Donna Noland, Ph.D.
4870 S Lewis Ave, Suite 230
Tulsa, OK 74105
918.749.6935

Client Contact Information

(PLEASE PRINT)

Date: ___________________________

Name of Client: ____

Gender: ___ M ___ F Age: _____ Birth date: ___________________________

Name of Parent/Guardian: ____

Address: _______________________________ City: _______________ State: _________ Zip: _______________

Phone Number(s): ____

Do you prefer reminder calls by call _____ text _____ none _____

Primary Care Physician: ____ Phone: ________________________

Primary Insurance Company: _______________________________________ ID: ____________________________
(If applicable)

Secondary insurance Company: _____________________________________ ID: ____________________________
(If applicable)

Emergency Contact: ____ Phone: ________________________

Relationship to client: ____

People living with the client:	Relationship to Client

Parents/siblings living elsewhere:	Relationship to Client

Behavior Checklist

Child's name: ______________________________ Date: ____________

Person completing form: ______________________________

Please indicate 1 for mild, 2 for moderate, and 3 for severe. If the behavior was never observed, leave blank.

_____ Often fidgets with hands or feet or squirms in seat
_____ Has difficulty remaining in seat when asked to do so
_____ Is easily distracted
_____ Has difficulty awaiting turns in games or group situations
_____ Often blurts our answers before questions have been completed
_____ Has difficulty following through on instructions
_____ Often shifts from one uncompleted activity to another
_____ Has difficulty playing quietly
_____ Often talks excessively
_____ Often interrupts or intrudes on others
_____ Often does not seem to listen to what is being said
_____ Often loses things necessary for tasks at school or home
_____ Often engages in dangerous activities without thinking
_____ Has stolen on more than one occasion, i.e. shoplifting
_____ Has run away from home at least twice
_____ Often lies
_____ Has deliberately engaged in fire setting
_____ Is often truant from school
_____ Has broken into someone's house, building, property
_____ Has been physically cruel to animals
_____ Has forced someone into sexual activity
_____ Has used a weapon
_____ Often initiates physical fights
_____ Has stolen directly from someone – robbery, mugging, etc.
_____ Has been physically cruel to other persons
_____ Often loses temper
_____ Often argues with adults
_____ Often actively defies or refuses adult requests
_____ Often deliberately does things that annoy other people
_____ Often blames others for own mistakes
_____ Often angry or resentful
_____ Often touchy or easily annoyed by others
_____ Often spiteful or vindictive
_____ Often swears or uses obscene language
_____ Unrealistic or persistent worry about possible harm coming to someone close, or fear of being left by that person
_____ Unrealistic or persistent worry that something will happen to separate the child from loved one – lost, kidnapped, hurt
_____ Persistent fascination with violence or death
_____ Persistent reluctance or refusal to go sleep without loved one near or to go to sleep away from home
_____ Clinging or shadowing – persistent avoidance of being alone
_____ Repeated nightmares involving themes of separation
_____ Excessive physical complaints – headaches, stomach aches, nausea, or vomiting on school days or before separation
_____ Temper tantrums, crying, pleading, etc. when faced with separation from home or significant loved one
_____ Excessive shrinking from contact with unfamiliar people
_____ Desires involvement with familiar people exclusively
_____ Excessive or unrealistic worry about the future, past behaviors, personal competence, social, academic, athletic
_____ Somatic complaints – headaches, stomach aches, etc.
_____ Overly self-conscious
_____ Overly tense, unable to relax
_____ Excessive need for reassurance about a variety of concerns
_____ Problems with eating – self induced vomiting, not eating, overeating, bingeing
_____ Problems with alcohol or drug abuse
_____ Beginning before age five, socially unresponsive – absence of visual tracking or responding to play, lack of vocal imitation or playfulness, apathy, little or no spontaneity, lack of curiosity or social interests
_____ Overly familiar and friendly with strangers by making requests and displays of affection
_____ When depressed has poor appetite or over eats, can't sleep or oversleeps, low energy or fatigue
_____ low self-esteem, difficulty concentrating, hopeless feelings
_____ Suicide attempts or threats
_____ Severe stressor such as loss of loved one, major accident, divorce, etc, that impairs ability to function
_____ A traumatic even is persistently re-experienced through distressing recollections, recurrent distressing dreams, sudden acting or feelings as if the traumatic event was recurring, intense distress at exposure to things that remind one of that past trauma.
_____ Self harm

