Bettina Lehnert PhD, PLLC
10149 N 92nd St, Suite 103
Scottsdale, AZ 85258-4557
480.285.7011

Private & confidential - Patient information

Today's date _____

Name (Last, First, Middle Initial) _____

Birth date _____-_____-_____ Age ____ Gender ____M____F

Address _____ City_____ State____ Zip_____

Home Telephone (_____)_____ Work Telephone (_____)_____

Cell Phone (_____)_____ E-Mail _____

Marital Status: ____married _____Single _____ widowed_____ Divorced_____ Separated ____#of years

Name of Spouse / significant other / Parent / Guardian: _____

May we contact them if necessary? _____

Your occupation _____

Referred by _____ Phone (_____)_____

Address _____ City_____ State____ Zip_____

May we be in contact with the referral source? ___Y ___N

Emergency Contact _____ Relationship _____

Telephone (_____)_____ Other Telephone (_____)_____

Billing/Responsible Party Information

Name (Last, First, Middle Initial) _____

Address _____ City_____ State____ Zip_____

Home Telephone (_____)_____ Work Telephone (_____)_____

Cell Phone (_____)_____ E-Mail _____

Credit Card Number:_____ Expiration:_____

Billing zip code: _____ Security Code _____

Child of divorce ___Y ___N Custody status _____

Has the patient had previous psychological care? ___Y ___N

If yes, please select one: _____Inpatient care _____Outpatient care

Family Members/others Now in Household:

Name	Relationship	DOB/Age	Birthplace	Occupation	Marital Status

Children living away from home?

Original Family Members:

Name	Relationship	DOB/Age	Birthplace	Occupation	Marital Status

Please provide the following information about your general health and your health history. Please Circle P for personal health history. Circle F for areas of family history.

P F Alcohol use/Drug use
P F Allergies: pollen, dust, animals
P F Allergies: medications
P F Asthma, Bronchitis
P F Arthritis, Gout
P F Eating disorder: anorexia, bulimia
P F Bone/joint condition
P F Back, neck, spine, disc problem or injury
P F Birth defects/ Deformity
P F Blood disease: anemia, leukemia
P F Blood vessel, circulation disorder
P F Breast disease
P F Breast implants (L/R)
P F Broken bones/ bone disease
P F Cancer of any type
P F Concussion/head injury
P F Diabetes
P F Ear/Nose/Throat disease or infection
P F Epilepsy/seizure disorder, convulsions
P F Hysterectomy
P F Female organ irregularity, abnormal Pap, menstrual
P F Gallbladder
P F Heart problem or condition
P F Hepatitis/liver disorder
P F Hernia
P F Hypertension, blood pressure disorder
P F Hormonal/Thyroid/Pituitary disorder
P F HIV/Aids
P F Immune system disorder, Lupus
P F Stomach/ colon/ Crohn's disease
P F Intestinal disorders
P F Kidney/Urinary tract condition or infection
P F Lung condition or infection
P F Male organ irregularity or condition: prostate, impotence
P F Nervous system conditions
P F Mental: nervous, depression, anxiety
P F Migraines/Headaches
P F Muscle/Tendon disorders
P F Prosthetic implant/ artificial limbs
P F Reconstructive/Cosmetic surgery
P F Sexually transmitted diseases
P F Skin disorders/lesions/cancer
P F Steroid use: Prednisone, anabolic
P F Stroke
P F Tumors, cysts, polyps, growths
P F Ulcers, digestive disorders
P F Weight problems

Has there been any family psychiatric history? _____

_____

_____

_____

Current & Past Medications (please indicate by circling past or current med)

C	P		C	P		C	P	
C	P		C	P		C	P	
C	P		C	P		C	P	
C	P		C	P		C	P	
C	P		C	P		C	P	

Have you ever been hospitalized? If yes, please state when, where, why: _____

_____

Have you ever had surgery? If yes, please state type of surgery and when, where, why: _____

_____

_____

Please check any of the following areas that you have experienced:

[ ] Head Injury [ ] Loss of consciousness [ ] Seizures [ ] convulsions [ ] other neurological diagnosis

Please briefly describe your family when you were growing up:

_____

_____

_____

_____

Please list any events from your childhood / or adulthood that has had a profound effect on your life: _____

_____

_____

_____

Highest grade completed _____ Degree _____ Where _____

How many hours a week are you employed? _____

How often do you spend time with others? _____

Please show history of substance abuse:

	Current	Past		Current	Past
Alcohol			Hypnotics		
Tobacco			Diet pills		
Caffeine (tea, coffee, soda)			Narcotics / Pain		
Cocaine			Nerve pills		
Marijuana			Sleeping pills		
Stimulants			Others (specify)		

Psychologist- Patient Informed Consent Agreement

This agreement has been prepared to help Dr. Lehnert's patients understand how the business office operates with respect to the psychologist-patient relationship. Please read all of the information contained in this agreement and indicate your confirmation by signing this document.

