KRISTOPHER L. WALTON & ASSOCIATES, LLC
1536 Midway Avenue Ammon, ID 83406
(208) 403-0135 Fax: (208) 441-1794

PATIENT INFORMATION

Date_____

Name_____S.S. #_____
Last First Initial
What name do you prefer being called (i.e. Kathleen, Kathy)_____

Address_____ Phone_____

City_____State_____Zip_____

Sex M F Age_____ Birthdate_____/_____/_____ Single Married Widowed Divorced Separated

Name/Relationship/Age of person(s) with whom you live_____
Employer_____ Occupation_____ Work Phone_____
Highest level of Education_____ College Degree (if applicable)_____
Whom may we thank for referring you?_____
In case of emergency who should be notified?_____Phone_____

RESPONSIBLE PARTY

Name_____S.S. #_____

Address_____Phone_____

City_____State_____Zip_____

Sex M F Age_____ Birthdate_____/_____/_____ Single Married Widowed Divorced Separated

Employer _____ Occupation_____
Work Address_____ Work Phone_____

PRIMARY INSURANCE

Insurance Company Name_____

Policy/ID number _____ Group Number _____ Phone Number _____

Policy Holder_____ Birthdate_____/_____/_____ Phone_____
Address (if different than responsible party)_____

ADDITIONAL INSURANCE

Insurance Company Name_____

Policy/ID number _____ Group Number _____ Phone Number _____

Policy Holder_____ Birthdate_____/_____/_____ Phone_____
Address (if different than responsible party)_____

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FINANCIAL POLICY AND CONTRACT FOR SERVICES

We are dedicated to providing you with the best possible care and service, and regard your understanding of my financial policies as an essential element of your care and treatment. To assist you, I have the following financial policy. If you have any questions, please feel free to discuss them with me or my staff.

Kristopher L. Walton & Associates, LLC does not accept Medicare or Medicaid.

Payment is expected at the time of service unless prior financial arrangements have been made in advance. All co-payments or private pay fees will be collected when you arrive for your appointment.

As a courtesy to you, we prepare and forward your insurance claim forms. We are willing to work with you regarding payments for the services provided. If arrangements need to be made, please talk to me or my staff. *We do require a minimum monthly payment of $25.00*. We do charge an interest fee of 1.5% (18% annual rate) for all accounts over 90 days past due. If payments are not received on a monthly basis for the amounts agreed upon, the account can and will be placed with an outside collection agency. If this account is assigned to an outside agency for collection, collection costs will be an additional 1/3 of your balance if sent to collections and no court costs. It will be an additional ½ of your account balance if balance is collected through the court system. I agree to pay all attorney's fees, court costs, and charges or commissions of 50% that may be assessed to us by the collection agency retained to pursue this matter, with or without suit.

I understand that regardless of insurance coverage, I am responsible for all charges and payments.

MINOR CLIENTS: For all services rendered to minor clients, the adult accompanying the client is responsible for payment. If your child comes in alone, please send payment for services with them.

I authorize all employees of **Kristopher L. Walton & Associates, LLC** to receive assignment of insurance payments. Employees of **Kristopher L. Walton & Associates, LLC** are hereby authorized to release medical information to my health insurance company that may be necessary for processing of this claim.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____ _____

Responsible Party Signature Relation to Patient Date

_____

Witness Date

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PATIENT INFORMATION AND CONSENT

Confidentiality from Third Parties

Psychotherapy is confidential from parties other than parents with important exceptions:

1. Information may be released to designated parties by written authorization of clients, parents, or legal guardians.
2. When clients seek reimbursement for psychotherapy from insurance companies or other third parties, information, including psychological diagnoses, and in many cases, explanations of symptoms and treatment plans, and in rare cases, entire client records, must be provided to the third party. If health coverage is provided by the employer, the employer may have access to such information. Insurance companies usually claim to keep psychological diagnoses confidential, but may enter this information into national medical information databanks, where it may be accessed by employer, other insurance companies, etc., and may limit future access to disability insurance, life insurance, jobs, etc. Your therapist will provide you with copies of reports submitted to insurance companies at your request.
3. Psychotherapist are required to release information obtained from you or from collateral sources (other individuals involved in a client's psychotherapy, such as parents, guardians, spouses) to appropriate authorities to the extent to which such disclosure may help to avert danger to a psychotherapy client or to others, e.g., imminent risk of suicide, homicide, or destruction of property that could endanger others.
4. Psychotherapists are required to report suspected past or present abuse or neglect of children, adults, and elders, including children being exposed to domestic violence, to the authorities, including Child Protection and law enforcement, based on information provided by the client or collateral sources.
5. If clients participate in psychotherapy in compliance with a court order, psychotherapists are required to release information to the relevant court, social service, or probation departments.
6. Your psychotherapist must release information, which may include all notes on your psychotherapy and contact with collateral sources, in response to a court order, and may also be required to do so in response to a legitimate subpoena.
7. Psychotherapists reserve the right to release financial information to a collection agency attorney, or small claims court, if you are delinquent in paying your bill.
8. Cell phone and e-mail communication can be intercepted by third parties. These forms of communication are reserved for urgent or time-sensitive matters. Psychotherapists are required to make a record of each client contact. E-mail communication are printed in full and become part of a client's file.

