

# *Personal Relationships, Inc.*

*Dr. Taylor Preston, MD*

*Dedicated to Building Healthy Families*

\*\*\*Please keep this page for your records\*\*\*

Thank you for selecting Personal Relationships, Inc. for your mental health needs. We strive to provide the highest quality and most professional services for promoting your well being. If you ever have any questions or comments, please do not hesitate to contact our office at (205) 979-6822. Our phones are generally answered Monday-Friday 8am-5pm. If necessary, please leave a message and we will return your call as soon as possible.

**Confidentiality:** All appointments, records, and identification information is kept strictly confidential. The limits of confidentiality apply when the clinician considers a client to be in danger of harming others or him/herself, if the records are subpoenaed, or when the client grants disclosure of information through a signed release form. Alabama law requires that child abuse be reported to the Department of Human Services. Support staff will have access to information regarding clients only as they make appointments, handle insurance filing, and perform ordinary business operations.

**Length of Session:** The length of an initial evaluation session will be fifty (50) minutes; additional medication management sessions will be twenty (20) minutes. Your clinician will also spend time reviewing your progress notes and making new notes. If you arrive late for your session, the missed time is forfeited in order to keep our schedule running smoothly. Always check in with the front office when you arrive for your appointment by signing in and paying for services.

**Phone Calls:** While therapy sessions over the phone are not possible, if you have an issue that requires immediate attention (such as a medication side effect), you may call the office and we will return your call within 1 business day. In the event of an emergency, dial 911 or go to the nearest hospital emergency room.

**Cancellations & Missed Appointments:** It is important that therapy appointments be kept. If you must cancel your appointment, **please call 24 hours in advance to avoid a full charge.** This office does not double book appointments; therefore your appointment time is reserved for you. Missed appointments CANNOT be filed with your insurance company and will be billed to you in full. Because of the nature of our schedule, clients that miss two appointments or repeatedly cancel appointments will be referred to another clinician's office.

**Dr. Preston's Fees:**

Initial Intake/Assessment Session.....	\$175
Medication Management Session.....	\$90

**Payments & Insurance:** Personal Relationships, Inc. is a non-profit organization that depends on counseling fees and private donations to continue our ministry. Additionally, part of therapeutic growth is being financially responsible. Therefore, full **payment is expected at the time of your visit.** If a client has a balance of 2 unpaid sessions, further sessions will not be scheduled until the balance is paid. Our office will file insurance on your behalf as a courtesy to you. However, insurance policies and requirements vary greatly by policy and it is the client's responsibility to understand the requirements and benefits of his/her policy. Our office will assist you as much as possible in understanding your insurance policy and meeting its requirements.

# Dr. Taylor Preston, MD

## Patient Information

If patient is a child, please list parent's place of employment and phone numbers.

Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Employer: \_\_\_\_\_ Position: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Gender: \_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

Marital Status: Single \_\_\_\_ Married \_\_\_\_ Separated \_\_\_\_ Divorced \_\_\_\_ Widowed \_\_\_\_

Education (Circle last year completed): Grade school: 1 2 3 4 5 6 7 8

High School: 9 10 11 12 College: 1 2 3 4 5 6 7+

Referred by: \_\_\_\_\_

List Members of Your Household (name, age, relationship): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

At which number do you prefer to be contacted regarding appointments or billing questions?

**Home**

**Cell**

**Other** \_\_\_\_\_

May we leave a message on voice mail at this number? Yes No

May we leave a message with a person at this number? Yes No

## Patient Health Information

Name of Primary Physician \_\_\_\_\_

Address \_\_\_\_\_

Phone Number: \_\_\_\_\_

Approximate Date of Last Physical Exam: \_\_\_\_\_

Rate your Physical Health: 1 2 3 4 5 6 7 8 9 10  
Very Poor Fair Excellent

List significant **present** illnesses or injuries: \_\_\_\_\_

\_\_\_\_\_

List all **current Medications & Treatments** that you are taking: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Dr. Taylor Preston, MD

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

## Patient Health Information (continued)

List all Medications that you are **Allergic** to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List significant **Past** Illnesses, Injuries, Hospitalizations or Disabilities: \_\_\_\_\_  
\_\_\_\_\_

List significant Medical Conditions in your **Family**: \_\_\_\_\_  
\_\_\_\_\_

Do you or any members of your family have a history of mental illness or substance abuse?

No      Yes (please explain)

\_\_\_\_\_  
\_\_\_\_\_

Do you use tobacco?      Y      N      If so, how often per day? \_\_\_\_\_

Do you drink Alcohol?      Y      N      If so, how often per day/week? \_\_\_\_\_

Have you used Drugs for other than medical purposes?      Y      N

If so, which Drugs have you taken? \_\_\_\_\_

Have you ever been admitted to a psychiatric unit of a hospital?      No      Yes (please explain)

\_\_\_\_\_  
\_\_\_\_\_

Have you ever seen a psychologist, psychiatrist, or counselor in a clinic setting?      No      Yes (please explain)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What medications, if any, have you tried for treatment of a mental illness in the past?

