Marisa Nava, Ph.D.
Licensed Clinical Psychologist
Child/Adolescent Registration Form

Client's First Name_____________________ **Last Name**________________________________ MI______
Birthdate ____/_____/___ Age___ Grade ______ School ____________________ Gender __F __M

Name of Parent/Guardian___________________________________
Address_________________________ City___________________ State_______ Zip______________
Phone:_______________________________________ Ok to leave a message on phone? ___yes ___no
Email: ____ Ok to use this email? ___ yes ___ no

Name of Other Parent/Guardian___________________________________
Address_________________________ City___________________ State_______ Zip______________
Phone:_______________________________________ Ok to leave a message on phone? ___yes ___no
Email: ____ Ok to use this email? ___ yes ___ no

Person Responsible for Payment____________________________________

Signature of Person Responsible for Payment **X**______________________________

Emergency Information

In case of emergency, contact:
Name ______________________ Relationship_______________ Phone____________Work/Cell__________

Insurance Information

Primary Insurance_____________________________
Phone_______________________________________
Contract/ID#_________________________________
Group/Acct#_________________________________
Subscriber____________________________________
Subscriber Date of Birth _________________________
Client's relationship to Subscriber
__Self __Spouse __Child __Other_____________

_____ (initial here). **Authorization to file insurance claims:** I authorize Marisa Nava, Ph.D. to file my insurance claims and I hereby authorize the release of any psychiatric, psychological, or other medical information to process those claims.

_____ (initial here). **Authorization to pay insurance benefits:** If I have not paid my visits in full, then I hereby now and forever authorize and direct all payment (s) to be made directly to Marisa Nava, Ph.D. who rendered service for the benefits payable from all plans of health insurance or benefit programs otherwise payable to me. A copy of this is as valid as the original.

Payment:

Payment is due at the time of service. Insurance companies require collection of deductibles and co-pays at the time of service. Specific coverage varies by plan and service. Self-pay clients are also required to pay at the time of service.

Credit Card Information:

Cash and personal checks are welcomed, but many clients find it convenient and preferable to allow this office to hold on file a credit card to facilitate transactions; it will provide you with a monthly record of expenditures.

Please initial if you agree to pay the fee/copays with your card listed below. ____ (initial here)

Type: ___Visa___Mastercard ___Discover __AMEX

Card Number: ____Expiration Date: ________________

Name on Card: ____ CVV: ________________

Reminder Service:

I offer a reminder system that can give you a phone, text, or email reminder to alert you to your appointment. You will still need to contact me directly via email or phone should you need to make any changes to your appointment. Please remember to provide at least 24 hours' notice when cancelling any appointment to avoid session charges.

For appointment reminders, I would prefer the following (all options available):

___ Phone call ___ Text ____ Email

_____ (initial here). **Authorization to use reminder service:** My personal information (name and contact information) will be provided to Theramanager and Carepaths (HIPPA compliant) so that such reminders can be sent.

Session Information:

- Psychotherapy sessions are scheduled for **50-60 minutes**
- Co-Parenting, Collaborative Practice, and Mediation Services are scheduled for **60 minute sessions**.
- It is important for me to remain on-schedule so I have time to return calls/emails and plan for each session.
- Please give 24 hours' notice if you need to cancel an appointment.

Telephone:

- My telephone is completely confidential. I am the only one who checks messages left on my voicemail. I generally return calls within 24-48 hours, not including weekends. Occasionally, I will ask my assistant, Mariann, to make calls on my behalf, particularly in relation to insurance questions.
- I am available via phone for quick check-ins, scheduling, and other routine matters; however, I do have to charge for calls lasting 15 minutes or longer ($50/15 minutes).

- I am available via phone for "phone sessions" and charge my regular office rates for this service. I am not able to bill insurance for "phone sessions".

Email:

- My email address is marisanavaphd@gmail.com. Confidentiality cannot be guaranteed with electronic communication.
- Emails sent to me become part of the medical record. When I work with a child or children, that medical record is available to both parents, regardless of custody.
- I use email for scheduling appointments with clients, as well as for brief communication with other professionals (teachers, MDs, etc.). I will address therapeutic issues that you may email me during our next session.
- If you send me lengthy emails and/or documents via email to read, this becomes part of the medical record and I must charge for the time required for proper review.
- When working with two-household families, we can discuss the option of me sending a brief summary after each session with the child if both parents were not present at the time of the appointment.

Fax:

- My fax number is 866-458-4479.
- I use an internet-based fax service. Faxes arrive to me through my email account, which is only viewed by me.