- *All payments are due at the time of service. I can provide you with a "superbill," which is a receipt that can be sent in for re-imbursement.*
- *There is a 24 hour cancellation policy for appointments. The full session fee will be charged if not cancelled 24 hrs ahead.*
- *You consent to Telepsychology sessions if you choose to continue Treatment and in person sessions are not possible*
- *I send appointment reminders as a courtesy to my patients. However, reminders are only a courtesy. Please keep track of your own appointments.*
- *Sessions are 50 mins. Telephone time and extending the session beyond 50 mins will be charged accordingly.*

Please Initial _____

Confidentiality Policy

All patient records will remain confidential unless otherwise instructed in writing by the patient, if subpoenaed by a court of law, if the patient presents a physical danger to self or others, or child/elder abuse/neglect is suspected.

Health Insurance Plans

Dr. Lehnert is not contracted with any insurance companies. Patients may elect to file claims individually. A Super Bill/receipt can be provided at the time of visit, for patients to submit the claim to their insurance plans.

The diagnosis and treatment information required on the claim form is often forwarded by the patient's insurance plan to the *Medical Information Bureau* (MIB). The patient's health history then becomes available to other insurance companies without the patient realizing he/she has given consent (usually in the fine print during the application process). Therefore, Dr. Lehnert believes that the release of any diagnostic information through the claims filing process may present a potential risk that could be personally damaging to unknowing patients. Therefore, Dr. Lehnert wants each patient to be aware of any potential risk of releasing medical information should an inappropriate party have access to the MIB national database.

Medicare Part B Entitlement Policy

Dr. Lehnert will gladly treat patients over the age of 65, but she does not participate in the Medicare Part B program. Medicare eligible patients must sign a Waiver of Medicare Part B Entitlement, indicating that services provided in Dr. Lehnert's office will not be claimed against the Medicare Part B Program, but instead is the patient's financial responsibility. Current laws require this waiver to be signed by Dr. Lehnert and the patient.

Payment Policy & Terms

A $25.00 fee will be charged for any returned check. The patient agrees to pay all charges, in accordance with the Payment Policy outlined in this agreement. Should Dr. Lehnert's office be forced to incur collection charges or legal fees, the patient agrees to pay them in full.

Termination Policy

Dr. Lehnert reserves the right to terminate any patient who violates treatment protocol, is generally non-compliant, or who willfully disregards other treatment objectives that could support positive clinical outcomes.

Protocol for secure Storage, Transfer, and Access to Client Records on Termination of the Practice

In the event of my terminating my practice, I will notify active clients that they may locate me by calling me directly at a number provided to them by letter or direct verbal communication or by contacting the Arizona State Psychological Association or the Arizona State Board of Psychologist Examiners, who may contact me directly and convey the request. For reasons of personal privacy, I will only provide direct access to current or recent (six months) clients via providing them with telephonic contact numbers. I will maintain a professional telephonic contact number for a period of three to six months, depending on circumstances at the time of closing of my practice. Inactive clients may contact me via the Arizona Psychological Association or the Arizona State Board of Psychologist examiners. I will maintain records at 10149 N 92nd St, Suite 103, Scottsdale, AZ 85258-4557.

I will maintain current contact information with the Arizona Psychological Association and the Arizona State Board of Psychologist examiners for the period of time required to maintain records. I will post two notices in the paper (two weeks apart) regarding the close of the practice and information for locating medical records.

I will respond in a timely manner to client requests for copies or access to their medical records. Unless prohibited by illness or temporary travel unavailability I will respond within 30 days or other legally or ethically responsible requirements. I will dispose of unclaimed records after the current legal and/or legally specified time requirements by destroying records so that no confidential information remains in usable form. In the event that circumstances require, I will forward record access and responsibility to another professional who will respond to record requests in accordance with legal and professional standards. Currently records are located at 10149 N 92nd St, Suite 103, Scottsdale, AZ 85258-4557.

Patient Responsibilities

Each patient is responsible for providing accurate contact information as well as billing information. If telephone numbers and/or addresses change, patients must inform Dr. Lehnert's business office. Furthermore, the patient understands that the examination and treatment provided by Dr. Lehnert is limited to outpatient psychology services. This does not necessarily constitute total or definitive psychological care. Further evaluation and treatment may be required in some cases. It is the patient's responsibility to obtain follow up medical care for general health as needed, or when advised to do so by Dr. Lehnert.

I have read, understand, and accept, the provisions of this agreement, and have no questions about the policies outlined herein. I understand that if I violate any provisions of this agreement, my treatment may be terminated. I understand that this agreement is binding in the State of Arizona and that the provisions are for my protection and for the protection of Dr. Lehnert. The original copy of this agreement will become a part of my private medical record.

_____ _____

Patient/Guardian Signature Date

INFORMED CONSENT CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES

Prior to starting video-conferencing services, we agree to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.

