ALAN CONGER, PSY.D.
PSYCHOLOGIST

Confirmation/Cancellation Policy for All Appointments

1. We will call the day before your appointment to confirm that you are planning to keep the appointment. All appointment require a return call from you to either confirm the appointment, or cancel/reschedule the appointment. Please call us back as quickly as possible when we leave a message regarding your appointment.

2. When we call to confirm an appointment, you may want to consider rescheduling the appointment if you or your child is ill. If you have another doctor's appointment, a scheduled activity such as a field trip or court appearance, you may want to consider rescheduling your appointment. In order to avoid a missed appointment charge, please do not wait until the last minute to cancel your appointment.

3. Once you have confirmed the appointment, you will be charged if you fail to keep the appointment. The charge for a missed appointment is $75.00.

4. If you do need to cancel an appointment after 5:00 in the evening, please call immediately and leave a voice mail message. We do check our voice mail messages on a regular basis throughout the evening.

5. We ask that the $75.00 charge be paid prior to your next scheduled appointment.

6. We appreciate your cooperation with our Confirmation/Cancellation Policy

X _____ Date _____

5512 SOUTH LEWIS / TULSA, OK 74105-7140 / 918747-1600 / FAX 918749-2774

ALAN CONGER, PSY.D.

PATIENT NAME_____SS#_____

BIRTHDATE_____AGE____SEX_____RELIGION_____SCHOOL_____

ADDRESS_____CITY_____STATE_____ZIP_____

PATIENT'S CELL_____WORK_____HOME_____

IF MINOR: MOTHER'S NAME_____CELL_____WORK_____

MOTHER'S ADDRESS _____CITY_____ST_____ZIP_____

MOTHER'S BIRTHDATE_____SS#_____EMPLOYER_____

IF MINOR: FATHER'S NAME_____ CELL_____WORK_____

FATHER'S ADDRESS_____CITY_____ST_____ZIP_____

FATHER'S BIRTHDATE_____SS#_____EMPLOYER_____

REASON FOR APPOINTMENT_____

EMERGENCY CONTACT NAME /RELATIONSHIP_____

CONTACT NUMBER _____REFERRED BY_____

PLEASE COMPLETE IF PATIENT IS AN ADULT:

MARITAL STATUS **S M D** YRS MARRIED___SPOUSE NAME_____# OF MARRIAGES___

NAMES OF CHILDREN_____AGES_____

HIGHEST LEVEL OF EDUCATION_____OCCUPATION_____

PLACE OF EMPLOYMENT_____PHONE_____

***Reminder calls/texts are made the day before your appointment.**

A confirmation call/text in return is required.

Which do you prefer? Call_____Text_____

- Payment is expected at the time of your appointment. We accept cash, personal checks and Visa, MasterCard, Discover credit cards.
- *In order to provide the best possible service, we will appreciate your cooperation in scheduling appointments. If you find that you cannot keep your appointment, please notify us at least 24 hours in advance. There will be no charge for these cancellations. However, the regular hourly fee will be charged for appointments canceled with less than 24 hours' notice and for other non-emergency unkept appointments. Please keep in mind that your therapist sets aside a significant amount of time for each of your appointments.*

  Thank you for your cooperation.

I have read the above and I accept financial responsibility for services rendered.

SIGNATURE_____**DATE**_____

Primary Insurance Coverage

Policy Holder's Name _____ Relationship to the Patient_____

SSN* _____ Date of Birth _____ Male/Female ___ Phone Number_____

Address_____

Ins. Co. _____ Insured ID. No. _____ Group No. _____

Insurance Plan Name _____ Employer_____

Secondary Insurance Coverage

Policy Holder's Name _____ Relationship to Patient_____

SSN* _____ Date of Birth _____ Male/Female ___ Phone Number_____

Address_____

Insurance Co. _____ Insured ID. No. _____

Group No. _____ Employer _____

Insurance Plan Name _____

*Social Security numbers continue to be used for identification purposes by insurance companies and are invaluable for settling unpaid insurance claims. If you using an EAP, we must have your Social Security number to bill your insurance.

- **Please note:** Even if the primary insurance coverage will not pay for services, it must be filed for a response in order for secondary coverage to consider payment. Secondary coverage requires the dates of birth for policy holders. They may also require pre-authorization or notification.

Patient's or Authorized Person's Signature: I authorize the release of any medical or other information necessary to process insurance claims. I further authorize payment of medical benefits to the provider of services.

Signed _____ **Date** _____

INSURANCE INFORMATION FORM

PATIENT NAME_____

Many times, insurance coverage for mental health services differs from medical coverage. If you don't know any of the answers to the questions listed below, please take a few minutes to call the number on your insurance card to find out. The number is usually on the back and sometimes says mental health, or mh/sa. Please have this information done before your first visit. We do not want any of our patients to be surprised about needing authorizations or having a deductible to meet, as you will be responsible for any payment.

- Have you contacted your insurance company to verify your mental health benefits?
- Do you need an authorization? _____
- Auth number _____ Number of visits authorized? _____
- Facility that issued auth? _____
- Begin and end dates. _____
- Does your insurance cover your specific therapist by name? _____
- Do you have a deductible to meet before your insurance begins paying? _____
- If so, What is the deductible?_____
- How much of the deductible have you met to date?_____
- What is your copay for each visit? _____
- How many sessions per year are allowed? _____

SoonerCare/Medicaid information that is needed in order for us to file your insurance. Info must be provided on your first visit.

