CRAIG P. KURTZ LMHC,P.A Professional Counseling centers JACKSONVILLE -ORANGE PARK

FLorida.

Craig P Kurtz LMHC #5063, CAP# 2069L • Orange Park, Fl • Jacksonville, Fl

Phone: (904) 215-5282, •

New Client Information

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: \_\_\_\_\_ M\_\_\_\_\_ F Client Age:\_\_\_\_\_\_\_\_ If client is a child, name of parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OK to call/send report? \_\_\_\_ yes \_\_\_ no On any medications? No\_\_\_\_, \_\_\_Yes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ,Please list them:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital status: \_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ E-Mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OK to call in the event of an emergency \_\_yes no \_\_, we should call: \_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_

Financial: Person assuming payment Responsibility: \_\_\_\_\_\_\_\_Relationship to client: \_\_\_\_\_Gross Annual Income:\_\_\_\_K

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Drivers License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance referrals only, please complete the following:

Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_ Authorization #\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of insured: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Certificate #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , Please have insurance card ready for photocopying!

Psychiatric/Medical: Have you ever been in counseling/psychiatric care? \_\_\_ no \_\_\_ yes, When: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ With whom: \_\_\_\_\_\_\_\_\_\_\_, May I contact them? \_\_\_yes\_\_\_ no. Hospitalized for any reason? \_\_\_ no \_\_\_ yes. When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Any medical conditions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Allergic to any medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing here I agree to the following\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\* *Provide urine specimen for purposes of on going evaluation process:*

\****Read and sign HIPPA Privacy Policy***,\*Authorize therapeutic treatment, \*Authorize the release of any medical or other information necessary to process claims or secure authorizations, \*Request payment of government or insurance benefits to this provider for services rendered,

**\**(I agree to indemnify, hold harmless, and otherwise release from liability***

***Craig Kurtz, Craig Kurtz LMHC, P.A., Professional Counseling Services***

***(hereinafter referred to collectively as "therapist"), and their agents,***

***shareholders, and employees from any legal, administrative or regulatory***

***action taken by me or any third party, to the extent such action relates to***

***the therapist's treatment, if I do not follow all conditions of the***

***treatment. These conditions include (i) immediate payment of fees for***

***treatment, (ii) payment of a fifty dollar fee for appointments missed or not***

***cancelled within 48 hours of the appointment, (iii) payment (typically***

***$500.00) in advance for consultation and appearances related to legal,***

***administrative or regulatory proceedings without full refund, (iv) following all recommendations:***

***(2)***

***Of the therapist in the manner and time prescribed, (v) complete honest disclosure of all diagnostic information, and (vi) any other***

***conditions deemed appropriate by the therapist during the course of***

***treatment. Failure of any of these conditions may result in termination of***

***therapeutic treatment at the sole discretion of the therapist. Failure to***

***terminate the treatment is not, however, indicia or evidence that***

***performance of a condition has been waived or satisfied for any purpose,***

***including my agreement to indemnify, hold harmless and release the therapist and interns***

***from liability.)***

Allow brief feed back to professional referral sources, \*Accept full payment responsibility for any balance past due 30 days, **Act responsibly regarding any and all fee arrangements and understand it is my responsibility to keep and schedule all appointments.** Pay a$50.00 missed or late cancellation fee(less than 48 hour notice) \*Pay a $500.00 Legal Fee in advance for consultation & court appearance without full reimbursement ***\* Failure to follow recommendations and fee agreements will result in cause to terminate therapeutic agreement. \*I agree to fees involved in telephonic consultation and all written documentation and have discussed any concerns about the above and below listed information.***

PRIVACY, ACCESS, USE OF RECORDS, AND HEALTHCARE INFORMATION UNDER HIPPA.

The health Insurance Privacy and Portability Act of 1996 mandates the creation of nationally standardized rules to protect individual’s personal health information and to give patients increased access to their medical records. As a healthcare provider, it is my policy and responsibility to adhere to these rules.

1. You have the right to receive a written copy of these rights.

2. You have the right to inspect and copy protected health information, excluding psychotherapy notes.

3.You have the right to amend information in the information you receive.

4.You have the right to know whom information is being disclosed.

5.You have the right to request restrictions on the uses of protected information and on the disclosure of protected information.

6. You have the right to have reasonable requests for alternate communication methods.

7. Should you have any questions or complaints about these rights, please discuss them with your provider first.

8. Should you not be satisfied with the remedy in #7 above, you have the right to file a complaint with the Federal Department of Health and Human Services, office of Civil Rights. (http:/www.hhs.gov/ocr/hippa)

9. You have the right to review the policies and procedures of my practice in regard to the implementing and safeguarding these rights.

10. I understand that all information discussed in individual, group and telephonic consultation will be held in absolute confidence to protect these rights for myself and others involved in the counseling process.

