Integrated Psychological Center of Indiana
50 E. 91st Street, Suite 316
Indianapolis, IN 46240-1556
Tel: 317-550-3221
Fax: 317-550-3228

HIPAA NOTICE OF PRIVACY PRACTICES

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.

IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI)

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why, and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice. PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. Authorization is your written permission to disclose confidential health information. All authorizations to disclose must be made on a specific and required form. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this Notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time as permitted by law. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office and on my website. You may also request a copy of this Notice from me, or you can view a copy of it in my office (50 E. 91st Street, Suite 316, Indianapolis, IN 46240) or on my website (www.drmariahanzlik.com).

HOW I WILL USE AND DISCLOSE YOUR PHI

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization; others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

Uses and Disclosures Related to Treatment, Payment, or Health Care Operations Do Not Require Your Prior Written Consent

I may use and disclose your PHI without your consent for the following reasons:

- **For treatment:** I can use your PHI within my practice to provide you with mental health treatment, including discussing or sharing your PHI with my trainees and interns. I may disclose your PHI to physicians, psychiatrists, psychologists, and other licensed health care

providers who provide you with health care services or are otherwise involved in your care. For example, if a psychiatrist is treating you, I may disclose your PHI to your psychiatrist in order to coordinate your care.

- **For health care operations:** I may disclose your PHI to facilitate the efficient and correct operation of my practice. One example includes to ensure quality control; I might use your PHI in the evaluation of the quality of health care services that you have received or to evaluate the performance of the health care professionals who provided you with these services. I may also provide your PHI to my attorneys, accountants, consultants, and others to make sure that I am in compliance with applicable laws.
- **To obtain payment for treatment:** I may use and disclose your PHI to bill and collect payment for the treatment and services I provided you. For example, I might send your PHI to your insurance company or health plan in order to get payment for the health care services that I have provided to you. I could also provide your PHI to business associates, such as billing companies, claims processing companies, and others that process health care claims for my office.
- **Other disclosures:** Your consent isn't required if you need emergency treatment provided that I attempt to get your consent after treatment is rendered. In the event that I try to get your consent, but you are unable to communicate with me (for example, if you are unconscious or in severe pain), I may disclose your PHI.

Other Uses and Disclosures Require Your Prior Written Authorization

In any other situation not described in above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures (assuming that I haven't taken any action subsequent to the original authorization) of your PHI by me.

Certain Other Uses and Disclosures Do Not Require Your Consent

In most situations, I can only release information about your treatment to others if you sign a written authorization. This authorization will remain in effect for a length of time you and I determine. You may revoke the authorization at any time; however, there are some disclosures that do not require your authorization. I may use and/or disclose your PHI without your consent or authorization for the following reasons:

- **Child Abuse:** If I have a reasonable suspicion of child abuse or neglect, I must report this information to the Indiana Department of Child Services.
- **Elder/Disabled Adult Abuse:** If I have a reasonable suspicion that an elderly adult or disabled adult is being abused or neglected, I am legally mandated to report this information to Indiana Adult Protective Services.
- **Danger to Yourself, Others, or Others' Property:** If you let me know, or if I have reason to believe, that there is an imminent risk of harm to yourself or to another individual(s), I may disclose your PHI to prevent the threatened danger and protect that person from harm.
- **Federal, State, or Local law; Judicial, Board, or Administrative proceedings; or, Law Enforcement:** For example, I may make a disclosure to the appropriate officials when a law requires me to report information to government agencies, law enforcement personnel and/or in an administrative proceeding. If you are involved in a court proceeding and a request is made for information by any party about your treatment and the subsequent records, it is not to be released without a court order. Information about all other psychological services (e.g., psychological evaluation) is also privileged and cannot be

released without your authorization 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.

- **For Public Health Activities:** For example, in the event of a patient's death, if a disclosure is permitted or compelled, I may need to give the county coroner information that constitutes PHI.
- **Health Oversight Activities:** I may disclose your PHI if I am required to provide information to assist the government in the course of an investigation or inspection of a health care organization or provider. Other oversight activities can include licensure or disciplinary actions. Furthermore, if a client files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- **Specialized Government Functions:** I may disclose PHI of military personnel and veterans under certain circumstances. Also, I may disclose PHI in the interests of national security, such as protecting the President of the United States or assisting with intelligence operations.
- **For Research Purposes:** In certain circumstances, I may provide PHI in order to conduct medical research.
- **For Workers' Compensation Purposes:** I may provide PHI in order to comply with Workers' Compensation laws.
- **If disclosure is otherwise specifically required by law.**

YOUR HEALTH INFORMATION RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of my responsibilities to help you.

