Date _____

Sandra Bowker and Associates

Child's name _____ date of birth _____ Age _____

Address _____ City/State _____ Zip _____ Pronoun(s)_____

Primary phone number (cell, home, work) _____ is it okay to leave voice messages? Yes/No

Text number (if different from primary number) _____ Text message ok? Yes/No

Email_____ is it okay to send email correspondence? Yes/No

Parent name _____ Date of Birth _____

Parent name _____ Date of Birth _____

**** Please be aware that the parent presenting with the minor child will be financially responsible for all costs incurred with Sandra Bowker and Associates. ****

Name of school _____ Current game _____

Emergency Contact Person (other than primary parents)

Name of contact person _____ Relationship _____ Ph Number _____

Parental Status (please circle)

Legal parents: Married/Divorced/Never Married/Deceased/Other _____

Legal Custody Status (if applicable) _____

Please provide address and phone number of other parent/guardian (if applicable):

Name _____ Address _____

Phone _____

Insurance Information (please bring your insurance card(s)with you to the first appointment and/or mailing address for auto claims)

Primary Insurance: _____ Insurance ID Number _____

Name of Policy Holder _____ Policy Holder's Date of birth _____

Policy Holder's Social Security Number _____ If auto related, date of injury _____

Secondary insurance: _____ Insurance ID Number _____

Name of Policy Holder _____ Policy Holder's Date of birth _____

Policy Holder's Social Security Number _____ If auto related, date of injury _____

Referral Information

Has your child or any family members been seen by Dr. Bowker before? Y/N. If yes, who was seen? _____

Approximately when was that? _____

How were you referred to our practice? _____

Name of primary care physician? _____ is it okay to contact this provider? Y/N

_____ Please initial here to indicate that you have received a copy of the HIPPA privacy policy.

If you are requesting that we submit claims to your insurance company, please review and sign the back of this form.

One Time Authorization for Payment

I am giving Sandra Bowker and Associates permission to ask for payment from my child's insurance carrier. I understand that the insurance company needs information about my child's medical or mental condition(s) to make a decision about these payments. I give permission for that information to go to my health insurance company and/or the companies that handle insurance payment requests.

I request that payment of benefits be made to Sandra Bowker and Associates for any services furnished to my child.

I understand that ultimately, I am responsible for ALL costs associated with the services provided at Sandra Bowker and Associates. Further, I understand that if insurance does not cover costs with Sandra Bowker and Associates, I will be held financially responsible.

Printed Name of Responsible party _____

Signature of responsible party _____ date_____

Social Security number of responsible party _____

Sandra Bowker and Associates

Office policies and consent

Welcome to our practice. The following information is presented to avoid any misunderstandings. A copy of this document has been provided to you and further copies will be provided upon request at any time.

About our Practice

- Our office is staffed Monday, Tuesday, Wednesday, and Thursday from 9am to 4pm. Office staff is unavailable Fridays, weekends, and Holidays. If an emergency arises outside of our business hours, please contact your primary care physician, call 9-1-1, call Gryphon Place at 269-381-HELP, or go to your local emergency room.
- All our providers schedule patients by appointment only. If you are more than 15min late for a therapy appointment, it may be necessary to reschedule the appointment and may be considered failed. Our appointments fill up several weeks to months in advance. There will be a fee for late cancellations and/or failed appointments. The fees are outlined in the financial agreement section.
- All phone calls and emails are answered by general office staff. The best way to secure the time and attention of your provider is to make an appointment. The office staff can answer most of your general questions. If the staff is unable to successfully answer your questions, they will get the attention of your provider and return your call. Please be advised that our providers will not engage in therapeutic topics via email.

Insurance

- Our office participates with *most* BCBS-PPO and standard Medicare plans. Note that some BCBSM plans have contracted your mental health benefits out to another vendor not considered a BCBSM product. We are not in-network with those carriers. If you are uncertain if your BCBS-PPO plan has a separate mental health carrier, you should contact your insurance company directly. Typically, the number is on the back of your insurance card.
- All contracts are between you and your insurance company. We do not pre-authorize any services that are a non-BCBSM product nor are we able to give any promise as to what your carrier will cover for your services. You are responsible for knowing your own coverage, deductible and insurance limitations.
- If you have insurance that is NOT Blue Cross Blue Shield, you will be responsible for paying all charges up front and in full. Upon request, we will submit claims to *most* non-BCBSM insurance plans on your behalf. However, we do not submit claims for any plans that are HMO or a Medicaid plan.

