WONDER YEARS Psychiatric Services

New Client Information

Date: 2022-08-12 17:43:18

✱**NAME:** First: Test Last: tst
✱**DOB**: 8 February, 2021
Marital Status(if applicable): S / M / D / W : S
✱**Address**: Mani-Casadona IT Building, East Tower, Unit Apt # _____
City Kolkatta State: WEST Zip: 700156

✱**Email address**: mriganka.jana@capitalnumbers.com
✱**Contact Tel**: +44789456123
Work Tel: 56768687987
Home Tel: 67943657687979
Occupation/School: zsds Employer/College ssdsad

✱**Emergency Contact Info:**
✱Name: Test tst
Relationship: father
✱Address: Mani-Casadona IT Building, East Tower, Unit No 8E4
✱Phone: 07894561231

For *MINORS* only

✱**Parent/Guardian-1**
✱**NAME:** First: _____ Last: _____ DOB: _____
Marital Status(if applicable): S / M / D / W
✱**Address**: _____ City _____ State: ___ Zip: ___

✱**Email address:** _____
✱**Contact Te**l: _____
Work Tel: _____
Home Tel: _____
Occupation: _____
Employer/college _____

Parent/Guardian-2
NAME: First: _____ Last:_____ DOB: _____
Marital Status(if applicable): S / M / D / W
Address:_____City_____State:___Zip:___

Email address: _____
Contact Tel: _____
Work Tel: _____
Home Tel: _____
Occupation: _____
Employer/college_____

INSURANCE COVERAGE

What Insurance Carrier do you have? (Drop down menu)
□ Aetna
□ Cigna
□ United Healthcare
□ Self Pay

Aetna

✱Insurance ID Number (If Self Pay, write NONE)
e4464784

✱Policy Holder's Name
demo

✱Policy Holder's DOB
17 February, 2021

How did you hear about OUR services? (this could be drop down menu)
❏ Psychology Today
❏ Yelp
❏ Google Search
❏ Facebook
❏ Healthgrades
❏ Park Slope Parents
❏ Insurance company website
❏ Other: Please Specify-

Google Search

✱What is your **reason** for making an appointment?(Please describe your symptoms)

checkup

PRIMARY CARE PROVIDER:

☑ check if none

Name: _____
Phone: _____
Date of last visit: _____ Frequency of visits: _____

PSYCHOLOGIST OR THERAPIST:

☑ check if none

Name: _____
Phone: _____
Date of last visit: _____ Frequency of visits: _____

CURRENT/FORMER PSYCHIATRIST:

☑ check if none

Name: _____
Phone: _____
Date of last visit: _____ Frequency of visits: _____

This information is for our records only and any communication with the above named providers will only occur with your signed authorization.

MEDICAL CONDITIONS: *(please list all medical conditions that you have been evaluated for,diagnosed with, and/or treated for, both current and past):*

sadsf

SPECIALISTS SEEN: *(at any point in the past)*

sdsf

CURRENT MEDICATIONS: *including OTC (over-the-counter) drugs, herbal remedies, and nutritional supplements, both daily and occasional use:*

sfetret

PAST MEDICATIONS:

tyuyiuo

FAMILY HISTORY:

wewre

✱**ALLERGIES** *(to medications or foods):*

dfdgfh

HOSPITALIZATIONS, SURGERIES, & EMERGENCY ROOM VISITS:

retry

Have you ever had: (this could be drop down menu)

- ❏ seizures
- ❏ blackouts
- ❏ fainting spells
- ❏ heart palpitations
- ❏ chest pain
- ❏ shortness of breath/asthma
- ❏ fracture or severe injury a head injury/concussion
- ❏ NONE OF THE ABOVE

heart palpitations

NEW CLIENT AGREEMENT

Welcome to Wonder Years Psychiatric Services PLLC (hereby referred to as 'Wonder Years'). This document (the Agreement) contains important information about professional services and business policies provided at Wonder Years. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that Wonder Years provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail, and Wonder Years is in general accordance with HIPAA policies. The law requires that Wonder Years obtain your signature acknowledging that Wonder Years has provided you with this information. Although these documents are long and sometimes complex, it is very important that you read them carefully before signing them. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between you and Wonder Years. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless Wonder Years has taken action in reliance on it or if you have not satisfied any financial obligations you have incurred. The first session will involve a comprehensive evaluation of your needs, though it may extend past the first session. By the end of the evaluation, the provider at Wonder Years will be able to offer you some initial impressions of what your particular treatment plan should include. You should evaluate this information as well as your own assessment about whether you feel comfortable working with your provider at Wonder Years. Psychiatric treatment can involve a large commitment of time, money, and energy—so you should be selective about who you involve in your treatment. If you have questions about the provider's educational background, experience, procedures, or fees, feel free to discuss them whenever they arise.