- **The Right to See and Obtain Copies of Your PHI** In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request, but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed. If you ask for copies of your PHI, I will charge you not more than $.25 per page. I may see fit to provide you with a summary or explanation of the PHI, but only if you agree to it, as well as to the cost, in advance.
- **The Right to Request Limits on Uses and Disclosures of Your PHI:** You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.
- **The Right to Choose How I Send Your PHI to You/Request Confidential Communications:** It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example, via email instead of by regular mail). I am obliged to agree to your request providing that I can give you the PHI, in the format you requested, without undue inconvenience. I may not require an explanation from you as to the basis of your request as a condition of providing communications on a confidential basis.
- **The Right to Get a List of the Disclosures I Have Made:** You are entitled to a list of disclosures of your PHI that I have made. The list will not include uses or disclosures to which

you have already consented, i.e., those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15, 2003. After April 15, 2003, disclosure records will be held for six years. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years unless you indicate a shorter period. The list will include the date of the disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I will charge you a reasonable sum based on a set fee for each additional request.

- **The Right to Amend or Supplement Your PHI:** If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may deny your request, in writing, if I find that: the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI. Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.
- **The Right to Get This Notice by Email:** You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

HOW TO FILE A COMPLAINT

If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice, Dr. Maria Hanzlik. I can be reached at **Maria P. Hanzlik, PsyD, HSPP 50 E. 91st Street, Suite 316, Indianapolis, IN 46033, 317-550-3221, dr.mariaphanzlik@gmail.com.**

All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint. If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. You can also call 1-877-696-6775 or visit **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

NOTIFICATIONS OF BREACHES

In the case of a breach, Integrated Psychological Center of Indiana is required to notify each affected individual whose unsecured PHI has been compromised. Even if such a breach was caused by a business associate, Integrated Psychological Center of Indiana is ultimately responsible for providing the notification directly or via the business associate. If the breach involves more than 500 persons,

OCR must be notified in accordance with instructions posted on its website. Integrated Psychological Center of Indiana bears the ultimate burden of proof to demonstrate that all notifications were given or that the impermissible use or disclosure of PHI did not constitute a breach and must maintain supporting documentation, including documentation pertaining to the risk assessment.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on July 1, 2015, the opening date of business for this practice. This notice will remain in effect unless we make any changes. Upon making changes, we will inform youat our next appointment.

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ACKNOWLEDGMENT: RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I have received a copy of HIPAA Notice of Privacy Practices from IPCI effective July 1, 2015.

Patient Name (please print): _____

Patient Signature: _____

Date: _____

(For couples)
Name (please print): _____

Signature: _____

Date: _____

I am a parent or legal guardian of _____ (patient name). I have received a copy of Notice of Privacy Practices from IPCI effective July 1, 2015.

Name (please print): _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____

FOR OFFICE USE ONLY:

Notice of Privacy Practices effective July 1, 2015 was given to individual on _____ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other _____

Reason individual or parent/legal guardian did not sign this form:
☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _____

Signature: _____ Date: _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In person conversation _____
☐ Telephone contact _____
☐ Mailing _____
☐ Email _____
☐ Other _____

Staff Name (please print): _____ Title: _____

Signature: _____ Date: _____

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Office Policies & Patient Agreement

Welcome to Integrated Psychological Center of Indiana (IPCI). This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so that you can discuss them with your clinician at your next meeting. When you sign this document, it will represent an agreement between you and your clinician.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you bring forward. There are many different methods your clinician may use to deal with the problems that you hope to address. We draw on a number of approaches including, but not limited to, cognitive-behavioral, psychodynamic, humanistic-existential, family systems, emotionally-focused therapy, and eye-movement desensitization and reprocessing (EMDR). Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about both during our sessions and at home.

