TINA DICICCO REYNOLDS, PSY. D.
LICENSED CLINICAL PSYCHOLOGIST

Thank you for contacting me to address some of the issues that are concerning you.

Before our first session, it is necessary to read over and complete the initial paperwork. In this packet, you will find important information regarding the scope of services, as well as information about confidentiality and payment.

Please take the time to fill out this information and bring it with you to your first visit.

The following forms are enclosed:

- **Client Information and History Form:** This provides information about you, your current concerns, and history.
- **Consent and Psychological Services Agreement:** This form indicates that you are voluntarily seeking services and what therapy entails. Please review, initial each point, and sign at the bottom.
- **Health Insurance & Consent Form (for clients using insurance):** Please complete as much information as possible
- **Payment Contract for Services:** This form can be completed during our first session. It covers what the approximate rate of each session is (if you are paying out of pocket) or what your portion of out of pocket payment is (if you are utilizing insurance as well as benefits from your insurance company).
- **The Notice of Mental Health Practitioner's Policies & Privacy Practices to Protect the Privacy of Your Health Information (HIPAA):** This form is standard for any healthcare provider and is required by HIPAA law. It discusses your protected health information (PHI). Please keep the three pages of the HIPAA policy for your records (pages 7-9 in this packet).

Please bring your Driver's License or valid picture ID and Insurance Card to our first appointment so a copy can be made for your record.

I will be happy to discuss any questions that you may have during our first session.

Thank you,

Tina DiCicco Reynolds, Psy.D.
Licensed Clinical Psychologist
PY 7384

TINA DICICCO REYNOLDS, PSY. D.
LICENSED CLINICAL PSYCHOLOGIST

CHILD INFORMATION & HISTORY FORM Today's Date: _____

Child's Name: _____ Date of Birth: _____ Gender:_____

Address: _____ Age:_____ Grade:_____

_____ Email address: _____

Parent 1 Name: _____ Name of School:_____

Parent 1Preferred Phone Number: _____ Teacher's Name:_____

Parent 2 Name: _____ Who is child's legal guardian: _____

Parent 2 Preferred Phone Number: _____ Guardian Driver's License#:_____

Emergency Contact other than parents/guardians:

Name: _____ Relationship:_____

Address: _____ Phone Number: _____

_____

I consent and authorize Dr. Tina DiCicco Reynolds to contact the above-designated person in the event of an emergency.

Signature: _____ Date:_____

Reason that you are seeking treatment for your child at this time

_____

_____

List any recent stress/challenges/life events _____

_____

Has your child experienced any of the following in the past year?

Inattention	_____	Behavioral Problems	_____	Oppositional Behaviors	_____
Impulsivity	_____	Anxiety	_____	Aggressiveness	_____
Depression	_____	Difficulty with Peers	_____	Substance Abuse	_____
Mood Swings	_____	Weight Loss/Gain	_____	Academic Difficulties	_____
Low Self Esteem	_____	Tantrums/outbursts	_____	Other_____	

Medical History

Pediatrician:_____ Phone Number:_____

Current Medications & Dosages: _____

Allergies or other significant medical information: _____

_____

Previous Therapy/Psychiatric Medications (date/reason/name)_____

_____

Developmental History

Any complications or problems during pregnancy or birth:_____

_____

Any developmental delays? ☐ No ☐ Yes If yes, please describe: _____

_____

Any current bedwetting concerns: ☐ No ☐ Yes If yes, please describe: _____

_____

Any speech, hearing, or language difficulties ☐ No ☐ Yes If yes, please describe: _____

_____

Family History

Describe current living situation:_____

_____

If parents are divorced, what is custody arrangement? _____

Siblings (Names/ages):_____

Briefly describe child's relationship with parents/siblings: _____

_____

History of physical or sexual abuse, violence, or neglect? ☐ No ☐ Yes If yes, please describe: _____

_____

History of psychiatric/psychological disorders on family: ☐ No ☐ Yes If yes, please describe: _____

