PLEASE SEND US A COPY OF YOUR DRIVER'S LICENSE OR GOVERNMENT IDENTIFICATION.

IF A CHILD IS BEING SEEN IN THIS OFFICE, PLEASE SEND US A COPY OF THE LEGAL GUARDIAN'S DRIVER'S LICENSE OR GOVERNMENT IDENTIFICATION.

REGISTRATION FORM FOR PSYCHOLOGICAL SERVICES - STUART W. BASSMAN, Ed.D.

PATIENT'S NAME_____ DATE_____

PARENT/LEGAL GUARDIAN (IF UNDER 18)_____

DATE OF BIRTH_____ AGE_____ SOC. SEC. #_____

ADDRESS (Number/Street)_____

_____
City State Zip

HOME PHONE_____ BUSINESS PHONE_____

CELL PHONE_____ May we leave a message for you on your phone _____

EMAIL_____ EMAIL is not considered confidential

MARRIED_____ SINGLE_____ WIDOWED_____ DIVORCED_____

PLACE OF EMPLOYMENT_____

REFERRED BY_____

PREFERRED PAYMENT: CASH_____ CHECK_____ CREDIT CARD_____

PERSON RESPONSIBLE FOR ACCOUNT_____

RELATIONSHIP TO PATIENT_____DATE OF BIRTH_____

ADDRESS (if different from patient)_____

SOC. SEC. #_____ PHONE #_____

I have been provided with the Patient Information Brochure and Privacy Notice and with the opportunity to ask questions about office policies, patient's rights and responsibilities.

_____
Patient's Signature

I understand that I am responsible to pay for all services rendered.

_____
Patient's Signature

I understand that if I do not give 24-hour advance notice in either not attending or canceling an appointment, I will be charged the full fee for the session.

_____
Patient's Signature

In case of emergency our office is authorized to contact:

_____ _____ _____
Name Relationship Phone numbers

STUART W. BASSMAN, Ed.D.
Professional Psychological Corp.

1955 Mears Avenue
Cincinnati, Ohio 45230-1980
Telephone: (513) 314-6111

MEDICAL INFORMATION FORM

NAME: _____ DATE _____

1. Check your current physical condition:
   _____ excellent _____ good _____ fair _____ poor
2. When did you have your last complete physical examination?
   _____
3. Are you currently being treated for medical problems?
   Condition _____
   Physician _____
   Address _____
4. Have you been treated in the past for any significant medical problems?
   _____
   _____ Date _____
   Physician _____ Address _____
   Condition _____
5. Are you currently experiencing any physical symptoms and problems? (Describe)
   _____
   _____
6. Are you currently taking any medications? _____
   Medication _____ For _____
   Medication _____ For _____
7. Have you been treated in the past for any significant psychological/psychiatric problems?
   _____ Date _____
   Mental health professional(s) _____
   Address _____
   Please describe _____
   _____
8. What are your present symptoms? _____
   _____
9. What prompts you to seek treatment at this time? _____
   _____
   _____
10. What are your goals for treatment? _____
    _____
    _____

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PATIENT NAME: _____
(Please print)

AUTHORIZATION FOR DISCLOSURE/RELEASE OF INFORMATION

_____ Please initial I, the undersigned, hereby authorize Stuart W. Bassman, Ed.D., Inc. (included but not limited to Dr. Bassman, his associates, his Assistants and _____ to **release and/or obtain** (please circle) information from records pertaining to the person named below to/from the agency/person indicated. This authorization includes release of information concerning psychological/psychiatric evaluation/treatment of drug or alcohol abuse, drug-related conditions, alcoholism, and medical conditions. All matters pertaining to patient records are considered privileged and confidential and are treated as such by the workers in this office. Information regarding such matters cannot be given without the consent of the patient.

AUTHORIZATION FOR DISCLOSURE/RELEASE OF INFORMATION BY ELECTRONIC MEDIA

_____ Please initial I give my permission and authorization for staff, associates, assistants and office staff of Stuart W. Bassman, Ed.D., Inc., to receive and send faxes, text messaging and/or e-mail data and attachments. I understand that this office will do what they can reasonably provide to maintain confidentiality, however, I realize that this office cannot guarantee the security of the web and faxes.

PROHIBITION ON REDISCLOSURE: Information disclosed or requested from records whose confidentiality is protected by Federal and/or State Law, may not be disclosed without the specific written consent of the person to whom it pertains.

