The office of Thomas E. Thorsheim, Ph.D.
Incorporated
Licensed Psychologist (SC Lic. # 996)
1326 Haywood Road, Suite 102
Greenville, SC 29615
Tel: 864-421-0098 / Fax: 864-421-0099

Date ___________

Patient Information for Provider

Melanie M. Albers, PhD (Licensed Psychologist – SC Lic. # 1377)

Patient Name:______________________________ **Referred by:______________________**
Address:___________________________________ **Home Phone:______________________**
____ **Date of Birth:____________________**
Gender:__________
Parent Marital Status (please circle): Single / Married / Partnered / Divorced / Widowed

If applicable:

School__________________________ District______________________ Grade/Year in School:__________

Parent Profession/Employer:____

Please indicate the primary phone number or preferred mode of contact:__________________

Are there any special instructions for contacting you? (i.e. for your privacy or convenience)______

____

Email Address(es):____

If you wish, please provide the name/number of an emergency contact:___________________

Other Household Members:

Last Name:______________ First Name:______________ Birthdate:__________ Relationship:__________

Last Name:______________ First Name:______________ Birthdate:__________ Relationship:__________

Last Name:______________ First Name:______________ Birthdate:__________ Relationship:__________

Last Name:______________ First Name:______________ Birthdate:__________ Relationship:__________

Last Name:______________ First Name:______________ Birthdate:__________ Relationship:__________

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Provider: Melanie M. Albers, PhD (Licensed Psychologist)

A. MEDICAL HISTORY (Y= YES, N= NO, U= UNKNOWN)

Have you ever had any of the following medical conditions?

	Y	N	U			Y	N	U	
1.				Hearing problems	16.				Venereal disease
2.				Vision problems	17.				Measles (what type)
3.				Headaches	18.				Mumps
4.				Head injury	19.				Chicken Pox
5.				Blackouts / fainting	20.				Rheumatic Fever
6.				Seizures / convulsions	21.				Tuberculosis
7.				EEG / Brain wave test	22.				Diphtheria
8.				Diabetes (or anyone in the family?)	23.				Enuresis/Encopresis
9.				Asthma / breathing problems	24.				GI Problems
10.				Serious accident / injury	25.				Repeated infections
11.				Surgery	26.				Urinary
12.				Hallucinations	27.				Cardiovascular
13.				Congenital defects	28.				Respiratory
14.				Suicide gesture / attempt	Date of last pregnancy (if applicable)				
15.				Female/Gyn. problems / pregnancy					

If "yes" to any of the above, please comment: ____

____

____

____

B. Allergies / Type of Reaction:

1. **Medications** ____
2. **Foods** ____
3. **Other** ____

C. Medication History

Are you currently on any medications or supplements? (include both prescription and non-prescription)

NAME DOSAGE REASON EFFECTIVE?

____

____

____

____

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What medications have you previously taken or been prescribed?

NAME	DOSAGE	REASON	EFFECTIVE?

Adverse side effects? Yes __ No ___
If yes, please explain: ______________________________

____

Date of last physical exam: ____________________

Name of family physician: ____________________

Are you currently under a physician's care for any reason? Yes __ No _____

If yes, please explain: ______________________________

____

____

D. DRUGS AND ALCOHOL

Do you: Smoke? Yes _____ No______ How much? ______________

Drink? Yes ______ No ______ How much? ______________________________

Have you ever used "recreational drugs" or "street drugs"? Yes _____ No _____

TYPE	HOW LONG	WHEN

E. PREVIOUS THERAPY, PSYCHOLOGICAL OR PSYCHIATRIC TREATMENT

Are you now or have you previously seen a mental health practitioner? Yes ___ No ___
If so, whom do/did you see? ______________________________
What were your reasons for seeking treatment?______________________________

____

Was it helpful?______________________________
Have you previously had formal psychological testing? Yes _____ No ____
If yes, by whom?______________________________

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Provider: Melanie M. Albers, PhD (Licensed Psychologist)

CONSENT TO MENTAL HEALTH EVALUATION & TREATMENT

Patient Name: ________________________________ Date of Birth: __________ Age: ______

I hereby authorize Dr. Albers to provide mental health services to me (or to my minor child – if the child is the patient being treated).

____
Printed Name of Client

____
Signature of Client (or guardian, in the case of a minor) Date

____
Signature of Child (assent to treatment - if child is primary client) Date

Melanie M. Albers, Ph.D.____
Provider

____
Signature of Provider Date

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Provider: Melanie M. Albers, PhD (Licensed Psychologist)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

I may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*.