As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

Patient Name: _____

Signature of Patient or Legal Representative:

_____ Date:_____

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Medicare Opt Out Private Contract (sign only if you have Medicare)

• I Bettina Lehnert, PhD have not been excluded from Medicare under [1128] §§1128, [1156] 1156 or [1892] 1892 of the Social Security Act. I, Bettina Lehnert, PhD, have opted out of participating in Medicare as a provider.

• I the Medicare beneficiary or my legal representative accept full responsibility for payment of charges for all services furnished by Dr. Bettina Lehnert.

• I the Medicare beneficiary or my legal representative understand that Medicare limits do not apply to what Dr. Bettina Lehnert may charge for items or services furnished.

• I the Medicare beneficiary or my legal representative agree not to submit a claim to Medicare or to ask Dr. Bettina Lehnert to submit a claim to Medicare.

• I the Medicare beneficiary or my legal representative understand that Medicare payment will not be made for any items or services furnished by Dr. Bettina Lehnert that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

• I the Medicare beneficiary or my legal representative enter into this contract with the knowledge that I have the right to obtain Medicare-covered items and services from a physician and/or practitioner who has not opted-out of Medicare, and that the I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

• The expected or known effective date and expected or known expiration date of the opt-out period is October 1, 2013 (effective date) and October 1, 2015 (expiration date).

• I the Medicare beneficiary or my legal representative understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

• This contract cannot be entered into by myself, the Medicare beneficiary, or by my legal representative during a time when I, the Medicare beneficiary, require emergency care services or urgent care services. (However, a physician/practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with §3044.28 of the Medicare Carriers Manual)

• I the Medicare beneficiary or my legal representative will receive or have received a copy (a photocopy is permissible) of this contract, before items or services are furnished to me under the terms of this contract.

• I Dr. Bettina Lehnert will retain the original contract (original signatures of both parties required) for the duration of the opt-out period.

• I Dr. Bettina Lehnert will supply CMS with a copy of this contract upon request.

• I Dr. Bettina Lehnert understand that the current private contract remains in effect for two years. If I again opt-out of Medicare, I will expediently complete a new contract for each Medicare beneficiary and will expediently submit the appropriate affidavit(s) to all local Medicare carriers.

Medicare Beneficiary Name (Printed)	Medicare ID Number (On Card)
Beneficiary Signature	Date Signed
Bettina Lehnert, PhD	Date Signed

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Authorization Form-

(Complete only if there is someone you would like me to talk to or bring to your session)

This form when completed and signed by you, authorizes me to obtain protected information from and / or release protected information to the person you designate.

I _____, authorize my psychologist, Dr. Bettina Lehnert and her administrative staff to release/ obtain:

____ My entire record
____ A summary of my treatment
____ Information via verbal contact

This information should only be released to / obtained from:

_____

_____

_____

I am requesting my psychologist to release / obtain this information for the following reasons:

____ At my request
____ Other: _____

This authorization shall remain in effect until _____ or until termination of treatment with Dr. Lehnert.

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 my psychologist 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.

_____ _____
Signature of Patient Date

_____ _____
If Minor, Legal Guardian Date

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Acknowledgement of Receipt of Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information

("Notice of Privacy Practices" is available to download from my website)

I, _____ acknowledge that I have been offered a copy of the Notice of Privacy Practices.

This Notice describes how Dr. Bettina Lehnert may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____
Signature of patient or representative Date

_____
Relationship to patient

Bettina Lehnert, PhD.
Informed Consent for Participants in Couples Therapy
(Sign only if couples therapy is being sought)

I, _____ understand and agree that I am freely choosing to participate in couple's therapy with Dr. Bettina Lehnert.

I understand that confidential and/or sensitive information may be disclosed and discussed during the session(s), which may be upsetting to me or the other person. I acknowledge that Dr. Lehnert is not responsible for any problems or discomfort that may arise from matters disclosed or discussed during the couple's therapy session(s).

I understand that, in comparison to individual therapy, the focus in couple's therapy is on the relationship and both participants are considered clients. Therefore, I agree that all information in the therapist's records will be fully accessible to both participants. I also understand that participants in couple's therapy with Dr. Lehnert will generally not have individual session(s) unless agreed to by all parties. If that happens, it will only be with the consent of both parties and for specified reasons.

By my signature below, I understand and agree that any and all information disclosed and discussed with Dr. Lehnert at any time, including phone calls, will not be confidential between the participants.

By my signature below, I acknowledge that Dr. Lehnert is required by law to report any information regarding the abuse or neglect of a child or a vulnerable adult to the proper authorities regardless of my wishes.

By my signature below, I confirm that no divorce or child custody case has been filed or is pending without the knowledge of the other party. If Dr. Lehnert's records for the couple's therapy sessions are later subpoenaed during divorce and/or custody proceedings, I agree that she may honor any lawfully issued subpoena/court order and release the records. I also understand that providing records in response to a lawfully issued subpoena may result in a loss of confidentiality for the issues disclosed and discussed during therapy session(s).

_____ _____
Signature of Client Date

_____ _____
Bettina Lehnert, PhD Date