You should evaluate this information along with your own opinions of whether you feel comfortable working with your clinician. Therapy involves a large commitment of time, money, and energy, so you should be selective about the therapist you choose. If you have questions about our procedures, please discuss them with your clinician whenever they arise. If your doubts persist, your clinician will be happy to help you set up a meeting with another mental health professional for a second opinion.

Psychotherapy can have benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress, but there are no guarantees of what you will experience.

MEETINGS:

The first 2 to 4 sessions will involve an evaluation of your needs. By the end of the evaluation, your clinician will be able to offer you some first impressions of what our work will include and a treatment plan to follow, if you decide to continue with therapy. During this time, you and your clinician can both decide if that person the best person to provide the services you need in order to meet your treatment goals. If you are being seen for couples/relationship therapy, the first session typically occurs between the couple, followed by 1-2 individual sessions with each partner, before resuming conjoint sessions to discuss treatment planning. If you are being seen for psychological evaluation, the initial session involves obtaining a thorough history, followed by several multi-hour sessions involving face-to-face test administration, and a feedback session 3-4 weeks later to review evaluation results. The feedback session is scheduled a later date to provide us with appropriate time to score and interpret test data as well as complete the report. Please note, feedback sessions will not be scheduled until all necessary forms are completed and returned to your clinician. If psychotherapy is started, your clinician will usually schedule one 55-minute session (one appointment hour of 55 minutes duration) per week at a time you and your therapist agree on, although some sessions may be longer or more frequent. Sessions will need to end promptly in order for the therapist to document the session, return phone

calls, etc. Once an appointment hour is scheduled, you will be responsible for paying for it unless you provide **24 hours** advance notice of cancellation. If you are able to to reschedule the appointment within the same week, you will not be charged for your missed appointment. Your first late cancelation/no show within one calendar year is not charged, given a variety of circumstances can occur. A second late cancelation/no show within a calendar year is charged at half of the typical session rate, and third and subsequent late cancelations/no shows in a calendar year are charged at the full typical session rate.

Therapy Relationship: Developing a collaborative therapeutic relationship is one of the biggest predictors of therapy success. As a result, we at IPCI find it vitally important to ensure the therapeutic relationship is working well with you so that you may feel able to explore concerns and emotions is a safe space. Therapy never involves sexual, business, or any other dual relationships that could impair your clinician's objectivity, clinical judgment, therapeutic effectiveness, or could be exploitative in nature. If you have any concerns during the course of therapy, your clinician always invites conversation between you to work through any concerns you may have.

If you and your clinician determine that it is time for therapy to come to a close, we have found it most helpful to have at least two sessions to process the work done to date, discuss reactions to ending the therapy process, and provide you with any further information and/or referrals that could be helpful to you in the future.

CONFIDENTIALITY

All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written permission except under certain conditions.

When Disclosure is Required or May Be Required By Law: There are some circumstances where disclosure is required or may be required by law. These include the following:

1.) Where there is a reasonable *suspicion* of child, dependent, or elder abuse or neglect. We are required to report this information to the Indiana Department of Child Services or the Adult Protective Services agencies, depending on the age of the individual at risk.

2.) Where a client presents a danger to self. If the patient threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her or to contact family members or others who can help provide protection.

3.) When a client presents a danger to others. If we believe that a patient is threatening serious bodily harm to another person, we are required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.

4.) Duty to report if the patient presents a "serious and present danger to the health of others" under the following conditions: (a) The carrier engages repeatedly in a behavior that has been demonstrated epidemiologically (as defined by rules adopted by the state department under IC 4-22-b) to transmit a dangerous communicable disease or that indicates a careless disregard for the transmission of the disease to others.[1]

5.) Disclosure may also be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by your clinician. If we receive a court order to turn over your records, we are required to do so by law.

[1] IND. CODE ANN. § 16-41-7-1.

No authorization from you is required to release protected health information about you under the following circumstances:

1.) For "legitimate business practices" (i.e. submission of claims for payment from third parties; collection of accounts; litigation defense; quality assurance; peer review; scientific, statistical, and educational purposes).

2.) Your clinician may consult from time to time with other mental health professionals regarding clients to provide you with the best possible care. Each client's identity remains completely anonymous and other mental health professionals are legally and ethically bound to maintain client confidentiality just as your clinician is. Unless you specifically state otherwise, your clinician will not tell you about the consultations, unless they believe it is important for your continued work together. If, your clinician believes, it is important to consult with another mental health professional in a more in-depth nature, they will explicitly discuss this with you and ask you to sign a release of information allowing the clinician to share your information with that individual.