I may use/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. *"Psychotherapy notes"* are notes I have made about our conversation 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.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

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

- Child Abuse: If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must make a report of such within 48 hours to the South Carolina Department of Protective and Regulatory Services (Child Protective Services) or to any local or state law enforcement agency.

- Adult and Domestic Abuse: If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services (Adult Protective Services).

- Health Oversight: If a complaint is filed against me with the State Board of Examiners of Psychologists, the Board has the authority to subpoena confidential mental health information from me relevant to that complaint.

- 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 information, without written authorization from you or your personal or legally appointed representative, or a court order.

The above 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 the evaluation is court-ordered or is being conducted for a third party.

- Serious Threat to Health or Safety: If it is determined that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.

- Worker's Compensation: If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

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 you are notified of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will post notice of such revision in a visible location. I may also elect to notify you by mail at the billing address which you have provided to me.

Complaints

If you are concerned that your privacy rights have been violated, or you disagree with a decision made about access to your records, you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

____________________________________ _______________

Patient Signature (or responsible party) Date

____

Printed Name of Patient (or responsible party)

____________________________________ _______________

Provider Signature Date

Melanie M. Albers, Ph.D.

Printed Name of Provider

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DR. ALBERS' PAYMENT POLICY & FEE RATES

All services rendered are your financial responsibility. You are responsible for full payment at time of service regardless of insurance coverage. Dr. Albers will bill you directly and will not bill your insurance provider. However, you may independently attempt to seek reimbursement from your insurance carrier. Dr. Albers will provide you receipts and specific billing codes for you to expedite any reimbursement from your insurance carrier.

If you are issued reimbursement from your insurance, please ask that your insurer send payment directly to you, as my office does not cash third-party checks from insurance.

FEE SCHEDULE

* **PLEASE NOTE:** 48 hours advanced notice is requested to change or cancel an appointment. A minimum of a full 24 hour notice of cancellation is required. Appointments canceled less than 24 hours prior will be billed at the full fee rate.

- Initial Diagnostic Interview (60 min):............... $140
- Individual Psychotherapy (45 min):.................. $130
- Individual Psychotherapy (60 min): $140
- Family Psychotherapy (60 min):....................... $140
- Group Psychotherapy (75 min):........................ TBD
- Psychological Testing: Fees vary based on testing required. Please call to discuss.

By signing below, I acknowledge understanding of the above fee schedule. I am aware that Dr. Albers has chosen not to participate in insurance panels and that she does not receive third-party reimbursement from insurers. In addition, I understand that she is not a Medicaid or Medicare provider.

*****I also understand that in the event of a missed appointment or late cancellation (i.e. less than minimum of a full 24 hour notice), I would be charged in full.***

PLEASE INITIAL HERE ___

SIGNED:____ **DATE:**__________

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Request/Authorization to Release Protected Health Information

DO YOU WISH TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM I - YOUR PROVIDER - MAY DISCUSS YOUR TREATMENT/MEDICAL CONDITION? IF SO, SPECIFY WHOM BELOW.

This form, when completed and signed by you, authorizes me and my office to release protected information about you from your clinical record to the person or people you designate. It also permits us to obtain information from those individuals and/or institutions you designate. By signing, you attest that you have had explained to you and fully understand this request/authorization to release and obtain records and information, including the nature of the records, their contents, and the consequences and implications of their release or acquisition.

I,__________________, authorize my psychologist, Melanie Albers, Ph.D. or the clinical staff of Thomas Thorsheim, PhD, Inc. to release or obtain the following information pertaining to ____________________.
(insert patient name above)

[Check all that apply and cross out all other options]

- o Psychological evaluation
- o Progress notes
- o Summary of clinical record
- o All information
- o Other ______________________________________

This information should only be released to or obtained from:

[Check all that apply and cross out all other options]

- o My physician
- o My attorney
- o My previous therapist
- o Family member
- o Other______________________________________

Name, address, and/or telephone number of person/people to whom information is to be released:

____

____

____

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Request/Authorization to Release Protected Health Information-Continued

Provider: Melanie Albers, PhD (Licensed Psychologist)

I am requesting that Dr. Albers release this information for the following reasons: ("'at the request of the individual" is all that is required if you are my client and you do not have a more specific purpose")

AT THE REQUEST OF THE INDIVIDUAL/OTHER REASON:________________________________

____

This authorization shall remain in effect until you request otherwise or (in the event that you do not revoke it), it shall remain in effect for 2 years from date of signature.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that Dr. Albers generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

SIGNED:____ DATE:____________