_____

History of substance abuse in family: ☐ No ☐ Yes If yes, please describe: _____

_____

History of suicide in family: ☐ No ☐ Yes If yes, please describe: _____

_____

Education History

What kind of grades does your child usually earn: _____

Placement in special classes? ☐ No ☐ Yes If yes, please describe:_____

Grades repeated: ☐ No ☐ Yes If yes, please describe: _____

Behavioral problems at school: ☐ No ☐ Yes If yes, please describe: _____

_____

Recreation/Social Activities/Social Support

Hobbies/Interests/Activities:_____

_____

How does your child get along with peers: _____

_____

Any legal history: ☐ No ☐ Yes If yes, please describe: _____

_____

Any concerns about substance use? ☐ No ☐ Yes If yes, please describe_____

_____

Please describe any other relevant information: _____

_____

_____

_____

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Consent and Psychological Services Agreement

Please read and initial each section and sign on the bottom of the page:

_____ I am voluntarily choosing to seek psychological services for _____, a minor or person under my legal guardianship, with Tina DiCicco Reynolds, Psy.D. The rights, risks, and benefits associated with psychological services have been explained to me. I understand that at any time, I have the right to discontinue psychological services.

_____ I certify that I am the parent/guardian of _____, a minor or person under my legal guardianship, and that I am authorized to make medical decisions for this person. If any split or shared custody or shared guardianship agreement exists, I certify that I have notified the other party and they agree to this treatment. I will provide Dr. Tina Reynolds with a copy of the parenting plan and/or custody order.

_____Confidentiality of client records is protected by Federal and/or State laws and regulations. Current law requires clinicians to maintain complete confidentiality of information revealed in treatment as well as attendance or involvement in services, without written consent. Unless the disclosure is, 1) court ordered by a judge, 2) if Dr. Reynolds has reason to suspect potential for immediate harm to self or others, or 3) if Dr. Reynolds has reason to believe a child, elderly person, or handicapped adult, has been or is at risk for abuse or neglect. In any of the above-mentioned circumstances, normal assumptions of confidentiality will not apply and Dr. Reynolds is mandated by law to report these concerns

_____ Payments, copayments, and deductibles are due at the time of service. All fees are due at the beginning of each session. I understand that if I am using an insurance plan, payment by insurance company cannot be guaranteed therefore I accept responsibility for unpaid balances not covered by my insurance company.

____I acknowledge that since my appointment time has been reserved exclusively for me, I am required to cancel or reschedule appointments at least 24 hours in advance to avoid a $55 cancellation fee. I am aware that my insurance company will not pay for missed appointments.

____I understand that Dr. Tina DiCicco Reynolds does not provide on-call service. If I need to contact Dr. Reynolds between my sessions, I will leave a message and she will return my call in a timely manner. If an emergency arises, in which I believe that I am a danger to myself or others or my child may be a danger to him/herself or others, I must call 911, Henderson Mental Center Crisis Response Team (954) 463-0911, or go to the nearest emergency room.

____ I have received a copy of this form for my records.

My signature below indicates that I have read, understand, and agree to abide by the above stated policies and agreement.

_____ _____

Print Name Signature Date

My signature below acknowledges that I have received a copy of Notice of Mental Health Practitioner's Policies and Privacy Practices regarding the use and disclosure of my Protected Health Information. My signature authorizes Dr. Tina DiCicco Reynolds to bill my insurance carrier and to communicate with my insurance carrier under the limitations of the HIPAA notice.

_____ _____

Print Name Signature Date

TINA DICICCO REYNOLDS, PSY. D.
LICENSED CLINICAL PSYCHOLOGIST

Health Insurance Information and Consent

Patient's Name _____ Date of Birth _____
Primary Insurance Company_____
Insurance Company Contact Number(s)_____
Policy Number _____ Group Number_____
Name of Insured _____ Insured's Date of Birth_____
Insured's SS Number _____ Employer _____
Patient's relationship to Insured: Self ( ) Spouse ( ) Child ( ) Other ( )

Do you have secondary insurance? If so, please complete the following:
Secondary Insurance Company_____
Insurance Company Contact Number(s) _____
Policy Number _____ Group Number_____
Name of Insured _____ Insured's Date of Birth_____
Insured's SS Number _____ Employer _____
Patient's relationship to Insured: Self ( ) Spouse ( ) Child ( ) Other ( )