Please check all that apply

______ Depressed
______ Withdrawn
______ Low self worth
______ Physically abused
______ Sexually abused
______ Has sexually offended
______ Sexual acting out
______ Bizarre thinking/acting
______ Hallucinations
______ Hearing voices
______ Phobias
______ Agitation
______ Aggression
______ Self-Harm
______ Hostility/anger
______ Illegal acts
______ Abuse of alcohol
______ Abuse of drugs
______ Runaway episodes
______ Impulsive
______ Authority conflicts
______ Parent conflict
______ School conflicts
______ Gang involvement
______ Academic problems:
______ Not at grade level
______ On I.E.P.
______ Suicide threats or attempts

Recent or chronic medical problems:____
____

Allergies: ____

Primary Care Physician: _______________________________________ **Phone:** _______________________

Current Medications:

____
____
____
____

Has child ever seen psychiatrist or counselor before? ___ **Yes** ___ **No**

If yes, who? ____

Referral Source: ____

If you are not the birth parent, indicate relationship:

Adopted ___ Yes ___ No **Adjudicated** ___ Yes ___ No **Court Ordered** ___ Yes ___ No

Please describe main problem: ____
____
____
____

Donna Noland, Ph.D.
Licensed Clinical Psychologist

Consent for Treatment: I hereby authorize Dr. Noland to provide outpatient medical care, including, but not limited to, routine diagnostic procedures, psychological treatment, and any additional procedures deemed advisable or necessary. I further understand that the practice of medical/psychological treatment is not an exact science and acknowledge that Dr. Noland has made no warranty, guarantee, or assurance as to the results of treatments and/or examinations. I acknowledge that I have been informed of my rights as a patient, a copy of which will be furnished to me upon my request.

Confidentiality Statement: I understand that I am entering a psychiatric office that holds confidentiality in the highest regard. Therefore, I agree to hold confidential the identity of those I meet. I will also keep confidential all information disclosed during group sessions.

Understanding of Financial Responsibility

You will receive an evaluation and recommendations will be tailored for your specific needs. The service may be billed to your insurance carrier, Soonercare, Medicare, Medicaid, or you may pay the fee yourself.

Please indicate which of the following apply to you

- ○ Please bill my primary and secondary insurance carrier or designee, as appropriate, to pay for the service, directly to Donna Noland, Ph.D.. My insurance carrier(s) or health plan(s) are as follows:

  Primary: ______________________________ Secondary: ______________________________

I understand that if I provide Dr. Noland with accurate insurance information at the time of admission, her personnel will verify my insurance coverage. I understand that I am responsible for complying with all pre-certification requirements of my insurance plan and/or employee assistance program. Failure to comply with these requirements may lead to a reduction or denial of benefits. I also understand that I am responsible for all deductible and coinsurance. Payment of which is due at the time of service.

If for whatever reason my insurance carrier denies my claim, the office will work with me and the insurance company to resolve issues. I understand, however, that I am responsible for all denied charges and fees.

- ○ Soonercare, Medicare or Medicaid applies to me. These programs include fiscal intermediaries or program designees. I request that payment by Soonercare, Medicare or Medicaid be made directly to Dr. Noland on my behalf. I authorize Dr. Noland to submit a claim to Soonercare, Medicare or Medicaid on my behalf. The information I have given to Dr. Noland and to the Social Security Administration or the Department of Human Services is correct. I understand that I am responsible for health insurance deductibles and coinsurance.

- ○ I am responsible for my own bill
  Please send a reminder bill to:

  Name: ____

  Address: ____

  ____

Authorization to Release Information

I authorize Donna Noland, Ph.D. to release to my insurance carriers, the Primary Care Physician, Utilization Reviews, and/or any insurance carrier represented as contractually responsible for payment in whole or part of my health care bill, primary and secondary diagnoses and/or principal or other procedures and copies of the medical and billing record or verbal clinical information as requested, or may be necessary to determine benefits entitlement, process payment claims for the episode of care, and provide for continuing treatment. I also authorize release of information to a collection agency and its attorney in the event of my non-payment of the bill. I understand that I may revoke the authorization at any time except to the extent that action has been taken in reliance on the authorization. The authorization will expire upon the final payment of my account and any collection charges and fees. The authorization is not required for obtaining treatment, unless the sole purpose of the authorization is to determine a claim for benefits, however our office may require payment at the time of services if the authorization is declined.

Donna Noland, Ph.D.

