



INTEGRATED PSYCHOLOGICAL SERVICES
EMPLOYEE ASSISTANCE PROGRAMS INC.

Dear New Patient:

Welcome to Matrix Psychological Services. We are pleased that you have entrusted us with your behavioral health needs, and we are committed to providing you with a comfortable and beneficial experience.

For over 41 years, my staff of doctoral psychologists (Ph.D. and Psy.D.), social workers and certified chemical dependency counselors have assisted thousands of patients with a variety of concerns, including depression, grief, family and marital issues, job stress, and school-related problems. We operate four offices in the Columbus metro area, and if for any reason you would prefer to see your therapist in another location, would feel more comfortable with another therapist, or have any other questions regarding your experience at Matrix, please don't hesitate to contact me or my staff anytime (office: 614-475-9500 or home: 614-445-9171).

If you need to cancel your appointment, please let us know at least 24 hours in advance (Business Days Only) to avoid a \$35 cancellation fee. In this way, we can reschedule your appointment, and we can better accommodate patients that may be waiting for a visit. Cancellations made when the office is closed will count as being made at 8am the next business day. In the event of an emergency after our regular hours (Mon-Thurs 8am to 8pm and Friday 8am to 6pm) please call 614-475-9500 and choose option 3. Our 24-hour crisis line will either counsel you or contact your Matrix psychologist, as appropriate.

Thank you for choosing Matrix. We look forward to serving you.

Respectfully,

Kurt Malkoff, Ph.D.
President

NATIONAL HEADQUARTERS:
2 EASTON OVAL, SUITE 450
COLUMBUS, OHIO 43219

DUBLIN OFFICE:
5060-D BRADENTON AVENUE
DUBLIN, OHIO 43017

WORTHINGTON OFFICE:
110 NORTHWOODS BOULEVARD, SUITE B-1
COLUMBUS, OHIO 43235

GERMAN VILLAGE OFFICE:
249 E. LIVINGSTON AVENUE
COLUMBUS, OHIO 43215



Patient Information
Child/Adolescent

Patient Name _____ DOB _____

Address _____

Phone: Home _____ Ok to call? Y N Age _____ Gender _____

Father Cell Phone (to be used for emergency only) _____ Message ok? Y N

Mother Cell Phone (to be used for emergency only) _____ Message ok? Y N

Referred By: _____ Family Physician/Pediatrician & Practice Name _____

Phone: _____ Phone _____

Send Report to Referring Person? Y N Send Report to Physician? Y N

Parents Are: (Circle One) Married Separated Divorced Never Married Widowed Deceased

Custodial Parent or Guardian (if this applies): _____

Circle one if child is: Foster Adopted under Guardianship Other

Age When Child Came Under Your Care _____

Parent or Guardian Information (Indicate Home Address Only if Different from Patient's)

Mother: Name _____ Home Phone _____

Address _____

Employer _____ SS# _____

Work Phone _____ Job Title _____

Father: Name _____ Home Phone _____

Address _____

Employer _____ SS# _____

Work Phone _____ Job Title _____

Guardian: Name _____ Home Phone _____

Address _____

Employer _____ SS# _____

Work Phone _____ Job Title _____



I authorize Matrix to release/exchange treatment information with my family physician and health plan's utilization reviewers in order to facilitate my treatment by Matrix. I understand that I am financially responsible for any balance or copay not covered by my insurance.

Signature of Patient, Parent or Guardian

Date

Insured's or Authorized person's signature: I authorize payment of benefits to the undersigned physician or supplier for services provided:

Signed _____

For Office Use Only:

Patient # _____ Contact Date _____ Intake Date _____ Diagnosis: _____

M A T R I X

PROBLEM CHECKLIST: CHECK ALL THAT APPLY

- | | | | |
|--------------------------------------|---|--|---|
| <input type="checkbox"/> Agitated | <input type="checkbox"/> Restless | <input type="checkbox"/> Anxious | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Worries a lot | <input type="checkbox"/> Depressed | <input type="checkbox"/> Appetite increase |
| <input type="checkbox"/> Cries often | <input type="checkbox"/> Doesn't fit in | <input type="checkbox"/> Confused | <input type="checkbox"/> Appetite decrease |
| <input type="checkbox"/> Hopeless | <input type="checkbox"/> Helpless | <input type="checkbox"/> Sad | <input type="checkbox"/> No appetite |
| <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Desperate | <input type="checkbox"/> Feels guilty | <input type="checkbox"/> Self-harm (thoughts/actions) |
| <input type="checkbox"/> Suicidal | <input type="checkbox"/> Overly tired | <input type="checkbox"/> Distracted | <input type="checkbox"/> Personality changes |
| <input type="checkbox"/> Loses time | <input type="checkbox"/> Hears voices | <input type="checkbox"/> Sees "things" | <input type="checkbox"/> Can't concentrate |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Demanding | <input type="checkbox"/> Suspicious | <input type="checkbox"/> Too meticulous |
| <input type="checkbox"/> Homicidal | <input type="checkbox"/> Angry | <input type="checkbox"/> Combative | <input type="checkbox"/> Impaired performance |
| <input type="checkbox"/> Passive | <input type="checkbox"/> Irritable | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Feeling "out of control" |
| <input type="checkbox"/> Other _____ | | | |