Cell Phone:

- I will occasionally give clients my cell phone number to use for **urgent** matters only.
- There are many times when I am not able to answer my cell phone and I will return calls as soon as possible.

Emergency Info:

- If you are having an emergency and I cannot be reached in my office or by cell phone, you need to call 911 or go to the nearest emergency room. You may also contact the Tri-County Crisis Stabilization Center at (843) 958-3530.

Text:

- I do not communicate with clients via text messaging. Please do not send text messages to my cell phone.

Social Networking Sites:

- Although I may use social networking sites, I do not conduct business through them, nor do I "friend" clients.

Invoices/Receipts for Payment:

I can email, text, and/or send balance statements and/or receipts of payment.

_____ (initial here). Authorization to email and/or text balance statments and receipts of payment through Theramanager (HIPPA compliant). Please check preference: ____ Email ______ Text ______ Paper (through mail)

Treatment Consents - Please initial:

_______ I have had the opportunity to read the *Patient Services Agreement* and the *Notice of Psychologists' Policies and Practices to Protect the Privacy of Your Health Information* and have had the opportunity to ask questions about them. My signature below indicates that I agree to abide by the terms of the contract and that I consent to treatment with Dr. Nava for myself/my child.

_______I give Dr. Nava permission to speak with my (my child's) primary care physician. This consent includes sharing written initial diagnostic impressions, treatment recommendations and treatment updates.

_______I understand that payment is expected at the time of service. Although Dr. Nava files insurance, I understand that I may still be responsible for fees that are not covered, charges that go towards deductible, and co-pays.

_______I understand that appointments not cancelled within 24 hours will be charged the full session fee.

_______I agree not to request my child's records for court purposes that pertain to issues of divorce and/or custody.

______If my child is 10 years of age or older, I agree not to receive a copy of the therapy notes in order to protect the therapeutic process.

______ I understand that Dr. Nava maintains electronic records that are confidential and HIPPA complaint.

______ I understand Dr. Nava is a mandated reporter which means if she has reason to believe there is a situation involving abuse or neglect she is required by law to file a report with the appropriate agency.

______ I understand that although Dr. Nava and I may communicate via email, such communication is not necessarily secure or encrypted.

______ I understand that in the state of South Carolina both legal parents (regardless of custody) have full access to my child's medical record. My child's medical record includes the following: sessions with either parent, sessions with the child, phone and email communication with either parent and/or other professionals involve in my or my child's care.

Permission for Treatment or Services

My signature indicates that I have read the above registration information. I agree accept the fees for those services as lawful debt. I promise to pay said fees as outlined above. This includes an agreement to pay costs of collections, attorney fees, and court costs, if necessary. I waive now and forever the right to claim exception under the Constitution and laws of the State of South Carolina or any other state. I also understand that failure to pay these fees may result in release of my name, known phone numbers, and addresses, and other information during the collection process.

Permission is hereby given to Marisa Nava, Ph.D. to render treatment and/or service to

________________________ whose relationship to me is ___ Self ___Child ___ Other (Specify: ______________)

Your signature: ____ Date: _________________

Provider: signature ____ Date: _________________

Marisa L. Nava, Ph.D.
Licensed Clinical Psychologist

Patient Services Agreement

Welcome to my practice. This document contains important information about my professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that I provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice explains HIPAA and its application to your personal health information in greater detail.

PSYCHOTHERAPEUTIC/PSYCHOLOGICAL SERVICES

During our initial consultation(s), we will work together to establish the needs, concerns, and goals for your child and/or family. In order for therapy to be most successful, it will be essential for your child and/or family to work on various skills both during our sessions and at home between sessions. If you have any problems or concerns about the course or treatment, please discuss them with me immediately. If your concerns continue, I will be happy to help you set up a meeting with another mental health professional if you so desire. It is certainly your choice if you decide not to continue services for your child and/or family. I will also not agree to work with your child and/or family if I do not believe that there is a reasonable chance that we can work productively together.

MEETINGS

I typically schedule psychotherapy sessions once per week or biweekly for **50-60 minutes** at a time we agree on. It is important for me to keep appointments on this schedule so that I have time between sessions to write progress notes, consult with other professionals as needed, and return phone calls.

Although I make every effort to avoid interruptions and delays, I may occasionally be unavailable for part or all of our regularly scheduled appointments (e.g., due to emergencies with other patients). These possible interferences are sometimes unavoidable. I will try to provide you with a new appointment as soon as possible should this ever occur.

