



Patricia Korn, Psychiatric Nurse Practitioner
PATIENT INFORMATION FORM

(Please print)

Today's Date _____

Patient's Full Name SS#

Home Address City State Zip

Home Phone Work Phone Cell

Sex: M F Age Date of Birth Marital Status _____

Emergency Contact Phone

INSURED/RESPONSIBLE PARTY INFORMATION

Name on insurance card Relationship to Patient

Employer Work Phone _____

Home Address (if different from above)

Please include City State and Zip Code

Insured's SS# Date of Birth

Spouse Full Name Phone Cell _____

Primary Insurance I.D. #

Secondary Insurance I.D. #

Office Billing and Insurance Policy

1. I authorize use of this form on all of my insurance submissions
2. I authorize the release of information to my insurance company(s)
3. I understand that I am responsible for the full amount of my bill for services provided
4. I understand payment is due when services are rendered

Signature Date

Guardian: as parent or legal guardian of , I authorize his/her treatment.

Print patient's name

Signature Date

(Initials) I understand phone calls after hours (5:00) will have a charge of \$25.00 if the length of the call exceeds five minutes.

_____ There is a \$65.00 no show fee when you do not cancel 24 hours before an appointment.

Brief Description of the problem(s) that brought you here today:

**Patricia Korn, Psychiatric Nurse Practitioner
3030 Ashley Town Center Drive
Charleston, SC 29414**

Patricia Korn, NP Professional Disclosure Statement and Consent for Treatment

I acknowledge that I have received and read the **Patricia Korn, PMH-NP Professional Disclosure Statement and Consent for Treatment (version 08/02)** and the **HIPAA Client's Rights (version 08/02)**.

I further acknowledge that I seek and consent to treatment with **Patricia Korn, PMH-NP**. My signature below confirms that I understand and accept all the information contained in the **Patricia Korn, PMH-NP Professional Disclosure Statement and Consent for Treatment (version 08/02)** and the **HIPAA Client's Rights (version 08/02)**.

*Signature of Client _____ Date _____

If more than one individual (e.g., spouse or family member) is seeking therapy, please have each of the others sign below. Signatures below confirm that each understands and accepts all the information contained in the **Patricia Korn, PMH-NP Disclosure Statement and Consent for Treatment (version 08/02)** and the **HIPAA Client's Rights (version 08/02)** and that each seeks and consents to treatment. We will provide additional copies of the **Patricia Korn, PMH-NP Professional Disclosure Statement and Consent for Treatment (version 08/02)** and the **HIPAA Client's Rights (version 08/02)** upon request.

Signature of Client #2 Signature of Client #3

Acknowledgment of Receipt of Privacy Notice

I have been presented with a copy of **Patricia Korn, PMH-NP Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the notice. Please do not release my information to the following:

Further, I permit a copy of this authorization to be used in place of the original consent form on the front and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

*Signature of Client _____ Date _____

If not signed by client, please indicate relationship to client (e.g., spouse)

Relationship: _____ Witness by: _____

If you have complaints regarding any item in the privacy act please give your complaint in writing to **Patricia Korn, PMN-NP Privacy Officer, Patricia Korn, PMH-NP**, at the above address.

* _____ Today's Date: _____

Signature of Client

Office use: If patient or patient's representative refuses to sign acknowledgment of receipt or notice, please document the date and the time the notice was presented to patient and sign below.

Presented on (date and time): _____ By (name and title): _____

*Please sign where all asterisks are located.

Health Insurance Portability and Accountability Act 1996 (HIPAA)

February 16, 2005

On August 8, 1996, the US Congress passed Public Law 104-191, commonly known as the Health Insurance Portability and Accountability Act (HIPAA). The purpose of the HIPAA is to 1.) Promote the use of standards in healthcare for administrative and financial transactions, and 2.) Provide for the confidentiality and security of protected health information.

Patricia Korn, PMH-NP, which consists of independent practitioners, is considered a “covered entity” under the HIPAA regulations. As a result, we will be changing how we distribute our clients’ protected health information beginning on April 14, 2003. The following are our client’s rights under the HIPAA regulations:

1. As a client, you have the right to see your counseling/therapy file. Psychotherapy notes are afforded special privacy protection under the HIPAA regulations and are excluded from this right.
2. As a client, you have the right to receive a copy of your counseling therapy file.
3. As a client, you have the right to request amendments to your counseling/therapy file.
4. As a client, you have the right to receive a history of all disclosures of protected health information.
5. As a client, you have the right to restrict the use and disclosure of your protected health information for the purposes of treatment, payment and operations. If you choose to release any protected health information, you will be required to sign a Release of Information form detailing exactly what information you wish disclosed.
6. As a client, you have the right to register a complaint with the Secretary of Health and Human Services if you feel your rights, herein explained, have been violated.

