Insights For Life LLC.

Martha Reed PhD, Holistic Life Counselor, Coach, Hypnotherapist

20325 N. 51st Ave #112
Glendale, AZ 85308
(623) 444-4482

CONFIDENTIAL PATIENT INFORMATION
PLEASE FILL IN ALL PORTIONS OF THIS FORM
PLEASE ASK IF YOU NEED HELP

Name of Patient ____
Permanent Address ____
City ____________________ State ________ Zip ____________________
Temporary Address ____________________________ What dates? ____________
City____________________State__________ Zip ____________________
Date of Birth ______________ Age ________Marital Status ______________________
Phone (Home) ______________________ (Cell) ______________________
Fax ____________________________ e-mail ______________________
Work Phone ____________________
Employed by ____________________ Occupation ______________________
Name of spouse (or parent if minor) ______________________________
Work Phone ____________________ SS# ______________________
Employed by ____________________ Occupation ______________________
Name of relative not living with you ______________________________
Whom may we contact in case of emergency? __________________________
Phone ________________________

How did you hear about us? Yellow pages _______ Newspaper ______ Supermarket ___________
Location/Sign _______ Internet ________ Other (list) ____________
Referred by ____

CENTER POLICY REQUIRES PAYMENT AT TIME OF SERVICES

TODAY's PAYMENT WILL BE BY:

CASH _________ CHECK _________ VISA _________ MASTERCARD ___________

At time of payment, you will be given a copy of your superbill from our office. This will show diagnosis, services and charges. You can submit this form for reimbursement directly to your insurance company.

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible. Refunds will not be given on packages purchased if they are not fulfilled, and no refunds will be given for treatments deemed “unsuccessful”.
I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered me will be immediately due and payable. Further more, any charges, fees or court costs incurred as a result of collection efforts will be added to my account balance.

Releases may be requested prior to specific procedures being performed (i.e. minor surgery, etc.)

____ ____________________
Patient Signature Date

____
Parent/Guardian Signature

Confidential Client Information

Name and address of personal Physician:

Name and address of other therapist you are currently seeing:

How would you describe your family / social life right now?

How would you describe your childhood?

Any history of major illness / health problems / mental or emotional difficulties / addictions in your family?

Your current health:

How is your health now?

Past health problems / operations / conditions / accidents:

List any supplements / medications / tranquilizers you are on now:

Are you or have you been in any discomfort recently? Elaborate.

What do you do for stress in your life now?

Do you exercise? What method? How often?

Have you ever been treated for emotional problem / diabetes / epilepsy / heart condition?   When?

What have you already been doing to resolve this problem?

What brings you in today? Please elaborate.

What have you been currently doing about it?

How has that been working for you?

How would your life be different if you didn't have this problem?

Tell us about the times you don't have this problem:

Other things you would like to work on with us even if not done today:

Any questions you would like answered?

Hypnosis / Reiki patient questions:

Have you ever been hypnotized before?   yes / no   when?   For what?

Have you ever had Reiki before?   yes / no   For what?

Do you practice meditation / self-hypnosis?   How often?

Insights For Life LLC. Policy for:
Rescheduled / Cancelled Appointments
NSF Check Fees

PLEASE BE AWARE:

<u>Appointments:</u>
The patient is ALWAYS responsible to call **<u>24 hours prior to the scheduled appointment time</u>** to reschedule or cancel. Failure to do so will result in a $ 45.00 charge to the patient for the missed appointment.

<u>NSF Checks:</u>
NSF checks that are returned to us will automatically mean a charge to the patient account of $25. The patient will be responsible to replace the amount of the check in addition to the $25 Non-Sufficient Funds amount.

<u>Payment for services:</u>
The patient is ALWAYS responsible for payment of all charges incurred.

I certify that I have read and understand the above policies. I guarantee payment of all charges incurred made payable to Insights For Life LLC.

Signed: ____

Parent or Guardian (if minor): ____________________________

Date: ____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Insights For Life LLC. Notice of Privacy Practices.
(Attached)

______________________________________	________________________
Patient or legally authorized individual signature	Date
______________________________________	________________________
Printed Name if signed on behalf of the patient	Relationship (parent, legal guardian, personal representative, etc.)

Revisions (if any):

____

NOTICE OF PRIVACY PRACTICES

To our patients: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.
9. In cases of suspected child abuse or dependent adult or elder abuse, for which we are required by law to report.
10. If a client is threatening serious bodily harm to another person(s), we must inform the intended victim.
11. If a client intends to harm himself or herself, we must act to protect the life of the client.

Your rights regarding your health information

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that my be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Insights for life LLC., 20325 N. 51st Ave, Suite 112, Glendale, AZ 85308. Note: *We must respond to this request within 30 days.*

4. You may ask us to amend your health information if you believe it is <u>incorrect</u> or <u>incomplete,</u> and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Insights for life LLC., 20325 N. 51st Ave, Suite 112, Glendale, AZ 85308. You must provide us with a reason that supports your request for amendment.

Note: *We must respond within 60 days. The Privacy Officer or the patient's physician will usually do this. If the physician believes the information is complete and accurate, the physician can refuse to make any changes.*

5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact the front desk receptionist.

6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Office Manager at Insights for life LLC., 20325 N. 51st Ave, Suite 112, Glendale, AZ 85308. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact the Office Manager at Insights For Life LLC.