Patient Information

PLEASE COMPLETE ALL REQUESTED INFORMATION

If the patient is a minor (less than 18 years of age) please read and sign the following: I hereby authorize The Ludden Group to provide treatment to my child _____, and I further agree to pay all charges made as a result of this treatment:

_____ _____

Parent or Legal Guardian ***Date***

Please note that ***PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED*** unless prior arrangements have been made with this office and approved. As a courtesy to you, we will be happy to file your insurance. Please complete all items on this form.

PATIENT INFORMATION – PLEASE PRINT

Name_____ Sex_____ Age_____
Birth date_____

Address_____
City/State/Zip_____

Phone: Home_____ Cell_____
Employer _____Work # _____
Social Security #_____

EMERGENCY CONTACT
Name/Address/Phone # of Nearest Relative Not Living With You:
_____
_____

Marital Status_____ Spouse's Name _____

INSURANCE INFORMATION
Insurance
Company_____
Group # _____ Policy # _____
Responsible Party
(Last, First & Middle Initial) _____
Address _____
SS # _____ Birthdate _____

Your Relationship to Responsible Party _____

Worker's Compensation? ____YES____NO If yes, Claim Number_____

Adjuster _____ Phone #_____

Date of Injury_____ Employer at time of injury_____

WHO REFERRED YOU TO THIS OFFICE

It is in my practice to notify the referral source of clients who come to me. I hereby authorize The Ludden Group to inform this source.

Source's Name_____Profession_____

Phone Number_____Address_____

_____ _____

Signature of Patient *Signature of Legal Guardian*

OFFICE POLICY

1. Appointments: Standard appointment time is 45 minutes.
2. Payments: Make checks for services rendered to Dr. Linda Ludden at the end of each appointment. Please designate it counseling on the lower left side of the check. All fees will be paid at the end of each session. Statements are provided for insurance purposes.
3. **Cancellation and No Show Policy**: It will be necessary for The Ludden Group to charge your full fee for any appointments you miss by either not showing or by cancellation with less than **24 hours notice**.
4. Feedback: Therapy is a creative process between you and your therapist. Feel free to discuss with your therapist any positive or negative responses which you may have with regard to your treatment program. This will enable you and your therapist to attain your optimum personal development in either the solution, adjustment to or resolution to your problem.
5. Confidentiality: The information you share with anyone without your signing a "Release of Information" form unless the records are subpoenaed by the State in which we will make every effort possible to protect you. Exception: By the Texas law, child abuse and threats to commit suicide or a felony must be reported.

I HAVE READ COMPLETLEY AND AGREE TO THE STATEMENTS ABOVE.

_____

Patient Signature Witness Date

POLICY OF CONFIDENTIALITY

The information that you share with you therapist is not divulged to anyone without your written consent. However, this policy does not apply to the following circumstances:

1. If you have insurance coverage and or assignee of your EAP and the insurance company of the employer request information about your case.
2. If information is revealed which might indicate that you present a clear and imminent danger to yourself or another individual(s), we are obligated to report this information to a designated government agency.
3. If information is revealed that might indicate you have physically, sexually or emotionally abused a child, adolescent or senior citizen, we are obligated to report this information to a designated government agency
4. If your therapist is an employee of this practice and is regularly supervised, information pertinent to your case may be discussed with supervisor who will be held accountable to the policy of confidentiality.

If you have any questions regarding this policy, please discuss them with your therapist. By signing this document you acknowledge that you read, understood and accept this policy of confidentiality.

_____ _____

Client Signature Date

Patient Rights and Responsibilities

1. **Patient Relations**
   All patients have the right to be treated in a courteous, considerate, and dignified manner.

2. **Confidentiality**
   Privacy and confidentiality are of the utmost importance to the clinical relationship. Please feel free to discuss the legal limitations of confidentiality with your clinician. The Ludden Group we will provide your primary care physician with information related to your case if you request so in writing. The Ludden Group will follow these procedures unless otherwise notified by you in writing. Should The Ludden Group or anyone affiliated be subpoenaed, we normally provide the requested information, whether or not the information is favorable to the undersigned. In the event of a subpoena or attorneys request, it is fully understood that The Ludden Group my bill the patient an hourly rate of up to 300.00 per hour for reports, court appearances, travel, or cost not reimbursed by insurance companies.

