prior to the expiration date below.

Treatment may not be conditioned on obtaining the authorization if that is prohibited by the HIPPA Privacy Rule. The information disclosed pursuant to this authorization may be subject to re-disclosure by the designated recipient, and subsequently no longer protected by the HIPAA Privacy Rule.

*I understand that authorizing the disclosure of the above information is **voluntary** and I need not sign this form to ensure treatment.*

_____ _____
Signature of Client or Client's Designee *Designee's Relationship to Client*

_____ _____ *TO* _____
Witness *Date Authorized* *Date Authorization ends*