3.) In couple and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. Your clinician uses their clinical judgment when revealing such information. We will not release records to any outside party unless your clinician am authorized to do so by all adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult client.

A note about confidentiality in the context of couple's work: In order to build trust within the couple dyad, it is important that everyone is on the same page. As a result, IPCI has a "no secrets" policy. If one partner informs your clinician of information without their partner present, that information will be available to the other partner.

4.) We sometimes have other business professionals in the office to manage the upkeep of the office (cleaning staff, repair workers, etc.). As required by HIPAA, I have a formal business associate contract with these businesses in which they promise to maintain the confidentiality of PHI except as specifically allowed in the contract or otherwise required by law.

5.) To a coroner or medical examiner, in the performance of that individual's duties.

6.) If a patient files a complaint or lawsuit against your clinician or IPCI, we may disclose relevant information regarding that patient in order to defend the clinician/practice.

7.) If a patient engages, or attempts to engage, in violence against any clinician/employee of IPCI, their property, or the practice in any way, we will disclose this information to the proper authorities. This behavior may also result in automatic discharge from services.

8.) You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that provided to you for various purposes. We are required to provide a clinical diagnosis. Sometimes your clinician is required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. By signing the Consent to Treatment document, you agree that we can provide requested information to your insurance carrier.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions or concerns that you may have at your next appointment with your clinician. We are happy to discuss these issues with you if you have further questions, but formal legal advice may be needed because the laws governing confidentiality are quite complex, and we are not attorneys. If you request, we will provide you with relevant portions or summaries of the state laws regarding these issues.

MINORS:
If you are under eighteen years of age, please be aware that the law may provide your parents the right to examine your treatment records. We will provide them only with general information about our work together, unless we feel there is a high risk that you will seriously harm yourself or someone else or there is another safety issue they should know about. In this case, your clinician will notify them of their concern. Your clinician will also provide them with a summary of your treatment when it is complete. Before giving them any information, your clinician will discuss the matter with you, if possible, and do their best to handle any objections you may have with what they are prepared to discuss.

COMMUNICATION POLICIES

Phone: Feel free to leave a message on our confidential voicemail if your clinician is unable to answer. We strive to return all phone communication within 48-hour business hours of receiving your message. We are not available outside of office hours. As a result, in the event of an emergency, please dial 911 or go to your nearest emergency room. You can also go directly to psychiatric emergency departments including the following:

St. Vincent's Stress Center
8401 Harcourt Road
Indianapolis, IN 46260
(317) 338-4800

Community Hospital North
7165 Clearvista Way
Indianapolis, IN 46256
(317) 621-5100

Clinicians often not immediately available by telephone and do not answer the phone when in session with a patient. If you leave your clinician a message, please inform them of some days times when you will be available.

Email: We use a HIPAA-compliant, secure email system via Hushmail.com. In order to keep messages encrypted, Hushmail will prompt you to enter a passcode, similar to a password, that you must remember each time you open an encrypted email from your clinician. Please remember your passcode as there is no ability to reset your password and you will not be able to see the history of content of the email messages with a new passcode. Please note that any clinical information sent via email will be addressed during clinical session times, and all communication sent to your clinician will become a part of your medical record. We use email communication only with your permission and only for administrative purposes, like setting and changing appointments, billing matters and other related issues, unless we have made another agreement.

Social Media Policy: In order to maintain your confidentiality, we do not communicate with, accept "friend requests," or accept requests to follow any of clients on social media platforms including, but not limited to, Facebook, Twitter, or LinkedIn. If you have an online presence, there is a possibility that you may encounter one of our staff by accident. If that occurs, please discuss it with your clinician during your time together. In addition, if we discover that we have accidentally established an online relationship with you, we will cancel that relationship. This is because these types of casual social contacts can create significant security risks for you. We also believe that communications with clients online have a high potential to compromise the professional relationship. IPCI does have professional social media sites online; however, you are under no obligation to "follow" IPCI in any way. It is our utmost priority to ensure your confidentiality is maintained.

