SID BINKS, PhD
& ASSOCIATES
FORENSIC NEUROPSYCHOLOGICAL SERVICES

Sid Binks, PhD, ABPP-CN

3000 Connecticut Avenue, NW Suite 238
Washington, DC 20008
202 255-5187 (V) 877 684-8823 (F)
Sidney.Binks@GMail.com
www.DrSidBinksandAssociates.com

INSURANCE/DEMOGRAPHIC INFORMATION

(Please Complete as *Thoroughly* as Possible)

Patient

Date:_____ Full Patient Name:_____ DOB:_____

Full Patient Address:_____ SS#: _____
Zipcode

Patient Phone #'s: Home_____ Work_____ Cell_____

Please tell me how you found Dr. Binks:_____ Email:_____

If ***Couples or Child*** Treatment, enter Partner/Parents Name/s:_____

Send Bill to (Fill in ***only if*** different from above): Relationship to Patient:_____

_____
Name Phone Full Address Zipcode

List 2 Emergency Contacts (***in addition*** to any names listed above):

_____ _____
Contact #1 Phone Contact #2 Phone

Insured Person (Fill in ***only if*** different from above): Relationship to Patient:_____

Name on Insurance Card:_____ SS#:_____

Address/Phone#: _____ DOB of Insured:_____
Full Address Phone

Insurance

Insurance Company Name:_____ Insurance Plan Name:_____

ID #:_____ Group Code or Group #:_____

Phone # (# for Provider to use if 2 #'s are listed)_____ Check One: HMO:_____ PPO:_____
POS:_____ Medicare:_____

Claim *Submission* Address:_____

If you have Medigap Coverage, list Name/Address/Phone of Company here:

_____
Company Name Full Address Phone

Insured's Employer:_____

Authorization to Bill Insurance and Request Payment be Made Directly to Dr. Sid Binks & Associates

I hereby authorize Dr. Sid Binks & Associates to apply for benefits on my behalf for covered services rendered. I request payment from the above noted Insurance Company (and/or Medicare) be made directly to the above-named provider. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including psychological information, for this or any related claim to the above-named billing agent (or in the case of Medicare part B benefits, to the SSA and HCFA) and/or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above-named carrier at any time in writing. If I have a Medigap policy, I request that payment of authorized benefits be made either to me or on my behalf to the above-named provider for any services furnished to me by that provider/supplier. I authorize any holder of psychological information about me to release to the Medigap Company listed above any information needed to determine these benefits payable for related services.

_____	_____	_____
Date	Patient/Guardian Signature	Patient/Guardian Printed Name

Do not Write Below This Line

Deductible Amt:_____ How Much is Met?:_____ Will they pay Provider Directly:_____

Verify claims address_____ Verify if Within UC_____ If not, what is the UCR_____

% Covered_____ Number of Allowed Sessions_____ Tx Plan Required for PPO:_____

Maximum out of Pocket Limit_____

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PATIENT AGREEMENT

I, the undersigned, realize that I am financially responsible for all services rendered to me by the practice of Dr. Sid Binks & Associates, PhD, ABPP-CN (herein referred to as "The Practice"). In the event of nonpayment of my account within sixty (60) days after an invoice is rendered, I agree to pay interest at the rate of 1 percent (12 percent per year) on the unpaid balance until the account is paid in full. If the account is delinquent, and if the account is referred for collection, I agree to pay all expenses incurred in collecting the same, including without limitation, a reasonable attorney's fee equal to 50 percent of the amount owed at the time the account is referred, and all court costs.

For those insurance plans for which The Practice accepts assignment, I realize that I am personally responsible for all co-payments, deductibles and non-covered services, as dictated by my insurance coverage. For those insurance plans for which The Practice *does not* accept assignment, I realize that I am responsible for 100 percent of all charges which may include fee rates which are above what my insurance coverage might term "usual and customary." I also authorize the Practice to release to my insurance carrier(s) any clinical or treatment information necessary to obtain reimbursement. I authorize any and all insurance payments be made directly to the Practice for all rendered services. I permit a copy of this authorization to be used in place of the original.