WARNING: We have no control of information and records released to any person, firm, or agency, under the authorization and it therefore is possible that a release of the information or records may occur by such party.

Release: I release Donna Noland, Ph.D., and her employees and agents from any liability in connection with the use or disclosure of the information and records to any party pursuant to the authorization.

I understand the information authorized for release may indicate the presence of a communicable or non-communicable disease. The authorization for release of information cannot be used to obtain copies of any other information contained within my medical records other than that which I have authorized.

Drug/Alcohol Abuse Treatment Records: This category of medical information/records is protected by federal confidentiality rules (42 CUR Part 2). The federal rules prohibit anyone receiving the information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CUR Part 2. A general authorization for the release of medical or other information is not sufficient for the purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Information about Collection of Charge
If after 45 days, my insurance has not paid Dr. Noland, I will be responsible for the entire bill. I understand that payment of the outstanding bill is due promptly, payable directly to Dr. Noland. Payment is expected at time of discharge unless her office agrees to other arrangements. Any effort by her office to collect insurance proceeds does not affect the responsibility of the undersigned except to the extent Dr. Noland received insurance proceeds. Dr. Noland's acceptance, or check endorsement of less than payment in full at any time shall not waive Dr. Noland's right to release the remaining balance to be collected by an attorney. The undersigned hereby agrees to pay all collection expenses including reasonable attorney's fees. If any legal action is taken in accordance with the agreement, the proper venue for such action shall be Tulsa County, Oklahoma.

Our office will consider a payment plan; I understand that it is office policy, however, not to extend the payment plan beyond four installments within 90 days. If my account balance remains unpaid for 90 days it will be recommended for placement with an outside collection agency.

I have carefully read the consent for treatment, confidentiality statement, release of medical and billing information and financial agreement/assignment and fully understand the terms, and I voluntarily sign my agreement and acceptance with full knowledge of its content and significance.

Acknowledgement of Notice of Privacy Practices: A complete description of how your medical information will be used and disclosed by the office is in our Notice of Privacy Practices, which you should read before signing the agreement. A copy is included in your admissions packet and is posted in our office.

Patient - Signature: ______________________________ Date: ______________

Person authorized to sign for patient – Signature: ______________________________

Relation to patient: ______________________________ Date: ______________

Statement of Guarantor Responsibility (If other than patient)
In consideration of medical treatment and service given to the above-named patient, the undersigned unconditionally guarantees to pay in full all charges and fees incurred according to the terms of the Financial Responsibility Agreement.

Guarantor Signature: ______________________________ Date: ______________

Print Name: ______________________________

This is to certify that the preceding Understanding of Financial Responsibility and the Authorization to Release Medical Information has been read to the patient (or representative) in his/her native language. All representations, which appear in the Understanding of Authorization, were understood and authorized by the patient (or representative).

Notice of Policies and Practices to Protect the Privacy of Your Health Information

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- **"PHI"** refers to information in your health record that could identify you.
- **"Treatment, Payment and Health Care Operations"**
  - -**Treatment** is when I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychologist.
  - -**Payment** is when I obtain reimbursement for your health care. I may disclose your PHI to your health insurer for payment activities such as: determining eligibility and coverage under a health-care plan, reviewing services to determine medical necessity, and participating in utilization review activities.
  - -**Health Care Operations** are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, case management and care coordination, and providing reminders of appointment times.
- **"Use"** applies only to activities within my office such as sharing, examining, and analyzing information that identifies you.
- **"Disclosure"** applies to activities outside my office such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

- I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment, and health care operations, I will obtain an authorization from you before releasing this information.
- I will also need to obtain an authorization before releasing your psychotherapy notes in the event that I determine releasing those notes is appropriate and consistent with Oklahoma statutes governing mental health records. "Psychotherapy notes" are notes I have made about our conversations during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.
- I will also obtain an authorization from you before using or disclosing PHI in a way that is not described in this Notice.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have reason to believe that a child under the age of 18 years is the victim of abuse or neglect, the law requires that I report to the appropriate government agency, usually, the Oklahoma Department of Human Services. Once this report is filed, I may be required to provide additional information.
- **Adult and Domestic Abuse:** If I have reason to believe that a vulnerable adult (defined below) is suffering from abuse, neglect, or exploitation, I am required by law to make a report either to the Oklahoma Department of Human Services, the district attorney's office or the municipal police department as soon as I become aware of the situation. Once a report is filed, I may be required to provide additional information.