Initial here if this section has been read and understood_____

9. Psychotherapists often consult with other professional on cases, and teach or write about the psychotherapy process, but disguise identifying information when doing so. Please indicate to your therapist if you wish to place restrictions on consultation, teaching, or writing related to your case.

Initial here if this section has been read and understood_____

Professional Records

Psychotherapy laws and ethics require that Idaho licensed psychotherapists keep treatment records. Professional records can be misinterpreted and/or upsetting to untrained readers. You are entitled to receive a copy of these records unless your therapist believes that seeing them would be emotionally damaging to you, in which case your therapist will review them together with you, or will send them to a mental health professional of your choice, to allow you to discuss the contents. Client will be charged copying costs plus $150.00-per-hour for professional time spent responding to information requests.

Your record includes a copy of the signed informed consent form, acknowledgement of receipt of privacy policy and practices, progress notes, any release of protected health information, and copies of your super bill. Records are kept in a locked file cabinet.

Initial here if this section has been read and understood_____

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Fees for Psychotherapy

Psychotherapy sessions and collateral contact: $165 for initial intake evaluation, $150 per 45-50 minutes, including any time missed by being late. Payment is due at each session.
Phone calls/Crisis calls: $37.50 per 15 min conversation. This service IS NOT billable to insurance and 100% the responsibility of the client or responsible party.
Letters and reports: $150.00-per-hour.
Attendance and Participation in school IEP meeting: $150.00-per-hour. Travel time is charged at hourly rate as well, but adjusted if travel is less than one hour.

I understand that payment is due at the end of each session. I agree to cooperate with procedures required to collect from third-party payers. If I receive a third-party payment, I agree to turn it over to my therapist as soon as possible.

Initial here if this section has been read and understood_____

Appointments

Office visits are by appointment only Monday thru Friday from 8am to 6pm. Office visits take approximately 45-50 minutes. When you call for an initial appointment, you will be asked few questions regarding the nature and urgency of your concern or problem.

Initial here if this section has been read and understood_____

Cancellations

I understand that my psychotherapist reserves an appointment time for me. **I agree to call 24-hours in advance** if I must cancel a session in order to allow my therapist to reschedule his time. If I provide less than 24 hours' notice of a cancellation, unless a sudden emergency has occurred, I will pay the fee of $25.00 for the first missed session and $150.00-per-missed-session following.

Initial here if this section has been read and understood_____

Emergencies

My therapist agrees to furnish me with their emergency contact number. My therapist is not always immediately available by phone and may not be available until the late evening. If unavailable, my therapist will return my call as soon as possible. If I cannot reach my therapist, I can call the 24-hour Crisis Team at Eastern Idaho Regional Medical Center; Behavioral Health Unit at (208) 227-2100, or Region VII Mental Health Office at (208) 528-5717, or call 911. When my therapist is out of town, and if I am not also seeing another mental health professional, such as a psychiatrist, my therapist will provide me with phone numbers of alternate sources of help.

Initial here if this section has been read and understood_____

Length of Psychotherapy

Some psychological problems can be alleviated in a few sessions, while others require more time. It is often difficult to predict the length of therapy needed. Talk to your therapist if you have any questions. Some disorders cannot be properly treated with the limitations of some health insurance policies. Generally, hospitalization should be as brief as possible to limit disruptions to a client's life. The decision to terminate therapy belongs to the client. Terminating therapy with a client should be done over a number of sessions, particularly in cases of a long-term therapeutic relationship. Should you decide to terminate therapy prior to the therapist's recommendation, it is important that you have a final meeting with your therapist. If your therapist believes you are terminating your therapy before adequate treatment has been received for your psychological problems, your therapist will provide you with referrals for other therapist or you may choose to continue therapy with your current therapist. Some managed health care plans provide benefits for only a time-limited course of psychotherapy. Some companies have contracts with therapists that prohibit clients to remain in therapy with a therapist beyond the designated time-frame. If your therapist believes you need further psychotherapy after this period, your therapist will provide referrals to other therapists with whom you can continue treatment.