Appointments that are not kept, and are not cancelled with 24 hours notice will be charged at the standard rate per hour for the service. If this cost is not covered by the insurance company, I understand that I am responsible for it. The exception to this rule is when there is inclement weather and DC schools are closed, or if there is a medical emergency on the part of myself or my dependent.

_____ _____

Print Name of Patient Guardian (if Applicable)

_____ _____

Signature(s) Date

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NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF YOUR HEALTH INFORMATION

OVERVIEW

This notice provides you with information about how your mental health records may be used, the rights you have as a patient, and my legal duty as a provider of treatment. I am required to provide you with this notice under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, which took effect on April 14, 2003. This law is designed to protect the confidentiality of your treatment and records created as part of your treatment. Please review it carefully. Let me know if you have any questions or would like additional information. If you do not sign this consent form agreeing to what is in this notice, I cannot treat you.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

As part of your treatment, I will record, maintain, and use individually identifiable health care information about you. This may include information describing your history, symptoms, test results, diagnoses, treatment, treatment plan, billing, and health insurance information.

I may disclose your protected health information (PHI) for treatment, payment, and health care operations purposes with your consent. Treatment is when I provide or coordinate your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another therapist.

Your PHI may be disclosed in order to collect payment for services provided or to determine eligibility or coverage.

Health Care Operations are activities that relate to the performance and operation of my practice. Examples of health care operations include quality assessment and improvement activities, business-related matters such as audits and administrative services, care coordination, accreditation, certification, licensing or credentialing activities.

II. Uses and Disclosures Requiring Authorization

I will not use or disclose your medical information for any reason except those described in this Notice without your written consent. I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate written authorization is obtained.

I will also need to obtain a separate authorization before releasing your psychotherapy notes. Psychotherapy notes are notes that I write about your conversations during a private, group, joint, or family psychotherapy sessions, which I keep separate from the rest of your medical record. These notes are given a greater degree of protection than other PHI.

You have a right to refuse to authorize releasing your information to others, with certain exceptions which are listed below. You also have the right to restrict what information gets released when you sign an authorization for disclosing PHI. You may revoke all such authorizations at any time, provided each revocation is in writing, but this will not affect prior authorized uses or disclosures.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances, as required by state and Federal law:

* Healthcare Operations: If you request that I submit bills to an insurance company for payment, you are deemed to have consented to the disclosure of specific information, including dates of service, name, policy number, diagnosis, services offered, prognosis, progress, medications prescribed, and the patient's relationship to the subscriber of the insurance. Only the minimum information necessary to obtain reimbursement will be provided.

* Child Abuse: If I have reason to suspect that a child is abused or neglected, I am required by law to report the matter immediately to the District of Columbia Child Protective Services. I will discuss this with you as appropriate.

* Abuse of Elderly or Incapacitated Adults. When I have reason to suspect that an incapacitated adult (e.g. someone who is not able to advocate for himself or herself) is being abused, neglected or exploited, I am required by law to make a report and provide relevant information to the

District of Columbia Government. You will be notified of this action unless I believe that it would put you at risk of serious harm.

* Judicial or Administrative Proceedings (Court Orders): If you are involved in a court proceeding and a request is made for information about your treatment, I will not release information without your written authorization. If I receive a subpoena for your records, I am required to respond. I will attempt to contact you first to see if you consent to such release. If you object, you may file a motion with the clerk of the court to move to quash (block) the subpoena. Notify me as soon as possible; I am then required to place your records in a sealed envelope and provide them to the clerk of the court so that the court can determine whether the records should be released.

* Serious Threat to Health or Safety of Others: If you communicate to me a specific and immediate threat to cause serious bodily injury or death to an identified or to a readily identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I must take steps to protect the threatened person.

* Danger to Self: I can break confidentiality if you (or your child) are in danger of hurting yourself, in order to keep you (or your child) safe. This may include notifying emergency personnel.

* Worker's Compensation: If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant PHI to you, your employer, the insurer, or a certified rehabilitation provider.