I authorize Dr. Tina DiCicco Reynolds to obtain insurance benefits, submit claims, and receive payments of medical/mental health benefits on my behalf. By choosing to use my insurance for psychological services, my practitioner may be required to release certain information to the insurance company at their request. Information, which may be requested, includes types of services, dates/time of services, diagnosis, treatment plans, descriptions of impairment, progress of therapy, and, at times case notes and summaries. If it is the case that my insurance company utilizes a managed care company, my therapist/examiner may need to discuss my treatment with a case manager. I understand that my confidentiality may be compromised in such a case. I realize that his/her doing so is a necessity in the efforts to secure ongoing care.

_____ _____
Patient's Name Date

_____ _____
Insured's Signature (If different than patient) Date

_____ _____
Parent/Guardian's Signature Date

TINA DICICCO REYNOLDS, PSY. D.
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PAYMENT CONTRACT FOR SERVICES

Name_____

Address_____

Person Responsible for Payment of Services Relationship to Client:_____

Name_____

Address_____

Federal Truth in Lending Disclosure Statement for Professional Services

Part One: - Fees For Professional Services / Self Pay Arrangements

I (we) agree to pay Dr. Tina DiCicco Reynolds, a rate of $_____, per clinical session (defined as 45-50 minutes for assessment, testing and individual or family counseling. **I (we) agree to pay a fee of $55 for any appointments canceled less than 24 hours prior to the appointment.**

Part Two: Fees for professional services with insurance (deductible and copay agreement)

The following amounts are only an estimation of benefits based on what either you or your insurance company provided. There may be changes once a claim is processed by the insurance company as outlined in the explanation of benefits.

Estimated Insurance Benefits

1) Deductible Amount (Paid by Insurance Party): _____
2) Co payment (intake): _____ 3) Copayment (f/u) sessions: _____
4) The number of visits: _____ per _____ 5) Authorization after _____

The person responsible for payment shall make payments for services, which are not paid by insurance company, all copayments, and deductibles. Insurance companies may not pay for services that they consider non-efficacious, not medically or therapeutically necessary, or ineligible (not covered by the insurance company). If the insurance company does not pay the estimated amount then you are responsible for the balance.

Part Three: All Clients

Payments, co-payments, and deductible amounts are due at the time of service.

I hereby certify that I have read and agree to the conditions.

_____ _____

Client Name Signature Date

_____ _____

Print Name Person Responsible for Payment (If different) Signature Date

TINA DICICCO REYNOLDS, PSY. D.
LICENSED CLINICAL PSYCHOLOGIST

FLORIDA NOTICE FORM

Notice of Mental Health Practitioner's Policies & Privacy Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION

ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TOTHIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The law requires that you be provided with this Notice of the legal duties and the privacy practices with respect to your PHI (Protected Health Information). Dr. Reynolds is committed to maintaining the privacy of your health information and Dr. Reynolds has implemented numerous procedures to ensure that Dr. Reynolds does so.

Florida Law and Health Insurance Portability & Accountability Act of 1998 (HIPAA) require practitioner's to maintain the confidentiality of all your health care records and other individually identifiable health information used by or disclosed to us in any form, whether electronically, on paper, or orally, is a federal law that gives you significant new rights to understand and control how your health information is used.

I. USES AND DISCLOSURES FOR TREAMENT, PAYMENT, AND HEALTH CARE

OPERATIONS

Your **protected health information** (PHI) may be **used** or **disclosed for treatment, payment,** and **health care operation purposes** with your **consent.** In order to provide you with or coordinate health care treatment and services, Dr. Reynolds may review your health history to form a diagnosis and treatment plan, consult with other practitioners about your care, delegate tasks to ancillary staff, disclose needed information to your family or others so they may assist you with home care, arrange appointments with other providers, etc.