AGENCY/PERSON _____ PHONE # _____

ADDRESS _____

PURPOSE/NEED FOR DISCLOSURE of information between Stuart W. Bassman, Ed.D., Inc. and person/agency named above: _____

_____

_____

The following information may be released or reviewed.

( ) Discharge Termination
( ) Face Sheet with Final Diagnosis
( ) History and Physical Records
( ) Consultative Report(s)
( ) Inpatient Notes
( ) Reports of Tests
( ) Medical Records
( ) Outpatient Notes
( ) Other _____
_____

This Authorization for Disclosure and Release of Information may be revoked by me at any time with written notice to the parties involved, except to the extent action has been taken prior to revocation.

I understand that this Authorization for Disclosure and Release of Information will be in effect:

_____ Ninety (90) days after the date below, or sooner at my discretion, in which this Authorization will expire on: _____;

_____ Until such time as I receive written notification that I am no longer a patient at this office or I revoke in writing.

_____ Upon expiration of my period of supervision, which is currently scheduled for _____, or such other time, as the Court acts to revoke, terminate or extend my probation or parole period.

_____ Other: _____
_____
_____

In consideration of this consent, I hereby release the above parties from any and all liability arising there - from. Further, I hereby fully release Stuart W. Bassman, Ed.D., Inc., (included but not limited to Dr. Bassman, his associates, his Assistants and office staff_____) from any liability associated with sending and receiving information and/or transmissions from electronic media resulting from my contact with this office.

I understand that in certain situations this office may receive background information about me in the form of tests, reports, clinical records, social histories and/or other background from

_____.

These documents may contain information from professionals other than the referral source. Dr. Bassman, his associates, his Assistants and _____ may incorporate that information into a report that will be sent to the aforementioned person and/or agency.

I hereby acknowledge that I have read and fully understood the above statements as they apply to me. I hereby consent to the disclosure of the records for the purpose and extent stated above.

SIGNATURE OF PATIENT _____

SIGNATURE OF GUARDIAN
IF PATIENT IS A MINOR _____

DATE OF BIRTH _____ SOCIAL SECURITY NO. _____

This authorization was witnessed by _____ Date _____
(Signature)

STUART W. BASSMAN, Ed.D.
Professional Psychological Corp.

1955 Mears Avenue
Cincinnati, Ohio 45230-1980
Telephone: (513) 314-6111

drstuartbassman@gmail.com
drstuartbassman.com

PERMISSION FOR EVALUATION AND/OR TREATMENT

Authorization and Consent for Services

RE: _____
PATIENT NAME

_____ _____
SOC. SEC. # DATE OF BIRTH

I hereby give my permission for the staff of Stuart W. Bassman, Ed. D., Inc. (included but not limited to Dr. Bassman, his Assistants, and Associates) to treat and/or evaluate myself.

I understand that these services will be most useful if I am fully committed to treatment. This means that I will take an active role in planning treatment and working with the therapist to achieve desired results. I understand that this office will use their best efforts to assist me. Further, I know that their can be no assurances of results. No promises have been made to me.

I have been informed that it is important to provide feedback to the staff by asking any questions, providing comments and concerns about services. If I decide to stop therapy against the therapist's advice, or chooses not to follow the therapist's advice, or chooses not to follow the therapist's instructions and/or recommendations, then I will be assuming responsibility for this course of action. I have been informed that I may terminate treatment at any time. However, before I do so, I will discuss termination with my therapist and/or Dr. Bassman.

I hereby state that I have read and fully understand the above statements as they apply to me and have been given the opportunity to ask questions about them.

_____ _____
Patient's Name Signature

_____ _____
Witness Date

STUART W. BASSMAN, Ed.D.
Professional Psychological Corp.

1955 Mears Avenue
Cincinnati, Ohio 45230-1980
Telephone: (513) 314-6111

STUART W. BASSMAN, Ed.D., INC.
FINANCIAL POLICY

We are committed to provide you with the best possible care. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered and we ask you to pay before leaving the office. We accept cash, checks, MasterCard, Discover or Visa. Checks should be made to Stuart W. Bassman, Ed.D., Inc. We do not accept postdated checks or endorsed checks made out to you from others (third party checks). If a check is returned to us unpaid from your bank, there is a $35.00 fee. We expect the returned check amount plus the late fees to be paid to Dr. Bassman within 10 working days of notification. We must consider terminating services if there are continuing unpaid balances. You will receive a statement each month. Please let us know if you don't receive one. Please either pay in full or contact the billing office at 513-232-2605.