* Supervision: I may discuss your treatment with colleagues to improve the quality of your care. However, your name or other identifying information that could identify you will not be used.

* Debt Collection: Your name can be reported to a collection agency and/or a credit bureau if you fail to pay your bill. You will be notified before such a report is made.

* Legal Defense: Disclosure may be made if I must arrange for legal consultation if a patient takes legal action against me.

* Quality Assurance: If you are using insurance to pay for part or all of your treatment, an insurance company can periodically review records to insure quality care.

IV. Patient's Rights

· Right to Request Restrictions -You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.

· Right to Receive Confidential Communications by Alternative Means and at Alternative Locations - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, I can send your bills to an address other than your home if you request this.

· Right to Inspect Records - You have the right to inspect your records, including PHI and billing records for as long as the PHI is maintained in the record. I generally keep records for five years after your last visit here. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, I require that you initially review them with me or have them forwarded to another mental health professional so you can discuss the contents. I may deny your access to PHI and psychotherapy notes, but in some cases you may have this decision reviewed. One reason for denial is if I believe that releasing such information would likely cause substantial harm to you (or your child if your child is the patient). On your request, we will discuss with you the details of the request and denial process.

· Right to Amend - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request; if so, we will provide you with a written explanation.

· Right to an Accounting - You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). We must provide you with the accounting within 60 days of your written request.

· Right to a Paper Copy - You have the right to request a copy of this notice from me.

V. Privacy Safeguards

I have developed appropriate administrative, technical, and physical safeguards to protect the privacy of your Protected Health Information. These including placing locks on file cabinets, shredding documents with identifying information, using passwords on computers, as well as other safeguards.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice went into effect on April 14, 2003. I may revise my privacy policies, as permitted or required by law. These revisions, which may be retroactive, will apply to all PHI that we maintain. I will provide you with a revised notice.

VII. Uses and Disclosures Involving Personal Representatives

Where an incapacitated patient has a guardian or legal representative with authority to make health care decisions for the patient, I must treat the guardian or legal representative as the patient with respect to PHI. If the patient is a minor child, I must treat the parent (or legal guardian) as the patient with respect to PHI. However, if I have reasonable belief that a parent, guardian, or legal representative has subjected or may subject the patient to abuse or neglect or otherwise endanger the patient, and I believe that it is not in the patient's best interest to release such information, I may elect not to treat the parent or guardian as the patient and hence not disclose confidential information. A parent or guardian may allow a confidentiality agreement between the minor patient and the therapist.

VIII. Breech of Privacy Notification

You will be promptly notified of any breech of privacy that might occur (e.g., theft of clinical records, etc).

IX. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision made about access to your records, you may contact me, the HIPAA Privacy Officer, Sidney W. Binks III, Ph.D., to register a complaint or to obtain further information. A form to make the complaint will be provided upon request. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. I will not retaliate if you file a complaint.

X. Electronic Communication (Email/Texting)

Electronic Communication (Email/Texting) is not a secure form of communication. Nonetheless, your signature below authorizes this practice to communicate with you via email and texting. **If you do not wish to communicate via email/texting, please indicate by circling the following statement:**

"Do not communicate with me via email or texting."

I AGREE TO ACCEPT THE ABOVE NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF MY HEALTH INFORMATION BY SIGNING BELOW:

Sign Name_____ Witness Signature_____

(Patient/Guardian) (Date) (Date)

Print Name_____ Witness Print Name_____

(Patient/Guardian) (Date) (Date)

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CREDIT CARD PAYMENT AUTHORIZATION FORM

Date:_____

Name as it appears on Credit Card:_____

Check One: Visa MasterCard **CVV Code:**_____

Account #_____ **Exp Date:**_____

Billing Address:_____ **Zip Code:**_____

Please check below:

I authorized Dr. Binks and Associates to charge current and future rendered services to the above account on a monthly basis.

I authorize Dr. Binks and Associates to charge rendered services to the above account after payment is 30 days past due (60 days from the invoice date).

I authorize Dr. Binks and Associates to charge my past due balance at a rate of $_____ per month until paid in full.

_____

Signature