In order to bill or collect payment from you, an insurance company, a managed care organization, a health benefits plan, or a third party may need to verify your insurance coverage. Dr. Reynolds may also need to submit your PHI on claim forms in order to be reimbursed for our services, obtain pre-treatment estimates or prior authorizations from your health plan. You may be contacted by telephone, mail, or e-mail. Please inform the office of the numbers that you want to be reached at and the procedure, you want us to follow when or if another individual answers the call. Dr. Reynolds will automatically leave a message with the numbers you provide and mail information to the address you list us unless you indicate otherwise.

II. USES AND DISCLOSURES REQUIRING AUTHORIZAION

You may request **"authorization"** to use or disclose information for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An **"authorization"** is written permission beyond the general consent that permits only specific disclosures. In those instances when your practitioner is asked for information for purposes outside of treatment, payment, and health care operation, they will obtain an authorization from you before releasing your psychotherapy notes.

"Psychotherapy notes" are notes that have made about conversations during a private, group, joint, or family counseling session, consultation, or testing administration which have been 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 in writing. You may not revoke an authorization to the extent that (1) the practitioner has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer to the right to contest the claim under the policy.

III. USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

Exceptions to maintaining privacy occur under state law and under strictly limited circumstances. Under these circumstances, your PHI may be used or disclosed without your permission, consent, or authorization for the following purposes:

Serious Threat to Your Health or Safety or the Health or Safety of Other Persons: When you present a clear and immediate probability of physical harm to yourself, to other individuals, or to society, communication and relevant information concerning this to the potential victim, appropriate family member, or law enforcement or other appropriate authorities will be disclosed.

Child Abuse: If there is a reasonable cause to suspect, that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver or other person responsible for the child's welfare, the law requires that the practitioner report such knowledge or suspicion to the Florida Department of Child and Family Services.

Adult and Domestic Abuse: If there is a reasonable cause to suspect that a vulnerable adult (disabled or elderly) has been or is being abused, neglected, or exploited, the law requires the practitioner to report such suspicion to the Central Abuse Hotline.

Health Oversight: If a complaint is filed against your mental health practitioner with the Florida Department of Health on behalf of the Board of Psychology, the Board of Clinical Social Work, Marriage & Family Therapy & Mental Health Counseling, or Florida Board of Medicine and Nursing, the Department has the authority to subpoena confidential mental health information from the practitioner relevant to that complaint.

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

Worker's Compensation: If you file a worker's compensation claim for a work related injury or illness, your PHI, and relevant records must be furnished upon request of your employer, the insurance carrier, an authorized qualified rehabilitation provider, or the attorney for the employer or insurance carrier.

To Family Members, Friends and Others: If you are in an emergency situation involving you or another person (e.g. your minor child) and you cannot consent to your care because you are incapable of doing so or you cannot consent to the other person's care because, after a reasonable attempt, Dr. Reynolds has been unable to locate you, Dr. Reynolds may, based on professional judgment and the surrounding circumstances, determine that disclose is in the best interests of you or the other person. In these emergencies, your PHI will be disclosed, but only as it pertains to the care being provided and you will be notified of the specific disclosures as soon as possible after the care is completed.

IV. PATIENT'S RIGHTS

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, Dr. Reynolds is 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 being seen. Upon your request, your bills will be sent to another location).

Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI in the mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. On your request, your practitioner will discuss with you the details of the request process.

Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. This request may be denied. On your request, you will have a discussion with your practitioner about the details of the amendment process.

Right to **an Accounting:** You generally have the right to receive an accounting of disclosures of PHI regarding you. On your request, you practitioner 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 even if you have agreed to receive the notice electronically.

V. COMPLAINTS

If you are concerned that your privacy rights have been violated, or you disagree with a decision that was made about access to your records, you may contact the Security of Department of Health & Human Services. There will not be any retaliation against you for exercising your right to file a complaint.

VI. EFFECTIVE DATE RESTRICTIONS AND CHANGES TO PRIVATE POLICY

This notice is currently in effect and has been so since May 1, 2006. Your practitioner reserves the right to change the terms of this notice at any time as authorized by law and to make the new notice provisions effective for all PHIs that the office maintains. The changes will be effective immediately. If changes are made, they will be posted along with its effective date, in the business office. In addition, upon request, you will be given a copy of the current Notice.