Web Searches: We will not use web searches to gather information about you without your permission. We believe that this violates your privacy rights; however, we understand that you might choose to gather information about your clinician in this way. There is a vast amount of information available about individuals on the internet, much of which may actually be known to that person and some of which may be unknown or inaccurate. If you encounter any information about any IPCI staff through web searches, or in any other fashion, please discuss this with your clinician during your time together so that you can address it and its potential impact on your treatment together.

Recently, a trend has emerged for clients to review their health care provider on various websites. Unfortunately, mental health professionals cannot respond to such comments and related errors because of confidentiality restrictions. If you encounter such reviews of your clinician, IPCI staff, or any professional with whom you are working, please share it with your clinician so you can discuss it and its potential impact on your therapy together.

FINANCIAL POLICIES

Fees & Payment: Payment is due at the time of service unless otherwise approved or unless you have insurance coverage which requires another arrangement. Below is the fee schedule for 2018. If our fees are expected to change, we will provide at least 60 days' notice to you:

Rates:

- 55-minute intake: $210
- 55-minute therapy session (53-60 minutes): $190
- 45-minute therapy session (38-52 minutes): $145
- 75-minute therapy session: $230
- Psychological/Psychoeducational testing:
    - $1900 for a full evaluation (including intake, testing time, scoring, interpretation, report writing, and feedback session) [Does not apply to legal/forensic evaluations]
      –or--
    - $200/hour for other evaluations that do not require a full, comprehensive evaluation
    - For fee-for-service evaluations: Payment is due in full at the end of your first appointment in order for the remaining testing appointments to be scheduled. If you cancel an assessment appointment with less than **48-hour** notice, you will be charged**.** Please refer to the "Late Cancelations and No-Shows" section for more information.
- Educational consultation: $200/hour (including travel and attendance)
- Legal proceedings: $300/hour (including travel, preparation, and attendance paid in-full prior to the court appearance)
- Preparation of documents (including letters, forms): $25/15-minute increment (15-minute minimum)
- Returned check fee= $35
- Greater than 1 therapy session in a week=25% discount

If you become involved in legal proceedings that require your clinician's participation, you will be expected to pay for your clinician's professional time even if they are called to testify by another party. Because of the difficulty of legal involvement, we charge $300 per hour for preparation and attendance at any legal proceeding, at a minimum of 4-hour increments due to having to clear portions of your clinician's schedule. Payment, in full, for legal services is expected 48-hours prior to any court appearance; otherwise, your clinician will not be able to appear.

Please notify us if any problems arise during the course of therapy regarding your ability to make timely payments. We allow patients to carry a balance for only 2 sessions before services may be interrupted if an account is not brought up to current. If you are using insurance benefits, your clinician will tell you what your balance is at the time of the session based on the most recently received Explanation of Benefits (EOB). If your account has not been paid for more than 60 days, and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court. If such legal action is necessary, its costs will be included in the claim. In most collection situations, the only information we release regarding a patient's treatment is the name, the nature of services provided, and the amount due.

Insurance Reimbursement: Dr. Hanzlik and Dr. Walker are currently in-network providers with Anthem Blue Cross/Blue Shield insurance companies (except EAP and HIP plans). It is important you know that, by choosing to use your insurance benefits, the insurance company reserves the right to request mental health diagnoses, treatment plans, clinical notes, or in some cases, the full clinical record. In these cases, we will make every effort to release the minimum amount of information necessary for the requested purpose. Although insurance companies report their commitment to protecting your health information, we cannot guarantee the privacy of your information once it leaves our possession. This information will become part of the insurance company files and will probably be stored in a computer. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it.

If you have a health insurance policy, it will usually provide some coverage for mental health treatment, although it is important to note that not all issues/conditions/problems are reimbursed by insurance companies. If our clinicians are not in-network providers with your insurance company, you may consider looking into out-of-network benefits. We are happy to provide you with a document called a "superbill," which contains your identifying information, session and services codes, as well as appropriate diagnosis code(s). You can then choose to submit this form to your insurance company, and many times, they will reimburse you for a portion of the service rendered if you are entitled to out-of-network benefits. It is important to note that, you (not your insurance company) are responsible for full payment of our fees. Payment is due at the time of service. It is very important that you find out exactly what mental health services your insurance policy covers. Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end our sessions.