Initial here if this section has been read and understood_____

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Termination

Your therapist has the right to close your case after trying to contact you by phone two (2) times if you do not return to therapy

Initial here if this section has been read and understood_____

Alternative Treatments

Other treatment approaches are available as an alternative, or as an adjunct, to individual psychotherapy. These include family therapy, couples therapy, and group therapy.

Initial here if this section has been read and understood_____

Psychotherapy Contract for Client Receiving Therapy

I have read the above information, have asked questions as needed, and understand the issues related to risks and benefits of psychotherapy, medical concerns, assessment, the need for confidential psychotherapy, collateral contacts with others, treating separated or divorced families, professional records, confidentiality from third parties, alternative treatments, my diagnoses, and treatment plan, length of psychotherapy, fee for psychotherapy, emergencies, and cancellations.

Initial here if this section has been read and understood_____

I agree to treatment for myself based on my informed consent to proceed with psychotherapy with Kristopher L. Walton & Associates, LLC.

_____ _____

Print Name Signature Date

_____

Witness Date

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NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION, PLEASE REVIEW IT CAREFULLY.

PURPOSE OF THIS NOTICE

In the course of doing business, we gather and retain personal information about you. We respect the privacy of your personal information and understand the importance of keeping this information confidential and secure. This Notice describes how we protect the confidentiality of your personal information that we receive. We have implemented policies and procedures in accordance with Federal and State confidentiality and privacy laws to protect your privacy. We are obligated to maintain the privacy and confidentiality of your personal information. We are also obligated to provide you with notice of its legal obligations to maintain the privacy of your personal information and to provide you notice of its policies and procedures about privacy and confidentiality. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you. This information is called "protected health information" or "PHI". This notice describes your right and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

Federal law allows us to use and disclose your personal information in order to provide treatment, payment, or operations as described below:

For Treatment
We may use PHI about you to provide you with medical treatment or services. We may disclose PHI about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. Different personnel in our office may share information about you and disclose information to people who do not work in our office, in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and counseling sessions, coordinating care with counselors, behavioral or developmental support agencies, and school psychologists. Family members and other health care providers may be part of your medical care outside of this office and may require information about you.

For Payment
We may use and disclose PHI about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also inform your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment

For Healthcare Operations
We may use and disclose PHI about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

Appointment Reminders
Our practice may use your PHI to contact you and remind you of an appointment.

Release of Information
Our practice may release your PHI to friends, family members, or anyone else that is involved in your care, or who assists in taking care of you. However, you must be provided with an opportunity to object prior to the disclosure.

Special Situations
We are also allowed by law to use and disclose your PHI without your consent or authorization for the following purposes:
1. When required by law
2. For public health activities, such as reports about communicable diseases or work-related health issues
3. In reports about child abuse, domestic violence, or neglect
4. For health oversight activities, such as reports to governmental agencies that are responsible for licensing physicians or other health care providers
5. In connection with court proceedings or proceedings before administrative agencies
6. For law enforcement purposes, such as responding to a court order or subpoena
7. In reports to coroners, medical examiners, or funeral directors
8. For tissue or organ donation
9. For research, with the approval of certain oversight entities; otherwise, use and disclosure of your PHI requires for research requires your authorization
10. To avert a serious threat to the health or safety of a person or of the public
11. For national security and intelligence activities, including the protection of the President
12. In connection with services provided under workers' compensation laws

Other uses and disclosures of Health Information
All other uses and disclosures of your PHI will be made by us only with your written authorization. If you give us authorization to use or disclose PHI about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any uses or disclosures already made with your permission.

How we protect personal information
We restrict access to your PHI to those employees who need access in order to provide services to our patients. We have established and maintain appropriate physical, electronic and procedural safeguards to protect your PHI against unauthorized use or disclosure. We have established a training program that our employees must complete and update annually. We have also established a Privacy Officer, who has overall responsibility for developing, training and overseeing the implementation and enforcement of policies and procedures to safeguard your PHI against inappropriate access, use and disclosure, consistent with applicable state and federal law.