* By signing below, I fully understand this and responsibilities as a patient.

Client: (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client:(sign) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_

Craig P Kurtz, LMHC #5063, CAP# 2069 • Orange Park, Fl • Jacksonville, Fl

**Rights & Responsibilities (3)**

- Patients have the right to be treated with personal dignity and respect.

* Patients have the right to care that is considerate and respects member’s personal values and belief

system.

* Patients have the right to personal privacy and confidentiality of information.
* Patients have the right to receive information about a managed care company’s service, practitioners, clinical guidelines, and patient rights and responsibilities.
* Patients have the right to reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.
* Patients have the right to participate in an informed way in the decision making process regarding their treatment planning.
* Patients have the right to discuss with their providers the medically necessary treatment options for their condition regardless of cost or benefit coverage.
* Patients have the right of members’ families to participate in treatment planning as well as the right of members over 12 years old to participate in such planning.
* Patients have the right to individualized treatment, including

-Adequate and humane services regardless of the sources(s) of financial support,

-Provision of services within the least restrictive environment possible,

-An individualized treatment or program plan,

-Periodic review of the treatment or program plan, and

-An adequate number of competent, qualified, and experienced professional

clinical staff to supervise and carry out the treatment or program plan.

* Patients have the right to participate in the consideration of ethical issues that arise in the provision of care and services, including

-Resolving conflict,

-Withholding resuscitative services,

-Forgoing or withdrawing life-sustaining treatment, and

-Participating in investigational studies or clinical trials.

* Patients have the right to designate a surrogate decision-maker if the member is

incapable of understanding a proposed treatment or procedure or is unable to

communicate his or her wishes regarding care.

* Patients and their families have the right to be informed of their rights in a

language they understand.

* Patients have the right to voice complaints or appeals about a managed care

company or their provider of care.

* Patients have the right to make recommendations regarding a managed care

company’s rights and responsibilities policies.

* Patients have the right to be informed of rules and regulations concerning patients

conduct.

* Patients have the right to information about a managed care company Quality

Improvement Program.

* Patients have the right to be informed of the reason for any utilization

management non-certification including the specific utilization review criteria or

benefits provision used in the determination.

* Patients have the right to have utilization management decisions made based on

appropriateness of care. A managed care company does not reward practitioners

or other individuals conducting utilization review for issuing non-certifications of

coverage or service.

* Patients have the right to have access to their medical records.
* Patients have the responsibility to give their provider and managed care company

information needed in order to receive appropriate care.

* Patients have the responsibility to follow their agreed upon treatment plan and

instructions for care.

* Patients have the responsibility to participate, to the degree possible, in understanding

their behavioral health problems and developing with their provider mutually agreed

upon treatment goals.

* By signing below, I fully understand my rights and responsibilities as a patient.

Client: (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client:(sign) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Professional Counseling Centers Of Greater Jacksonville and Orange Park

**Craig P. Kurtz LMHC, P.A.**

**LMHC#5063 CAP#2069**

**(904) 215-5282**

**Authorization for Release of Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby grant my permission to release information pertaining to

Patient or Guardian

the diagnosis and treatment provided to me by \_Craig P Kurtz LMHC\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Craig P. Kurtz LMHC, P.A ,Craig P Kurtz LMHC, CAP

I understand that I will be releasing information from my medical record including general medical information as well as psychiatric, psychological, drug and or alcohol records in compliance with FS 90.503, 394.459(9), 395.3025(2)(3), 397.501(7)(a)(e1) and Federal Regulations 42 CFR, Part 2 and information concerning AIDS Human Immunodeficiency Virus Infection and the performance of any tests, counseling and the results and treatment for the exact purpose of providing this information is:

Continuity of Care\_\_\_ Referral\_\_\_ Coordination of Care\_\_\_

This information is to be released to and received from\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

As per Federal Confidentiality Rules (42 CFR Part 2) for the specific purpose of: Dates of Service\_\_\_, Diagnosis\_\_\_, Treatment plan\_\_\_, Treatment Report\_\_\_, Testing Reports\_\_\_, Summary of Treatment\_\_\_, Other \_\_\_\_\_\_\_\_\_\_\_\_\_ Fiscal Release \_\_.

The Federal Rules prohibit you from making any further disclosure of information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

This release of information should be valid for the duration of twelve months, upon completion of treatment, or for the duration of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand that refusal to grant this permission will in no way affect my treatment. This permission may be rescinded by written request at any time. This rescission shall not apply to any information rightfully released prior to the receipt of the rescission by \_\_\_\_Client\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Patient or Guardian

A copy, facsimile, or electronic transmission of the release shall be as valid as the original.

Client’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initial \_\_\_\_, I understand that I must participate in urinalysis and that the results will be sent to my referral source, I agree to do this as a condition of my treatment with this agency.

Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Guardian

Counselor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Supervisor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_