It is important to remember that you always have the right to pay for our services yourself to avoid the problems described above, unless prohibited by contract. If you chose to pay for our services yourself, rather than utilize in-network insurance benefits, we will ask to sign a separate agreement indicating your choice.

Late Cancelations and No-Shows: The appointment time for which you are scheduled is especially for you. As a result, we require a 24-hour notice for cancelations of therapy appointments and a 48-hour notice for cancelations of assessment appointments. If you do not provide the appropriate amount of notice of cancelation, we charge the following within a calendar year:

1st occurrence: No charge
2nd occurrence: Half the price of the service
3rd and subsequent occurrence in one year: Full price of the service

If we are able to reschedule your appointment within the same week, we will not charge you for your missed appointment. If you begin canceling appointments on a regular basis, it will be important to discuss whether it still feels like a good time to pursue services. If you are running late for your appointment, please call or email your clinician as soon as you can to let them know you will be late. If we do not hear from you by 20 minutes into your session, we will call to check in and may assume you do not plan to attend your session. If you are late for your session, we will still end at our regular time so that your clinician has time to prepare for the next appointment and can be on time for it.

If your clinician has a planned absence, and they will not be in the office, they will provide you with as much notice as they can so we can both plan accordingly. However, there may be times when they have to cancel your appointment with very little notice due to unforeseen circumstances (i.e. illness, emergency situations, or weather conditions). If this occurs, your clinician, or other office staff, will contact you to inform you of the cancelation and a plan for rescheduling. Your clinician will also have an outgoing message on their voicemail indicating their absence. If the office needs to close due to inclement weather, there will be an outgoing message on the general voicemail box.

Records Review

The laws and standards of my profession require that we keep treatment records. Unless otherwise agreed to be necessary, IPCI retains clinical records only as long as is mandated by Indiana state law. If you have concerns regarding the treatment records, please discuss them with your clinician. You are entitled to receive a copy of the records unless your clinician believes that seeing them would be emotionally damaging, in which case we will be happy to send them to an appropriate mental health professional. Because they are professional records, they can be misinterpreted and/or upsetting to untrained readers. We recommend that you review them in your clinician's presence so that you can discuss the contents together. Patients will be charged an appropriate fee for any time spent in preparing information requests. When more than one client is involved in treatment, such as in cases of couple and family therapy, we will release records only with signed authorizations from all the adults (or all those who legally can authorize such a release) involved in the treatment.

If a third party is requesting psychological testing be completed (i.e. Federal Aviation Administration, Social Security Administration), that third party is considered the holder of privilege and has the right to records. As a result, if you wanted to request your records, you would need to do so with that third party, rather than with IPCI.

Integrated Psychological Center of Indiana
50 E. 91st Street, Suite 316
Indianapolis, IN 46240
Tel: 317.550.3221
Fax: 317.550.3228

Consent to Treatment-Child/Adolescent Treatment

I have fully discussed with my clinician the various aspects of the patient agreement. This has included a discussion of my child's evaluation/intake as well as the method of treatment. The nature of the treatment has been described, including the extent, its possible side effects, and possible alternative forms of treatment. My clinician has discussed with me scheduling, the nature of the fee and policies regarding missed appointments. My clinician has explained to me the limitations of confidentiality, including respecting the child/adolescent's space to speak with me freely. I understand my clinician will provide me with progress updates and notify me immediately if there is a safety issue of which I should be aware. I understand I may withdraw my child from treatment at any time, but if I decide to do this, I will discuss my plan with my clinician before acting on it. My only financial obligation, should I decide to stop treatment, is to pay for the services my child has already received.

I have read the above and fully understand the nature of treatment, the alternatives to this treatment, the limits of confidentiality in this relationship, and the circumstances in which confidential communications may need to be breached.