Appointments are contracted time. When you make an appointment with me, I set aside that time to spend with you. Unlike many healthcare practices, I do not "overbook" my time. If you are unable to make a scheduled appointment, *please cancel 24 hours prior to the appointment time* so that I can offer the time to another client. **If you do not cancel at least 24 hours prior to your appointment time, you will be responsible for the session fee.** If you are late for a session, you will most likely miss part of your therapy time.

PROFESSIONAL FEES

I charge for all of my professional services. You will be expected to pay for each professional service at the time it is delivered, unless we agree otherwise beforehand.

Psychotherapy: Unless otherwise communicated to you and agreed upon: **My current fees are** ***$200*** ***for the initial 60-minute session*** **and** ***$175*** ***for each subsequent 50-60 minute session*****.** If I have an agreement with your insurance company to accept a different fee, I will honor that agreement.

Coparenting/Mediation: I charge **$200 per 60 minute session** of coparenting/mediation services. These services are not cover by insurance.

Other Professional Services (including phone conversations): I charge $200 per hour for other professional services you might need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 15 minutes, consulting with other professionals with your permission, school observations/consultations with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of me.

Legal consultations: Legal consultations (e.g. documents prepared for attorneys, telephone consultations with them, etc.) are charged at $300 per hour. If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation time, transportation costs, ancillary expenses, etc., even if I am called to testify by another party. You will be expected to pay me for my time in or at court (e.g., while waiting for testify when I've arrived when instructed, but not called upon until later), even when I am called to testify for another party. I will also require a $3000 retainer prior to being called to testify in court. Whatever portion of this retainer remains following the court proceedings will be reimbursed.

BILLING AND PAYMENTS

You will be expected to pay for each service at the time it is provided, unless we make other prior arrangements. Checks, cash, and credit card payments are acceptable. You may keep your credit card information on file with me so that I can easily charge each service as it is provided.

I collect co-pays at the time of service. If you are uncertain of your co-pay, please call your insurance company (there is usually a toll-free number on the back of the insurance card).

Unpaid balances should never accrue. If your account has not been paid for more than 90 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court, which will require me to disclose otherwise confidential information.

INSURANCE REIMBURSEMENT

You (not your insurance company) are responsible for full payment of my fees. Insurance companies often take 4-6 weeks to process a claim, so expect a delay. You will typically receive an explanation of your benefits before I receive payment. I suggest you keep a log of your sessions and your payments to me. If you have a restriction on the number of visits, I suggest you keep track of the number of visits we have.

If I am not a provider for your specific insurance company, I will not be considered an "in network" provider. If you have a health insurance policy, it will usually provide some coverage for mental health treatment, and it might do so by considering me an "out of network" provider. I will fill out forms and provide you with whatever assistance I can in helping you receive the benefits to which you are entitled, if you choose to submit claims after you have paid me in full for the service(s) I provide. **Payment is always due at or before the time of service.**

If you wish to file claims with an insurance provider, you should be aware that your contract with your health insurance company requires that I provide information relevant to those services. For example, I would be required to provide a clinical diagnosis in order for you to file claims and I might be required to provide additional clinical information such as treatment plans or summaries. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with this information once it is in their hands. By signing this Agreement, you agree that I can provide requested information to your insurance company. You always have the right to pay for services yourself, and can avoid the problems described above by not filing for reimbursement.

PROFESSIONAL RECORDS

The laws and standards of my profession require that I keep Protected Health Information (PHI) about you in your Clinical Record. Pursuant to HIPAA, I might keep Protected Health Information about you in two sets of professional records.

1. *Clinical Record*. Your clinical record includes information about your reasons for seeking therapy for your child and/or family, the ways in which these problems impact life for your child and/or family, the diagnosis, the goals set for treatment, progress towards these goals, medical and social history, treatment history, any past treatment

records received from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier.

Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to me confidentially by others, or the record makes reference to another person (unless such other person is a health care provider) and I believe that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, I am allowed to charge a copying fee of $1 per page (and for certain other expenses). If I refuse your request for access to your records, you have a right of review (expect for information supplied to me confidentially by others), which I will discuss with you upon request.

2. *Psychotherapy Notes.* These Notes are for my own use and are designed to assist me in providing your child and/or family with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of our conversations, my analysis of those conversations, and how they impact therapy. They also contain particularly sensitive information that you, your child, and/or your family may reveal to me that is not required to be included in your Clinical Record. These Psychotherapy Notes would be kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies, without your written, signed Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.

MINORS & PARENTS

If you are under 18 years old, please be aware that the law may provide your parents the right to examine your treatment records. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is my policy to request an agreement from parents that they consent to give up their access to their child's records. If they agree, during treatment, I will provide them only with general information about the progress of our work together and attendance at scheduled sessions, unless I feel there is a high risk that you will seriously harm yourself or someone else. In this case, I will notify parents of my concern.