FINANCIAL POLICY - CREDIT CARD ON FILE, FEES, BILLING, PAYMENT & INSURANCE

It is our policy to require all patients to provide credit card information at the time of booking an appointment. **You will be responsible for all charges incurred, including those amounts not paid by your insurance company.** Predetermined fees associated with an appointment are required before time of service. If you do not have health insurance or you have health insurance coverage with a plan we do not participate with, you will be required to pay for all services in full prior to the time of visit. For minor patients, the adult accompanying the patient is responsible for payment of the visit and related procedures. We can help prepare a statement for you to attach to your insurance claim form for payment processing. Your insurance company should send its payment directly to you.

We accept Visa, Mastercard, American Express, and Discovery. Your credit card information will be held securely. When payments are due, Wonder Years Psychiatric Services, PLLC and affiliated entities (hereinafter "Wonder Years") will collect payments up to one business day prior to your scheduled appointments. **It is your responsibility to keep your credit card information updated. Charges that fail to process or are denied by your credit card company will still remain your financial responsibility and will be subject to late fees.**

You must present us with your most current health insurance card and a valid government issued photo ID at the time of the appointment. It is your responsibility to notify our office immediately of any changes to your insurance. As a courtesy, we will bill the fees of our services to your insurance plan provided that we participate with your health insurance plan and the service is covered under your plan. **It is your responsibility to check with your health insurance carrier whether specific services or procedures are covered under your plan and to understand**

any policies they may have regarding your coverage of benefits. If your insurance requires you to have a pre-authorization or referral to be seen in our office, you must provide these prior to your first appointment.

If there is a remaining, unpaid balance on your account after your health insurance company has paid its portion, we will charge the remaining balance to your credit card and then send a copy of the charges to you. For specific information relating to the portion paid by your insurance, please refer to the Explanation of Benefits (EOB) that your insurance company is required to send you. Only your insurance company is responsible for determining your portion of the balance on the Explanation of Benefits form. In the event your health plan determines that a visit or service we already provided is not covered, declines payment for visits and services, or fails to pay, you will be responsible for payment in full and your credit card will be charged for the same.

You have carefully read the payment terms detailed above and you hereby authorize Wonder Years to keep your credit card information on file and to charge your credit card for all amounts owed by you to Wonder Years.

ADMINISTRATIVE FEES

In an effort to offer you the most value and highest quality of clinical service, we charge additional administrative fees for certain non-clinical services. Therefore, you (or your authorized representative) may incur or and are responsible for the payment of, certain administrative fees, as follows:

Emotional Support Animal Form/Letter	$25
Accommodation Letter	$25
Prior Authorization	$25
Prior Authorization Appeal (Letter of Medical Necessity) if Denied	$25
Disability Forms	$150
Medical Records ● Paper Records ● Electronic Records	 $0.75 per page $6.50 Flat fee

APPOINTMENTS & CANCELLATION

Services are most effective when meeting times are regular and consistent. If you need to cancel or reschedule a session, it is required that you provide **ONE BUSINESS DAY'S** notice. (24 hours' notice during the week, Friday notice for a change of a Monday appointment; holidays are treated like the weekend). If you miss a session without canceling, or cancel with less than one business day's notice, you will be billed for the full amount of the session. It is important to note that insurance companies do not provide reimbursement for cancelled sessions. In addition, you are responsible for coming to your session on time and at the time scheduled. If a client misses two (2) appointments without providing proper notice, they may be discharged from the practice and provided appropriate referrals for care.

NOTICE OF PRIVACY PRACTICES

Your health information includes information created in the course of providing you with treatment and in billing for those services. In general, we will not release your personal health information to anyone, including your spouse/partner, unless you provide consent in writing. We will only share your medical records pursuant to your consent and/or in accordance with HIPAA and/or other laws governing such disclosures.

Your health information may be shared if required or allowed by local, state, and federal law, including but not limited to matters of: public health, public safety, abuse, neglect, and court proceedings. There are other legal exceptions to this rule, which you may review with your provider.

Your information may be shared to evaluate practitioner or provider performance, or to educate healthcare professionals.

Your health information may be shared with business associates assisting us with business operations. All of our business associates are required to protect your health information.

I hereby authorize Wonder Years to release information for the purposes outlined in this privacy policy statement only and release Wonder Years from any liability which may arise as a result of the use of the information contained in the copy of records released.

I also hereby authorize Wonder Years to obtain my protected health information from other providers and/or services, including my medication history (e.g., via Allscripts, Practicefusion).

IN ORDER TO PROTECT THE PRIVACY OF OUR PRACTITIONERS AND PATIENTS, YOU AGREE NOT TO PHOTOGRAPH OR RECORD, VIA AUDIO, VIDEO AND/OR ANY OTHER MEANS, YOUR MEDICAL SESSIONS, WHETHER SUCH SESSION IS IN-PERSON OR VIA Telemedicine (AS DEFINED BELOW), OR OTHER PATIENTS AND/OR THE COMMON AREAS OF WONDER YEARS'S OFFICES.