Please initial after the following statements:

I authorize the release of any information acquired in the course of examination or treatment necessary to process an insurance claim. I also assign payment of insurance benefits to the provider for services rendered for in-network benefits. _____
Initial

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered, regardless of my insurance status. I understand that if collection proceedings are necessary, I will pay all fees associated with collecting this bill. _____
Initial

(*For out-of-network patients)* I understand that my clinician is not an in-network provider with my insurance company, _____. As a result, I understand that I am responsible for payment up front, and IPCI will provide me with the necessary documentation for me to file a claim with my health insurance company if I choose to do so. The cost of the session is _____. _____
Initial

I authorize communication between my clinician and referring physician/clinician _____ to inform that my child has initiated services (separate release is required for further exchange of information). _____

Initial

I would like to be contacted for appointment reminders and other correspondence via the following ways (check all that apply):

☐ Telephone (please provide preferred number): _____

☐ Voicemail Message _____

☐ Text Message (if different than above):_____

☐ Email: _____

☐ Postal Mail (include address if other than provided): _____

_____	_____
Parent/Guardian Signature	Date
_____	_____
Parent/Guardian Printed Name	Date
_____	_____
Witness Signature	Date
_____	_____
Witness Printed Name	Date

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Child/Adolescent Patient Information Form

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

Gender: _____ Preferred Gender Pronouns: _____ Current Grade:_____

Age: _____ Race/Ethnicity: _____

Parent/Guardian Name 1 & Relationship: _____

Parent/Guardian Name 2 & Relationship: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Phone Number (home/work/cell): _____

Referring Provider: _____

Current Medications: _____

Previous Mental Health Services: _____

Presenting Problems: _____

Contact Information in Case of Emergency

Name:_____ Relationship to Patient: _____ Phone: _____

PRIMARY INSURANCE INFORMATION

Insurance Company Name:_____ Phone#:_____

Insurance Company Address: _____

Policy Holder's Name:_____Date of Birth:_____

Relationship to Patient:_____

ID#:_____Group#:_____

Name of Policy Holder's Employer:_____

Integrated Psychological Center of Indiana
CREDIT CARD AUTHORIZATION FORM

NAME OF PATIENT: _____
NAME ON CARD:_____
BILLING
ADDRESS:_____
_____

Circle one: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

ACCOUNT #: _____

EXPIRATION DATE: _____

CVC # (ON BACK OF CARD): _____

By signing this form, I authorize IPCI and my clinician to charge this card. I may choose to use other forms of payment such as cash, check or an HSA account. I understand that should my account be **30 days overdue**, I authorize IPCI and my clinician to automatically charge this card.

I hereby grant permission to charge my credit card after every ____ session(s) _____ (initials)

or

I hereby grant permission to charge my credit card if my balance reaches $100 without further authorization.

AUTHORIZED
SIGNATURE:_____

DATE: _____

AUTHORIZED
SIGNATURE:_____

DATE: _____

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50 E. 91st Street, Suite 316
Indianapolis, IN 46240
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Fax: 317.550.3228

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____do hereby consent and authorize my provider and/or IPCI,

TO DISCLOSE to _____
Name/Address/Telephone Number

The following specific information regarding (self/child's name): _____

___ Admission
___ Attendance in Treatment
___ Progress in Treatment
___ Prognosis/Diagnosis
___ Discharge Summary
___ Patient Demographic Information
___ Treatment Plans
___ Progress Notes
___ Psychological Evaluation
___ Other: _____

I understand that this information is to be used for the purpose of : _____

_____ Patient/Guardian Signature
_____ Witness Signature

_____ Printed Patient/Guardian Name
_____ Witness Printed Name

_____ Date
_____ Date

I, _____do hereby consent and authorize my provider and/or IPCI,

TO RECEIVE from _____
Name/Address/Telephone Number

The following specific information regarding (self/child's name): _____

___ Admission
___ Attendance in Treatment
___ Progress in Treatment
___ Prognosis/Diagnosis
___ Discharge Summary
___ Patient Demographic Information
___ Treatment Plans
___ Progress Notes
___ Psychological Evaluation
___ Other: _____

I understand that this information is to be used for the purpose of: _____

_____ Patient/Guardian Signature
_____ Witness Signature

_____ Printed Patient/Guardian Name
_____ Witness Printed Name

_____ Date
_____ Date

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Child/Adolescent History Form

Child Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Grade: _____Biological Sex:_____

Identified Gender (if different than sex): _____

Preferred Gender Pronouns (if applicable): _____

Race/Ethnicity: _____ Religious/Spiritual Affiliation (if applicable): _____

Parent/Guardian Relationship Status: _____

Other Important Cultural Information: _____

Presenting Problem:
Reasons for seeking services:

Please list current symptoms:

Mental Health History:
How long have these concerns been present regarding your child?:

Please list past outpatient therapy your child may have received:
(Name of therapist/length of time in therapy/type of work completed/past diagnoses)

Please list past inpatient mental health hospitalization your child may have received:
(Name of hospital/location/length of stay/age of hospitalization/reason for hospitalization)

Please list past and current medications your child has been prescribed/is using:
Medication name Dosage Reason for med. Taking as prescribed? (Y/N)

Educational History:
School Name: Grade: Primary Teacher Name:

Please list/describe any trouble your child may be experiencing at school (academic or behavioral):

What are child's best and worst subjects?:

Has your child ever been diagnosed with a learning disorder?:

Does your child have an IEP/504 Plan in place?: (Y/N)
If Yes, please describe accommodations that have been recommended:

If Yes, are these accommodations, in your opinion, being implemented appropriately?

If No, do you think your child might need an IEP/504 Plan?: (Y/N)

Has your child ever received educational or psychological testing/evaluation in the past? (please describe):

Has your child ever been retained in a grade?: (Y/N) Please list reason for retention:

Has your child ever received special education services?: (Y/N) Please list reason for extra services:

Does your child enjoy school?:

Social Functioning:
Does your child make friends easily?

Does your child seem to have peers in whom your child can confide?:

Please list activities in which your child is currently involved:

Medical History:
Please list any medical conditions your child has and rate how well managed they are (good, fair, poor):

Please list any surgeries your child may have had:

Please list any hospitalizations your child may have had for a medical condition/length of stay:

Developmental History:
If child was adopted, please indicate age at adoption and any information you know about your child's life before the adoption:

Pregnancy history (please describe the pregnancy with the child including term of pregnancy, any pregnancy-related complications):

Birth process:
Vaginal/Cesarean section?

Please note any complications that occurred during the birth process:

As an infant, was your child breast-fed, formula fed, or both? Please explain:

If you attempted to breast feed, please describe any challenges you experienced:

Please describe your child as an infant (cuddly, easy, difficult, colicky, active):

At what age did your child complete the following milestones?:

Smile at others:	*Roll over from stomach to back:*	*Roll over from back to stomach:*
Crawl:	*Walk without holding on:*	*Use single words:*
Form 2-3 word sentences:	*Remain dry during the day:*	*Remain dry at night:*

Have you noticed regression on your child's part in any of those areas?

Did your child have any difficulty with sleeping as an infant/toddler?:

Did your child have any difficulty with eating as an infant/toddler?:

Discipline:

Please list what you have used historically and use presently for discipline with your child:

Are you experiencing any difficulty with consistently implementing effective discipline strategies?:

Family of Origin History:

Place of birth:

Who has cared for your child up to this point?:

Please list who currently lives in your household and the quality of those relationships:

Please list any current family stressors that are occurring:

Please list any family members who have diagnosed or suspected undiagnosed mental health conditions:

Trauma History

Please circle/highlight any of the following your child may have experienced:

Physical abuse *Emotional/verbal abuse* *Sexual abuse*

Witnessing violence (including domestic violence) *Bullying*

Confusing experiences/boundary violations *Peer rejection*

Natural disasters *Loss of a parent or other important caregiver*

Substance Use:

Please check the following substances your child has used or may have used in the past as well as any substances you are aware your child is using currently:

	Past	Current	Suspected
Alcohol			
Wine			
Liquor			
Beer			
Marijuana (any form)			
Cocaine			
Crack Cocaine			
Hallucinogens			
Inhalants			
"Club Drugs" (i.e. Ecstasy)			
Heroin			
Prescription Drugs (not as prescribed)			
Stimulants			
Tobacco			
Caffeine			
Other:			

Have you ever approached your child about your child's substance use? Please describe the outcome:

Please list any prior treatment for drug or alcohol use:
(Inpatient/Intensive Outpatient/Educational/Detox/Date/Location):

Legal History:

Charge Date of Arrest Juvenile Detention (Y/N) Probation (Y/N/Dates)

Strengths and Weaknesses:

Please list three of each to describe your child:

Strengths: *1.* *2.* *3.*

Weaknesses: 1. *2.* *3.*

Other Important Information About Your Child That Your Clinician Should Know:

Goals for therapy:

Short-Term	Long-Term
1.	1.
2.	2.
3.	3.