Your insurance policy is a contract between you and the insurance company. We are not a party to that contract. Your insurance company may or may not reimburse you for services we have provided.

Our office policy states that if an appointment is not canceled 24 hours before the time of the appointment, there will be a charge for that broken appointment.

In divorce situations, the person bringing the child into the office is responsible for payment at the time of service. Whoever the Courts determine is the financially responsible parent can later reimburse the non-responsible party for any such payment, if required. We send all statements and correspondence to the custodial parent even though that person may not be responsible for payment of the account.

We require immediate notification of any change of address or phone numbers.

Your fee for services is as follows: _____.

The aforementioned financial policy has been explained to me, and I have been given the opportunity to ask questions.

_____ _____
Name of Patient (Print) Signature

_____
Date

Dr. Stuart Bassman
1955 Mears Ave., Cincinnati, OH 45230
(513) 314-6111 / DrStuart@drstuartbassman.com

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW MENTAL HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes in most instances without your consent under HIPAA, but I will obtain consent in another form for disclosing PHI for other reasons, including disclosing PHI outside of my practice, except as otherwise outlined in this Policy. In all instances I will only disclose the minimum necessary information in order to accomplish the intended purpose. To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  - *Treatment* is when I provide, coordinate or manage your health care and other services related to 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.
  - *Payment* is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage, which would include an audit.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- *"Use"* applies only to activities within my practice, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of my practice, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances, when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information, including uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI. Examples of disclosures requiring an authorization include disclosures to your partner, your spouse, your children, except in some limited instances where they are involved in your health care, in which case I will obtain your consent first. Any disclosure involving psychotherapy notes, if I maintain them, will require your signed authorization, unless I am otherwise allowed or required by law to release them. You may revoke an authorization for future disclosures, but this will not be effective for past disclosures which you have authorized.

III. Uses and Disclosures Requiring Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization as allowed by law, including under the following circumstances:

- **Serious Threat to Health or Safety:** If I believe that you pose a clear and substantial risk of imminent serious harm, or a clear and present danger, to yourself or another person I may disclose your relevant confidential information to public authorities, the potential victim, other professionals, and/or your family in order to protect against such harm. If you communicate to me an explicit threat of inflicting imminent and serious physical harm or causing the death of one or more clearly identifiable victims, and I believe you have the intent and ability to carry out the threat, then I may take one or more of the following actions in a timely manner: 1) take steps to hospitalize you on an emergency basis, 2) establish and undertake a treatment plan calculated to eliminate the possibility that you will carry out the threat, and initiate arrangements for a second opinion risk

assessment with another mental health professional, 3) communicate to a law enforcement agency and, if feasible, to the potential victim(s), or victim's parent or guardian if a minor, all of the following information: a) the nature of the threat, b) your identity, and c) the identity of the potential victim(s). I will inform you about these notices and obtain your written consent, if I deem it appropriate under the circumstances.

- **Worker's Compensation:** If you file a worker's compensation claim, I may be required to give your mental health information to relevant parties and officials.
- **Felony Reporting:** I am allowed to report any felony that you report to me that has been or is being committed.
- **For Health Oversight Activities:** I may use and disclose PHI if a government agency is requesting the information for health oversight activities. Some examples could be audits, investigations, or licensure and disciplinary activities conducted by agencies required by law to take specified actions to monitor health care providers, or reporting information to control disease, injury or disability.
- **For Specific Governmental Functions:** I may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, and for national security reasons, such as for protection of the President.
- **For Lawsuits and Other Legal Proceedings:** If you are involved in a court proceeding and a request is made for information concerning your evaluation, diagnosis or treatment, such information is protected by law. I cannot provide any information without your (or your personal or legal representative's) written authorization, or a court order, or at times an administrative subpoena, unless the information was prepared for a third party. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information. If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- **Abuse, Neglect, and Domestic Violence:** If I know or have reason to suspect that a child under 18 years of age or a developmentally disabled, or physically impaired child under 21 years of age has suffered or faces a threat of suffering any physical or mental wound, injury, disability, or condition of a nature that reasonably indicates abuse or neglect of the child or developmentally disabled individual under 21, the law requires that I file a report with the appropriate government agency, usually the County Children Services Agency. Once such a report is filed, I may be required to provide additional information. If I have reasonable cause to believe that a developmentally disabled adult, or an elderly adult in an independent living setting or in a nursing home is being abused, neglected, or exploited, the law requires that I report such belief to the appropriate governmental agency. Once such a report is filed, I may be required to provide additional information. If I know or have reasonable cause to believe that a patient or client has been the victim of domestic violence, I must note that knowledge or belief and the basis for it in the patient's or client's records.
- **To Coroners and Medical Examiners:** I may disclose PHI to coroners and medical examiners to assist in the identification of a deceased person and to determine a cause of death.
- **For Law Enforcement:** I may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
- **Required by Law.** I will disclose health information about you when required to do so by federal, state or local law.
- **Public Health Risks.** I may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, non-accidental physical injuries, reactions to medications or problems with products.
- **Information Not Personally Identifiable.** I may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Other uses and disclosures will require your signed authorization, unless the use or disclosure is allowed or required by law.