\_\_\_\_\_  
\_\_\_\_\_

# Medical History

Have you ever had or do you now have any of the following?  
(please mark each item 'yes' or 'no')

	Yes	No
Sinus Problems		
Hearing Loss		
Head Injury		
Severe Headaches		
Eye Trouble (requiring glasses or contacts)		
Blindness (in one or both eyes)		
Fainting Spells		
Neck Problems/Surgery		
Asthma		
Bronchitis		
Pneumonia		
Lung Problems		
Chronic Cough		
Chest Pain/Angina		
Heart Disease		
Heart Murmur		
Swollen Ankles		
Stomach Ulcers		
Gastritis		
Gall Bladder Trouble		
Hepatitis		
Liver Disease		
Kidney Trouble		
Renal Disease		
Bladder Trouble		
Appendicitis		
Hemorrhoids		
Back Trouble/Surgery		
Broken Bones/Dislocations		
Arthritis		
Seizure Disorder		
Multiple Sclerosis		
Meningitis		
Cancer or Tumor		
Tuberculosis		
Skin Disorder		
Female Disorder		
Anemia		
Diabetes		
Thyroid Disorder		
Major Illness/Operations		

Other (please list) \_\_\_\_\_

Other \_\_\_\_\_

Other \_\_\_\_\_

**Insurance Information**

Patient Name \_\_\_\_\_ Insured's Full Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_ Insured's Date of Birth \_\_\_\_\_

Insured's Social Security Number (required for Value Options) \_\_\_\_\_

Insured's Address (if different from patient) \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Contract/Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**Guarantor Information** (person responsible for fees, if different from patient)

Guarantor Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Guarantor's Address (if different from patient) \_\_\_\_\_

**Acknowledgement**

Please read and initial all of the following statements (must be completed by parent/guardian if patient is under 18):

\_\_\_\_\_ I acknowledge that I have received a copy, as well as read and understand all of the Personal Relationships office policies and that my signature below indicates that I agree to abide by these policies.

\_\_\_\_\_ I have received a copy of the notice PRI privacy practices and I have read and understand my rights under HIPPA regarding my protected health information.

\_\_\_\_\_ I authorize the release of any medical information necessary to process my insurance claims.

\_\_\_\_\_ I understand that my insurance company may not pay for the entire counseling fee and that I am responsible for all fees incurred regardless of insurance payment.

\_\_\_\_\_ I understand that my insurance company may require authorizations or other information and that all such requirements are my responsibility.

\_\_\_\_\_ I consent to the exchange of treatment information between Personal Relationships clinicians for the benefit of my therapy.

I certify that to the best of my knowledge, that all of the information provided in these documents is true and correct.

Printed Name of Patient or Guardian

Signature of Patient or Guardian

Today's Date

## PERSONAL RELATIONSHIPS, INC.—NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

**OUR LEGAL DUTY:** We are required by applicable federal and state law to maintain the privacy of your health information. "Protected Health Information" is information about you, including demographic information, that may identify you that relates to your past, present, or future physical or mental health condition or related health care services. We are also required to give you Notice about your privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This Notice takes effect 1/1/05, and will remain in effect until we replace it.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information at the end of the Notice.

**USES AND DISCLOSURES OF HEALTH INFORMATION:** Uses and Disclosures of Protected Health Information are based upon your written consent. You will be asked by your therapist to sign an acknowledgment of receipt form. Your protected health information may be used and disclosed by your therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health care information may also be used and disclosed to pay your health care bills and to support the operation of this practice.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information as necessary to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may treat you when we have the necessary permission from you. Your protected health information may be provided to a physician to whom you have been referred to insure that the physician has the necessary information to diagnose and/or treat you. Additionally, your protected health information may be disclosed to another physician or health care provider (e.g. a specialist or laboratory) who becomes involved in your care, to a pharmacy as part of your treatment by your therapist, and may be used for research purposes.

**Payment:** Your protected health will be used as needed to obtain payment for your health care services. This may include certain activities that your health insurance company requires before it approves or pays for services we recommend for you such as; making a determination of eligibility or coverage for benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

**Healthcare Operations:** We may use or disclose, as needed, your protected health care information in order to support the business activities of your therapists' practice. These activities include, but are not limited to volunteer work, evaluating practitioner and provider performance, licensing or credentialing activities. (E.g. we may call you by name in the waiting room when your health care provider is ready to see you, or when contacting you to remind you of an appointment)

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time except to the extent that your therapist or the practice has taken action in reliance on the use or disclosure indicated in the authorization.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

We may use and disclose your protected health information in the following instances (emergencies, as required by law, or worker's compensation). You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object, then your therapist may, using professional judgment, determine whether the disclosure is in your best interest.

**Emergencies:** We may use or disclose your protected health information in an emergency treatment situation. If this happens, your therapist shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment.

**Required by Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and you will be notified, as required by law, of any such disclosures.

**Worker's Compensation:** Your protected health information may be disclosed as authorized to comply with worker's compensation laws and other similarly legally established programs

### YOUR RIGHTS

**Restriction:** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment or payment of healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your therapist is not required to agree to a restriction that you may request. If your therapist believes it is in your best interest to permit use and disclosure of your protected health information, it will not be restricted. You may request a restriction by verbally noting to your therapist or in writing.

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health care information for purposes, other than treatment, payment, healthcare operations and certain other activities that occurred after 1/1/2005. The right to this information is subject to certain exceptions, restrictions, and limitations.

**Alternative Communication:** We will accommodate reasonable requests. You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Complaints:** You may complain to us or to the Office of Civil Rights if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaints. We will not retaliate against you for filing a complaint.

Contact Person: Daniel G. Bowman, Ph.D., Executive Director, Personal Relationships, Inc.  
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