Financial Responsibilities

- You are responsible for all co-payments, deductibles, and non-covered charges. Please verify with your carrier what your financial responsibly will be prior to engaging in services.
- There is a fee of $300.00 for less than a two-business day notice for testing cancellation. There is a fee of $40.00 for less than a 24-hour notice for a therapy cancellation (exceptions to these fees are at the discretion of your provider). These fees are NOT covered by insurance and will need to be paid prior to rescheduling any appointment.
- Bills are expected to be paid within **15 days** of receipt. Any balances that are over 60 days, will be assessed a $10.00 per month late fee/service charge. Balances that go unattended for more than 90 days will be sent to an outside collection company (Receivables Management Partners) and you will be dismissed from the practice.
- Failure to keep your account in good standing can result in disruption of therapeutic services and/or termination of care with our office. We will provide you with alternative care options upon request.
- Upon completion of a neuropsychological examination, a summary of your results and recommendations will be sent to your treating medical providers at your request and with a written release. You will be provided with verbal and graphics summaries of the evaluation during your review session. To receive the formal extended report, your account balance must be paid in full.

Consent for Treatment

- **Voluntary:** I am voluntarily consenting to treatment or assessment for myself and/or my dependent.
- **Risks and Benefits:** I understand that no guarantees have been made to me about the results of the treatment or assessment. I understand that I should express any concerns regarding treatment/assessment to my provider and it is up to me to determine if I would like to proceed.
- **My Responsibility:** I understand that it is my responsibility to inform my therapist or the patient's therapist if there are any significant changes in my or the patient's physical or emotional condition.
- I understand that I have the right to terminate treatment with my provider at any time I choose.

I have read and understood the information presented in this document.

_____	_____	_____
Signature of Responsible Party	**Relation to patient**	**Date**

Sandra Bowker & Associates, PLC
5148 Lovers Lane, Suite 200
Portage, MI 49002
Phone: (269)343-3010

Notice of HIPPA Privacy Practices

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

We typically use or share your health information in the following ways:

Treat you: We can use your health information and share it with other professionals who are treating you.

Run our organization: We can use your health information to run our practice, improve your care, and contact you when necessary.

Bill for your services: We can use your health information to bill and get payment from health plans or other entities.

Help with public health and safety issues: We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research: We can use your health information for health research.

Comply with the law: We will share information about you is state or federal laws require it, including the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests: We can share your health information with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with the coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests: We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

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- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change you r mind.

Your Rights

Ask us to correct your medical record

- You can ask us to correct health information about you hat you think is incorrect or incomplete.
- We may say "no" to your request, but we will tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way or send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a copy of your medical records

- You can ask to see or get a copy of your medical record and other health information we have about you.
- We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Get a list of with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee thereafter.

You can ask for a copy of this Privacy Notice at any time

File a complaint if you feel your rights have been violated

- You can complain if you feel we have violated your rights.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hippa/complaints/.

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Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that pe rson can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

Your Choices

In these cases, you have both the right and choice to tell us to:

- Share information with your family, lose friends, o others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preferences, for example if you were unconscious, we may ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

In case of fundraising, we may contact you for fundraising efforts, but you can tell us not to contact you again.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request.

September 1, 2022

Sandra Bowker and Associates, PLC

Neuropsychology and Counseling Psychology

Authorization to Release Confidential Records and Information

Full Name of Patient_____

Date of Birth_____

I authorize the representatives and/or clinical staff of Sandra Bowker and Associates to release and/or receive medical, psychological and/or neuropsychological information regarding myself or the individual named above from/to the following:

(please list all providers and specialty involved in your care)

_____ (Primary Care)

_____ (other)

_____ (other)

_____ (other)

- I understand that, at any time, this authorization may be revoked, when the office receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.

- I understand that information used or disclosed, pursuant to this authorization, could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

_____ _____

Date Signature of Individual or Representative

_____

Authority or Relationship to Individual, if Representative

Unless otherwise stated, this authorization will expire six years from the date of this authorization.

Today's date: _____

MEDICATION LIST

Patient Name: _____ D.O.B: _____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING: prescription and over the counter medications, any medications and any nutritional supplements.

☐ NONE

MEDICATION	DOSAGE	REASON PRESCRIBED	FREQUENCY