If requested in writing, I will also provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless I feel that the child is in danger or is a danger to someone else, in which case, I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communication between a patient and a psychologist. In most situations, I can only release information about your child and/or family's treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together. I will note all consultations in your Clinical Record.

- You should be aware that I employ administrative staff. In most cases, I need to share protected information with these individuals for both administrative purposes, such as billing and insurance authorization/claims submissions. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

- I have a contract with an electronic billing clearinghouse (Office Therapy / Trizetto) to submit insurance claimant. As required by HIPAA, I have a formal business associate contract with this business, in which Office Therapy /

Trizetto promises to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.

- I use Bill Flash and Quickbooks to send invoices and collect payments. Quickbooks and Bill Flash do not receive any therapeutic information outside of billing information and promise to maintain the confidentiality of this data expect as specifically allowed in the contract or otherwise required by law.

- I have a contract with ReRemind.com to provide reminders about appointments. Reremind is HIPPA compliant. If you agree to this service, Reremind.com promises to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where I am permitted or required to disclose information **without either your consent or Authorization**:

- If you are involved in a court proceeding and a request is made for information concerning the professional services I provided you, such information is protected by the psychologist-patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with an attorney to determine whether a court would be likely to order me to disclose information.

- If a government agency is requesting the information for health oversight activities, I am required to provide it to them.

- I may disclose relevant information regarding a patient in order to defend or protect myself (for example, if a patient files a complaint or lawsuit against me).

There are some situations in which I am **legally obligated** to take actions which I believe are necessary to attempt to protect myself or others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice:

- If I receive information that gives me reason to believe that a child's physical or mental health or welfare has been or may be adversely affected by abuse or neglect, or by acts or omissions that would be abuse or neglect if committed by a parent or other caretaker, the law requires that I file a report with the county Department of Social Services. If I believe that a child has been or maybe abused or neglected by any other person, I must report that to the appropriate law enforcement agency. Once such a report is filed, I may be required to provide additional information.

- If I have reason to believe that a vulnerable adult has been or is likely to be abused, neglected, or exploited, the law requires that I file a report to the Adult Protective Services Program. Once such a report is filed, I may be required to provide additional information.

- If I believe that a patient presents a clear and substantial risk of imminent, serious harm to another, I may be required to take protective action, including notifying the potential victim, contacting the police, and/or seeking hospitalization for the patient.

- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

- If a patient reveals his or her intent to commit a crime, I may be required to take preventative action, such as calling the police.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action and I will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about the potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include the following:

- You can request that I amend your record.
- You can request restrictions on what information from your Clinical Record is disclosed to others.
- You can request an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent.
- You can have any complaints you make about my policies and procedures recorded in your records.
- You have the right to a paper copy of this Agreement.
- You have a right to a paper copy of the notice form and my privacy policies and procedures.

CONTACTING ME

Due to my work schedule, I am often not immediately available by telephone, as when I am in the office, I am often with clients. **I am generally in the office Tuesdays, Wednesdays, and Thursdays, although my hours each day may vary**. I am generally not in the office on Mondays or Fridays. When I am unavailable, my telephone is answered by voice mail. ***I will make every effort to return your call within 24-48 hours, with the exception of weekends and holidays.*** If you are difficult to reach, please inform me of some times when you will be available. If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact, if necessary.

I will also provide you with my email address. However, **I use email** ***solely for administrative purposes*** such as scheduling appointments. Any issues that you need to email me about will be discussed during our next appointment and not via email. **Email should never be used in the case of an emergency.**

In case of **emergency** (e.g. your child and/ or a member of your family needs immediate help to maintain his/her safety) you may call the **Mobile Crisis program at (843) 727-2086**, which can respond 24 hours per day. Or, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call. You can also call 911 or go to a local hospital emergency room. Please ask the professionals who see you to attempt to contact me so that I may provide a consultation to them for the purposes of your treatment.

PLEASE INITIAL AND SIGN THE REGISTRATION FORM TO INDICATE THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS. YOUR SIGNATURE ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE BEEN OFFERED A COPY OF MY SUMMARY OF PATIENT PRIVACY NOTICES FORM, WHICH IS POSTED IN MY OFFICE.

A copy of this form will be provided to you at your request.

South Carolina provides the consumer the opportunity to file inquiries with its Board of Examiners in Psychology. Board offices may be reached at:

South Carolina Board of Examiners for Psychologist, Counselors, & Therapists

PO Box 11329

Columbia, SC 29211-1329