As you will note in Item #1 and #2, psychotherapy notes are afforded special protection under the HIPAA regulations. Because of this, **Patricia Korn, PMH-NP** will no longer release psychotherapy notes. In lieu of psychotherapy notes, we will be happy to provide you with the following information which HIPAA allows to be released—HIPAA calls the following data a “designated record set”. This includes: psychotherapy start and stop times, modalities and frequencies of treatment, results of any clinical testing, functional status, treatment plans, progress to date, symptoms, diagnoses, prognosis and medication prescription and monitoring.

You will be required to pay a copying fee of \$ 0.20 per page.

Fee: It is customary to pay for professional services at the time they are rendered. Insurance will be filed for you at no additional cost. The fee for services will be based on our contracts with your insurance company. You will only be required to pay the contracted fee or co-pay for your session.

Confidentiality: The information you share in sessions with your counselor, psychiatrist, or psychiatric nurse practitioner is considered confidential by South Carolina Statute law and federal regulations. The patient file can be subpoenaed in South Carolina through a court order (signed only by a judge) but is considered privileged in the federal court system. Psychotherapy notes on individual sessions are exempt. Clinicians are mandated by state and federal regulations, through duties to warn, to breach confidentiality if they discover: 1.) you are threatening self-harm or suicide; 2.) you are threatening to harm another or homicide; 3.) a child has been or is being abused or neglected; 4.) a vulnerable adult has been or is being abused.

Ethics:

Psychiatric Nurse Practitioners follow the Code of Ethics of the following organizations:

The American Nurses Association Code of Ethics

Psychiatric Nurse Practitioners are Board Certified by:

American Nurses Credentialing Center, 8515 Georgia Ave., Suite 400, Silver Spring Maryland 20910-3492, (800) 284-2378

Any type of sexual behavior between therapist and client is unethical. It is never appropriate and will not be condoned.

Informed Consent: Your signature verifies that you have been given this document and the HIPAA document; that you have read and understand these documents and that you consent to treatment. Further you need to be aware:

- Treatment isn't always successful and may open unexpected emotionally sensitive areas.
- Medications do have side effects occasionally; discuss with your prescribing practitioner.
- Your counselor, psychiatrist, and/or psychiatric nurse practitioner may need to consult with your physician, attorney, or other counselor, but only with a signed release of information form.
- Psychiatric Nurse Practitioners are licensed through the S.C. Board of Nursing. This Board can be contacted at Synergy Business Park, Kingtree Building, 110 Centerview Dr., Suite 202, Columbia SC 29210. Phone (803) 896-4525.

Contact information; **Patricia Korn, PMH-NP** is located at 3030 Ashley Town Center Charleston, SC 29414. This is also our mailing address. Her clients are seen by appointment only and special appointment for evenings, weekends, and other selected times can be considered. Her telephone number is 843-735-5900, ext. 105; fax is 843-735-7323, and her emergency phone is (843) 442-4100.

Patricia Korn, PMH-NP Professional Disclosure Statement and Consent for Treatment

The majority of this document is mandated by both South Carolina State Law and Public Law 104-191. It is provided for your protection. **Patricia Korn, PMH-NP** has tried to anticipate the risks you may face as a result of being in therapy. If you have any questions regarding any documents you have received, please feel free to discuss them with your provider.

Health Insurance Portability and Accountability Act 1996 (HIPAA)

Use or disclosure of the following protected health information

Does not require your consent or authorization:

1. Uses and disclosures required by law-example: files subpoenaed by a Judge
2. Uses and disclosures about victims of abuse, neglect, or domestic violence-example: the duties to warn explained in your counselor's Disclosures Statement
3. Uses and disclosures for health and oversight activities-example: correcting records or correcting records already disclosed
4. Uses and disclosures for judicial and administrative proceeding-example: a case where you are claiming malpractice or breach of ethics
5. Uses and disclosures for law enforcement purposes-example: when you claim mental health issues as a defense in a civil or criminal case
6. Uses and disclosures for research purposes-example: using client information in research; always maintaining confidentiality
7. Uses and disclosures to avert serious threat to health or safety-example: calling Probate Court for a commitment hearing
8. Uses and disclosures for Workers' Compensation-example: the basic information obtained in therapy/counseling as result of your Worker's Compensation claim

It will be necessary for you to sign the page indicating that you have received, read, and understand this document. This form will be placed in your counseling/therapy file. Please do not sign the certification if you do not understand any part of the HIPAA Client's Rights or the Professional Disclosure Statement and Consent for Treatment. Your counselor or doctor will be happy to explain these documents further.

*Signature _____ Date _____

Guardian: as parent or legal guardian of _____, I authorize his/her treatment.

Signature _____ Date _____