IV. Patient's Rights and Duties

Patient's Rights:

- ***Right to Request Restrictions and Disclosures*** - You have the right to request restrictions on certain uses and disclosures of protected health information about you for treatment, payment or health care operations. However, I am not required to agree to a restriction you request, except under certain limited circumstances, and will notify you if that is the case. One right that I may not deny is your right to request that no information be sent to your health care plan if payment in full is made for the health care service. If you select this option then you must request it ahead of time and payment must be received in full each

time a service is going to be provided. I will then not send any information to the health care plan for that session unless I am required by law to release this information.

- ***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. If your request is reasonable, then I will honor it.

- ***Right to Inspect and Copy*** – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record, except under some limited circumstances. If I maintain the information in an electronic format you may obtain it in that format. This does not apply to information created for use in a civil, criminal or administrative action or proceeding. I may charge you reasonable amounts for copies, mailing or associated supplies under most circumstances. I may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to your PHI, you may ask that my denial be reviewed. Under certain stances where I feel, for clearly stated treatment reasons, the disclosure of your record might have an adverse effect on you, I will provide your records to another mental health therapist of your choice.

- ***Right to Amend*** – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request, but will note that you made the request. Upon your request, I will discuss with you the details of the amendment process.

- ***Right to an Accounting*** – With certain exceptions, you generally have the right to receive an accounting of disclosures of PHI, not including disclosures for treatment, payment or health care operations for paper records on file for the past six years and for an accounting of disclosures made involving electronic records, including disclosures for treatment, payment or health care operations, for a period of three years. On your request I will discuss with you the details of the accounting process.

- ***Right to a Paper Copy*** – You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

My Duties:

- I am required by law to maintain the privacy of PHI, to provide you with this notice of my legal duties and privacy practices with respect to PHI, and to abide by the terms of this notice.
- I reserve the right to change the privacy policies and practices described in this notice and to make those changes effective for all of the PHI I maintain.
- If I revise my policies and procedures, which I reserve the right to do, I will make available a copy of the revised notice to you on my website, if I maintain one, and one will always be available at my office. You can always request that a paper copy be sent to you by mail.
- In the event that I learn that there has been an impermissible use or disclosure of your unsecured PHI, unless there is a low risk that your unsecured PHI has been compromised, I will notify you of this breach.

V. Complaints

If you are concerned that I have violated your privacy rights, or you disagree with a decision I make about access to your records, you may file a complaint with me and I will consider how best to resolve your complaint. Contact me, the Privacy Officer, if you wish to file a complaint with me. In the event that you aren't satisfied with my response to your complaint, or don't want to first file a complaint with me, then you may send a written complaint to the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., 200 Independence Avenue S.W., Washington, D.C. 20201, Ph: 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

There will be no retaliation against you for filing a complaint.

VI. Effective Date:

This notice is effective as of July 1, 2020.

VII. Privacy and Security Officer: I, Dr. Stuart Bassman, act as my own Privacy and Security Officer. My contact information is listed at the beginning of this form.

Acknowledgment of Receipt of Notice of Privacy Practices for Psychological Services at the offices of Dr. Stuart Baseman, his Assistants and Associates.

I, _____ (print name) have been presented the Notice of Privacy Practices for this office, detailing how my health information may not be used and disclosed under federal and state laws.

_____ _____

Patient/Legal Representative Signature Date