TELEMEDICINE INFORMED CONSENT

NATURE OF TELEMEDICINE: Telemedicine provides psychiatric and/or therapy services using interactive audio, video and/or text conferencing tools in which the practitioner and the patient are not at the same location. Telemedicine will allow the patient to receive care without the need to visit the office.

MEDICAL INFORMATION & RECORDS: All existing laws regarding access to medical information and disseminating medical records apply to care via Telemedicine.

PHYSICIAN CHOICE OF CARE: The use of Telemedicine is determined by the provider.

RIGHTS: I have the right to withhold or withdraw my consent to the use of Telemedicine at any time during the course of my care in writing. Alternatives to Telemedicine include traditional face-to-face sessions.

CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with Telemedicine. All confidentiality protections that exist under federal law apply to information disclosed during Telemedicine sessions.

POTENTIAL RISKS: Potential risks include, but may not be limited to: information transmitted may not be sufficient (poor resolution of audio and/or video); delays in medical evaluation and treatment due to deficiencies or failure of the equipment; security protocols can fail, causing a breach of privacy; and a lack of access to all the information available in a face-to-face visit may result in errors in medical judgment. In the event that you are mentally compromised, due to the variability of patient location during Telemedicine, emergency services may fail to locate and treat you. In order to assist your emergency contact or emergency service providers, SohoMD will require you to identify your physical location prior to commencement of each Telemedicine session.

I hereby authorize Wonder Years to use Telemedicine in the course of my diagnosis and treatment.

COMMUNICATION VIA EMAIL AND TEXT MESSAGES

Please be aware that emailing and text messaging with Wonder Years practitioners and staff is not the most secure means of communication, may not be HIPAA compliant and may compromise your confidentiality. However, we realize that many of our patients prefer to communicate via email and text message because it is a quick and convenient way to convey information. Therefore, Wonder Years provides email and text message communications with patients. Such unencrypted email and text message communications may include the status of a patient's membership in any of our subscription services and/or billing matters, which may or may not contain protected health information. Nonetheless, we strongly suggest that you exercise caution and only communicate through a private device that you know is safe and technologically secure (e.g., has anti-virus protection, is password protected, not accessing the internet through a public wireless network, etc.). As always, if you have an emergency, call 9-1-1.

I hereby acknowledge that my communications with Wonder Years via unencrypted emails and text messages constitutes my consent to communicate via such means, and I further authorize Wonder Years to send emails and text messages that may include unencrypted protected health information.

GROUP THERAPY GUIDELINES AND RULES

If you are a participant in any group therapy services provided by Wonder Years, you agree to the following guidelines and rules:

Confidentiality and Privacy. You have the right to confidentiality and privacy in connection with group facilitators and other group members. Confidentiality within the group setting is a shared responsibility of all members and facilitators. While group facilitators may not disclose any client communications or information except as provided by law, group members' communications are not protected. As such, confidentiality within the group setting is often based on mutual trust and respect. Nevertheless, by participating in group therapy, you hereby agree to strict compliance of the following rules:

- As a member of this group, you agree to not disclose to anyone outside the group any information that may help to identify another group member. This includes, without limitation, names, physical descriptions, and specifics regarding any content of interactions with other group members.

- You shall not engage in discussion of group issues outside of group.
- You agree to participate in each session yourself and by yourself (i.e., you shall not have any other individuals appearing in your stead or present with you during a session, unless specifically authorized by Wonder Years).
- You may not use drugs or alcohol before or during group sessions.
- You agree not to photograph or record, via audio, video and/or any other means, your group sessions, the group facilitator or other patients.

Security of Your Personal Information. YOU UNDERSTAND AND HEREBY ACKNOWLEDGE THAT USING ANY INTERNET-BASED SERVICE CARRIES INHERENT SECURITY RISKS, SUCH AS DATA BREACHES, THAT CANNOT BE 100% PREVENTED. Wonder Years employs reasonable, HIPAA compliant, security measures designed to protect the security of information submitted through its services. Confidentiality of audio and video communications in individual and group therapy is protected by encryption and on a secure site. However, the security of information transmitted through the Internet can never be guaranteed. To protect you and your personal information we may suspend your use of Wonder Years services, without notice, pending an investigation, if any breach of security is suspected.

Your Responsibilities. Group members are responsible for maintaining the security of any password, user ID or other form of authentication involved in obtaining access to password protected or secure areas of any of the online services offered by Wonder Years. Access to and use of password protected and/or secure areas of Wonder Years's services are restricted to authorized users only. It is your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, or other third-parties could either overhear your communications or have access to the technology that you are interacting with. You should only communicate through a computer or device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).

I HAVE READ AND AGREED TO THIS WONDER YEARS AGREEMENT IN IT'S ENTIRETY

NAME (Print): test

SIGNATURE:

DATE: 2022-08-12 17:43:18