Psychotherapy Notes
In the course of your care with our practice, you will receive treatment from a mental health professional (such as a psychiatrist) who keeps separate notes during the course of your therapy sessions about your conversations. These notes, known as "psychotherapy notes", are kept apart from the rest of your medical record, and do not include basic information such as your medication treatment record, counseling session start and stop times, the types and frequencies of treatment you receive, or your test results. They also do not include any summary of your diagnosis, condition, treatment plan, symptoms, prognosis, or treatment progress.

Psychotherapy notes may be disclosed by our practice only after you have given written authorization to do so. (Limited exceptions exist, e.g. in order for our practice to prevent harm to yourself or others, and to report child abuse/neglect). You cannot be required to authorize the release of your psychotherapy notes in order to obtain health-insurance benefits for your treatment, or enroll in a health plan. Psychotherapy notes are also not among the records that you may request to review or copy (see discussion of your rights below). If you have any questions, feel free to discuss this subject with our practice.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Right to Inspect and Copy
You have the right to inspect and copy your PHI, such as medical and billing records, that we use to make decisions about your care (except psychotherapy notes). In order to do so, you must submit a written request to our office on a form that will be provided to you. If you request a copy of the information, we will charge a fee for the cost of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your PHI, you may ask that the denial be reviewed in writing. If such a review is required by law, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

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Right to Amend Personal Information
If you believe PHI we have about you is incorrect or incomplete. You may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. To make this request, you must submit a written request on a form that will be provided to you. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request.
In addition, we may deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the PHI that we keep
- You would not be permitted to inspect and copy
- Is accurate and complete

Right to Receive an Accounting of Disclosures
You the right to request an accounting of all disclosures of your PHI made by us that are not directly related to your treatment, payment for your treatment, or health care operations as outlined above. To obtain this list, you must submit a written request on a form that will be provided to you. We will provide this accounting to you within a reasonable period of time after your request and in accordance with the policies and procedures established by our office. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. There may be a cost involved in obtaining this list. We will notify you of the cost involved and you may choose to withdraw you request.

Right to Request Restriction on Disclosure of Personal Information
You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for it, such as a family member or friend. For example, you could ask that we not use or disclose information about a diagnosis with a family member. To make this request, you must submit a written request on a form that will be provided to you.

Right to Confidential Communications
You have the right to request that we provide your PHI to you in a confidential manner. For example, you may request that we send your PHI by alternate means or to an alternate address, such as by telephone to a different telephone number or to an office address rather than your home address. Also, you may, for example, request that your PHI be sent in a sealed envelope rather than on a postcard.

Right to receive this notice
You have the right to request and receive a copy of this Notice in written or electronic form. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain a copy, provided to you at no charge, contact our office.

Changes to this notice
We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

Right to complain
We are obligated to comply with the privacy practices set forth in this Notice. If you believe that we have violated this privacy policy, you have the right to file a complaint with our office, your Health Plan, or the United States Department of Health and Human Service, Office of Civil Rights. You will not be penalized for filing a complaint.

Contacting us regarding your rights
If you should have any questions regarding your rights or wish to make any of the above requests or complaints, you should direct your inquiries to our Privacy Officer, Jessica Stanfield at the address above.

Effective Date
The effective date of this Notice is October 1, 2009.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information 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 operation such as quality assessments and physician certification.

I have received, and read and understand your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I understand that his organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization at any time the address above to ovtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____
Patient Name Date of Birth

_____ _____
Signature Date

_____
Relation to Patient

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices Acknowledgment, but we unable to do so as documented below:

KRISTOPHER L. WALTON & ASSOCIATES, LLC
1536 Midway Avenue Ammon, ID 83406
(208) 403-0135 Fax: (208) 441-1794

AUTHORIZATION FOR RELEASE AND EXCHANGE OF CONFIDENTIAL RECORDS AND INFORMATION

Patient Name: _____

Date of Birth ___/___/___ Social Security # ____-____-____

Consent is given to the following to release and/or exchange information:
1)_____
2)_____
3)_____
4)_____
5)_____
6)_____

Information authorized to be released and/or exchanged:
_____
_____

I hereby authorize the above named persons to release and exchange the above specified information. I release the liability from Kristopher L. Walton & Associates, LLC concerning the release and/or exchange of confidential information. I understand that I may take back this consent at any time with written notice. I also understand that this consent is valid for one year.

_____ _____
Signature Date

_____ _____
Witness Date