- Name_____
- Social Security number _____
- Medicaid id _____
- Race (Check One) __White __Black/African American __ Native Hawaiian or other Pacific Islander __Native American ___Asian
- Hispanic/Latino: YES NO (You must circle one)
- Days absent from school in the last 90 days? _____
- Annual Income _____
- # of dependants_____

Dr. Alan Conger

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PRIMARY CARE PHYSICIAN

PATIENT NAME: _____ DOB: _____
Social Security Number: _____

I hereby authorize the release of the medical information listed below which pertains to my medical history, mental or physical condition, or treatment, including information relating to my mental health diagnosis or treatment and/or substance abuse diagnosis and treatment to my primary care physician:

PHYSICIAN NAME: _____
ADDRESS: _____
TELEPHONE NUMBER: _____

I understand that the release of this information is to permit my primary care physician to monitor my health status and to coordinate all the care which I may receive from specialist. This authorization becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance hereon. If not earlier revoked, this authorization shall terminate automatically with one year of date of execution. I understand that I have a right to receive a copy of this authorization upon my request.

_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

Dear Dr. _____

In order to coordinate care, I wish to inform you that your patient, _____
Was referred to me for treatment on ___/___/___. The DSM-IV diagnosis code is _____.
Outpatient care is being delivered and the treatment plan consists of the following modalities:

____Individual Psychotherapy ____Couples Therapy
____Family Psychotherapy ____Medication Management
____Group Psychotherapy ____Other(_____)

Medication(s) are being managed by Dr. _____.

Medications and Dosages:

If you need additional information, contact me at _____
Sincerely,

_____ _____
Clinician's Name Signature

5512 S. Lewis Tulsa, OK 74105 918-747-1600. fax 918-749-2774

CONSENT FOR TREATMENT

I acknowledge that I have received and understand the information about the therapy I am considering. I have had all my questions answered fully.

I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with this therapist and regularly reviewing our work toward meeting the treatment goals are in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I understand that the information I share about myself is considered confidential and will not be shared with anyone without my written consent except under the following circumstances:

1. In extreme circumstances such as a life-threatening emergency.
2. To discuss my benefits or case with my managed care and/or insurance company.
3. A specific court order signed by a judge.
4. Any information regarding abuse of a child, disabled adult or aged person.

I am aware that I have the right to refuse treatment except in an emergency situation. If I do refuse treatment in an emergency situation, I have the right to be informed about the responsibility of the therapist to seek appropriate legal alternatives. Otherwise, I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have received.

I am aware that an agent of my insurance company, other third-party payer, or managed care company may be given information about the type(s), cost(s), and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all of these statements.

_____ _____

Signature of Client (or person acting for client) Date

_____ _____

Printed Name Relationship to client

_____ _____

Signature of Therapist Date

_____

Name of Child (If Child is Client)

Please sign below confirming that you were offered the "Notice of Privacy Practices" form.

_____

Signature indicates receipt of Notice of Privacy Practices

Notice of Privacy Practices
(Effective Date: September 1, 2012)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability Accountability Act (HIPAA) requires licensed mental health professionals to notify clients of the ways your mental health information and records are used and released by your mental health care providers and the client's rights regarding control over such information.

1. **Restrictions and Disclosure:** All medical records and all communications between a physician or psychotherapist and his/her mental health client are confidential and may not be disclosed without a written release by the client (or his/her representative) or by an order of the court (Okla. Stat. Tit. 43A, 1-109). Disclosure without the client's consent is permitted to other persons or agencies actively engaged in the client's treatment or in related administrative work. With the client's consent, a limited disclosure of information may be made to responsible family members. If the client is a minor, written consent of the parent or childcare agency with legal custody of the child is required.
2. **Appointment Reminder:** Our facility and its professional staff may use and disclose your protected health information to contact you as a reminder that you have an appointment for treatment or mental health care at the facility. This may be done through an automated system or by one of our staff members. If you are not at home, we may leave this information on your answering machine or in a message left with the person answering the telephone. You have the right to stop appointment reminders if you will let us know your decision.
3. **Serious Threat to Health and Safety:** Our facility and it's professional staff may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. This includes release of information regarding abuse of a child, adult, or aged person.
4. **Payment and Insurance Benefit:** Our facility and it's administrative and/or professional staff may ordinarily use and disclose protected health information about you so that the treatment services you receive at the facility or by professional staff may be billed to and payment collected from you, an insurance company, or a third party. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. Some insurance companies and/or managed care agencies may periodically audit client charts to ensure that appropriate documentation of services provided has been completed by your therapist.
5. **Patient Access:** A mental health client is not entitled to personal access to the information contained in his/her psychiatric or psychological records unless the treating practitioner consents or a court orders access (Okla. Stat. Tit. 43A, 1-109(B)). This provision encompasses the psychiatric and psychological records maintained by psychotherapists, mental health institutions, drug or alcohol abuse treatment facilities and others. The treating practitioner is to determine not only what information is to be released, but also the manner in which it is to be disclosed to the patient.