  A "vulnerable adult" means an individual who is an incapacitated person or who because of physical or mental-disability, incapability, or other disability, is substantially impaired in the ability to provide adequately for the care or custody of him or herself, or is unable to manage his or her property and financial affairs effectively, or to meet essential requirements for mental or physical health or safety, or to protect him or herself from abuse, neglect, or exploitation without assistance from others.

- **Health Oversight:** If you file a disciplinary complaint against me with the Oklahoma State Board of Examiners of Psychologists, the Board would have the right to view your relevant confidential information as a part of the proceedings.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release the information without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If you communicate to me an explicit threat to kill or inflict serious bodily injury upon a reasonably identifiable person, and you have the apparent intent and ability to carry out that threat, I have the legal duty to take reasonable precautions. These precautions may include disclosing relevant information from your mental health records, which is essential to protect the rights and safety of others. I also have such a duty if you have a history of physical violence of which I am aware, and I

have reason to believe there is a clear and imminent danger that you will attempt to kill or inflict serious bodily injury upon a reasonably identifiable person.

- **Worker's Compensation:** If you file a worker's compensation claim, you will be giving permission for the Administrator of the Worker's Compensation Court, the Oklahoma Insurance Commissioner, the Attorney General, a district attorney (or a designee for any of these individuals) to examine your records relating to the claim.
- **Use and Disclosure Allowed Under Other Sections of Section 164.512:** When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of PHI. However, I am not required to agree to a restriction you request.
- **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations:** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address designated by you.
- **Right to Inspect and Copy:** You have the right to inspect and/or obtain a copy of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process. This right does not apply to a very narrow category of medical information referred to as "psychotherapy notes."
- **Right to Amend:** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.
- **Right to an Accounting:** You generally have the right to receive an accounting of disclosures of PHI regarding you. You may request one free listing of disclosures every 12 months. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003.
- **Right to Notice:** You have the right to obtain a paper copy of the notice.
- **Right to Restrict Disclosures When You have Paid for Your Care Out-of-Pocket.** You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.
- **Right to Be Notified if There is a Breach of Your Unsecured PHI.** You have a right to be notified if: (a) there is a breach (a use of disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

You must submit a written request to exercise any of these rights. You may request forms to exercise these rights by contacting my privacy office as follows:

Privacy Officer
4870 S Lewis Ave, Suite 230
Tulsa, Oklahoma 74105

Psychologist's Duties:
I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
I reserve the right to change the privacy policies and practices described in this notice.
Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
If I revise my policies and procedures, I will provide written notice in the first treatment session following the change or by mail if you are no longer in treatment and if it has been less than six years since the last date of treatment.

V. Complaints

If you are concerned that I may have violated your privacy rights, or you disagree with a decision I have made about access to your records, you may contact my privacy officer as noted above. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The privacy officer will provide you with the appropriate address upon request.

I will not retaliate against you if you file a complaint against me.

This notice takes effect April 14, 2003.

Notice of Privacy Practices Acknowledgment and Consent

The notice of Privacy Practices tells you how I may use and disclose your protected health information (PHI):

I will use and disclose your PHI to treat you and to bill for the services provided.

I will use and disclose your PHI to run my business.

I will use and disclose your PHI as required by law.

All of the ways I may use and disclose your PHI are explained in more detail in the Notice of Privacy Practices.

You have the following rights with respect to your PHI:

You have the right to examine and receive a copy of your PHI.

You have the right to receive a list of individuals or agencies to whom I have given your PHI.

You have the right to ask for an amendment to your PHI.

You have the right to ask that I not disclose your PHI.

You have the right to ask that I change the way I contact you.

You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for my services.

You have a right to be notified if: (a) there is a breach (a use of disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) your PHI has not been encrypted to government standards; and (c) my risk assessment fails to determine that there is a low probability that your PHI has been compromised.

All of these rights are explained in more detail in the Notice of Privacy Practices.

I have received a copy of Dr. Noland's Notice of Privacy Practices.

Signature____ Date______________________

CONSENT:

I consent to the use and disclosure of my protected health information for treatment, payment and operation purposes in the Notice of Privacy Practices.

Oklahoma law (63 OS, Sec.1-5-2.2) requires that I advise you that the information authorized for disclosure may include records which may indicate the presence of a communicable or non-communicable disease. It may also include mental health or other sensitive information.

Signature_______________________________________ Date______________________