3. **Complaints and Grievances**
   Any client, who is convinced that The Ludden Group has failed to achieve a satisfactory standard of care, and wishes to express his-her concerns, is advised to submit a written complaint. The Ludden Group Will respond to complaints and grievance within 10 business days, but in order to expedite the resolution, you are encouraged to simultaneously discuss your concern with The Ludden Group, giving them the opportunity to present information, facilitating the investigation and resolution of the issues.

4. **Financial**
   Patients are responsible for payment of all applicable fees at the time of the visit. If you are a parent/guardian of a minor, all costs not covered by your insurance company are your responsibility

   MANAGED CARE PATIENTS: Patients are responsible for the payment of co-pays at the time of visit. IF you miss more then two co-payments, your eligibility for outpatient services with The Ludden Group may be jeopardized. If you exhaust your benefits, you may make private arrangements with The Ludden Group, to continue care.

   PAIN MANAGEMENT / INSOMNIA / DEPRESSION / ANXIETY / STRESS MGMT
   Patients renting or purchasing **Alpha-Stim** device for the above therapies are responsible for payment in the event that the insurance company does not cover the cost. Many insurance companies will pay.

5. **Appointments**
   The Ludden Group will make every effort to arrange appointments that are convenient to you. Specific hours vary by provider, but generally are during normal business hours. Appointments at other times may be available for special needs. **IN THE EVENT THAT YOU MUST CANCEL AN APPOINTMENT, PLEASE CALL AT LEAST 24 HOURS IN ADVANCE. FAILURE TO GIVE ADEQUATE NOTICE WILL RESULT IN YOU BEING BILLED FOR THE APPOINTMENT**

6. **Authorization for Services- Managed Care Plans**
   In accordance with your insurance plans, The Ludden Group must pre-approve all mental and chemical dependency service.

7. **Exclusions**
   Some insurance plans do not cover Involuntary or Court-ordered treatment. Including some psychological testing requested by the school system and to fulfill some job requirements.

Testing or Therapy not covered by insurance can be arranged for privately, Please consult with my office manager for these arrangements.

I have read the above and understand my rights and responsibilities

_____ _____

Printed Name Signature

COURT APPEARANCES

If any provider in The Ludden Group is subpoenaed or requested to provide testimony by your side or an opposing side in court action, you agree to provide travel and preparation time expenses, and hourly or per diem fees at $300 per hour, with a minimum of four hours per courtroom visit per day. That will cover preparation time and travel time from the time they leave the office until they return. **The anticipated cost will be expected in full prior to court appearance.**

_____ _____
Printed Name Signature

_____ _____
Spouse/Guardian Signature

_____ _____
Date Witness

HIPPA COMPLIANCE

I hereby knowledge receipt of The Ludden Groups Notice of Privacy Practices for Personal Health Information. (If you need a copy of this for your records or are unfamiliar with this disclosure please contact our office and we will provide you with a copy.)

_____ _____
Printed Name Signature

_____ _____
Date Witness

The Ludden Group, P.C.

935 West Ralph Hall Parkway Ste 105
Rockwall Texas 75032
972-772-8484

HIPPA POLICY

PURPOSE: To ensure that client rights/confidentiality are respected and protected to inform clients of their rights and provide a confidential environment in which their rights can be exercised.

POLICY STATEMENT:

The Ludden Group respects the privacy of protected health information and understands the importance of keeping this information confidential and secure. This Notice describes how we protect the confidentiality of the protected health information we receive.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) The Ludden Group in conjunction with the health care community to maintain a comprehensive system to ensure compliance with applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Since our goal is to provide the highest level of service to our clients our HIPAA Privacy Policy contains procedures addressing the protection, use and disclosure of protected health information ("PHI"), accounting of disclosures, access by individuals and third parties to PHI, protection of PHI by contractors, business associate agreements and training of employees.

_____ _____

CLIENT NAME DATE

_____

CLIENT SIGNATURE

_____ _____

WITNESS SIGNATURE DATE

The Ludden Group, P.C.

935 West Ralph Hall Parkway Ste 105
Rockwall Texas 75032
972-772-8484

CONFIDENTIALITY POLICY

PURPOSE: To ensure that our clients rights/confidentiality (by HIPAA law) are respected and protected to inform clients of their rights and provide a confidential environment in which their rights can be exercised.

POLICY STATEMENT:

A client's record is a legal document and, as such, it must be kept confidential and used only for the documentation of information necessary for the delivery of services to that client. Any information by or about a client shared with a staff person must be treated as confidential.

_____ _____

CLIENT NAME DATE

_____

CLIENT SIGNATURE

_____ _____

WITNESS SIGNATURE DATE