1. How long have problems lasted? _____ Why have you decided to seek help now? _____

2. What have you done to solve them? _____

3. What are your child's strengths/abilities? _____

Disabilities/health problems? _____

4. Where does he/she get support? Include community involvement and leisure activities. _____

5. Check any changes or stressors that might have contributed to your child's problem:
- | | | |
|---|---|---|
| <input type="checkbox"/> New brother/sister | <input type="checkbox"/> Family financial pressures | <input type="checkbox"/> Job changes |
| <input type="checkbox"/> Traumatic experience | <input type="checkbox"/> School pressures | <input type="checkbox"/> Moves |
| <input type="checkbox"/> School change | <input type="checkbox"/> Activity/sports pressures | <input type="checkbox"/> Alcohol use |
| <input type="checkbox"/> Divorce/separation | <input type="checkbox"/> Marriage/new relationship | <input type="checkbox"/> Drug use |
| <input type="checkbox"/> Loss/change of friends | <input type="checkbox"/> Family medical problems | <input type="checkbox"/> Deaths |
| <input type="checkbox"/> Health problems | <input type="checkbox"/> Witnessing abuse or violence | <input type="checkbox"/> Legal problems |

6. Please list below all prior psychiatric/psychological treatment or counseling:

Provider	Treatment Dates
_____	_____
_____	_____
_____	_____

M A T R I X

7. Has there been any exposure to abusive behaviors? Yes No If yes, please answer the following:
 Current exposure Past Exposure If so, when? _____

Type of abuse: Physical Sexual Verbal
 How experienced: Personally Witnessed
 Did it occur: Within the family Outside the family

8. Has your child had any contact with children's services? Yes No If yes, please describe when this occurred and the circumstances: _____

9. Court and/or police contact? Yes No If yes, please describe when this occurred and the circumstances: _____

People now living in the patient's home:

Name	Relation	Age	Gender	Grade in School or Occupation
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Family members living away from home:

Name	Relation	Age	Gender	Grade in School or Occupation
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

CHEMICAL ABUSE/DEPENDENCY HISTORY

Patient history of alcohol, street drugs, and/or medication abuse/dependence? Yes No If yes, please describe: _____

Alcohol/Medications	Age at Onset	Dose/Amount	How Often	Last Used
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Family history of alcohol or drug abuse/dependency? Yes No If yes, please describe: _____

SCHOOL HISTORY

Name of School: _____ Grade: _____ Grades repeated: _____
 School District: _____ Number of School Changes (Districts): _____
 Special Services (Circle any that apply): Individual Testing Speech/Language SBH LD DH
 Home Tutor Other _____

M A T R I X

Do any of the following exist?

- | | | |
|---|---|---|
| <input type="checkbox"/> Language barrier | <input type="checkbox"/> Sensory problems | <input type="checkbox"/> Diminished comprehension |
| <input type="checkbox"/> Learning disability | <input type="checkbox"/> Reading problems | <input type="checkbox"/> Diminished concentration |
| <input type="checkbox"/> History of noncompliance | <input type="checkbox"/> Cultural issues | |

Level of motivation: High Average Low None

HEALTH INFORMATION

Your child's physical and emotional health are highly interdependent. To help us understand his/her concerns, we ask you to provide the following information:

1. How would you rate your child's present health? Excellent___ Good___ Fair___ Poor___
2. When did he/she last see a physician? _____ Whom and why? _____

3. Any current physical symptoms or illness? _____

4. Is he/she on any special diet? Yes___ No___ If yes, specify _____
5. Does he/she have difficulty sleeping? Yes___ No___ If yes, specify _____

Please check if he/she or anyone in your family has any of the following:

	Child	Family		Child	Family
A. Alcoholism	___	___	L. Seizures	___	___
B. Arthritis	___	___	M. Anorexia/Bulimia	___	___
C. Cancer	___	___	N. Sexual abuse/incest	___	___
D. Cirrhosis of liver	___	___	O. Physical abuse	___	___
E. Diabetes	___	___	P. Physical disability	___	___
F. Drug abuse	___	___	Q. Developmental disability	___	___
G. Hepatitis	___	___	R. Allergies	___	___
H. High Blood Pressure	___	___	S. Blood problems	___	___
I. Multiple sclerosis	___	___	T. Asthma	___	___
J. Pregnancy	___	___	U. Heart Disease	___	___
K. Psych. Hospital	___	___	V. Other	___	___
			Specify _____		

Any other pertinent health history not mentioned above _____

Is your child presently on or has he/she been on medication? Yes___ No___
If yes, please list medications _____

M A T R I X

Person to contact in case of emergency:

Name _____ Home Phone _____

Work Phone _____ Relationship _____

Date: _____ *Signature _____

*Signature will be considered your permission to contact named person in case of emergency.



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Authorization for patient appointment information

Please complete this form if someone other than the named adult patient is authorized to schedule appointments.

Patient's Name _____

I authorize the following individuals to (check all that apply)

- Schedule appointments
- cancel appointments
- change appointments
- inquire about appointment dates/times
- Discuss/Handle billing, insurance, and payment issues

Name _____

Relation to patient (i.e. parent, stepparent, grandparent, babysitter, caregiver, etc) _____

I understand that no information other than what is indicated above will be shared with the individuals indicated on this form.

Signature of patient _____

Signature of parent or guardian _____

Date _____

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Welcome to Matrix. This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new 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 we 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. The law requires that we obtain your signature acknowledging that we have provided you with this information at the end of this session. Your signature on this document represents an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Similarly, psychotherapy has benefits and risks. Since therapy often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

Early in your therapy, your doctor will offer you some first impressions of what your work will include, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with that doctor. S/he will be willing to discuss any questions or concerns as they arise. At any point if you would like to speak with someone else, the office staff will be happy to help you set up a meeting with another mental health professional for a second opinion or to find a better fit.

MEETINGS

Our doctors generally schedule one session per week at a mutually agreed upon time. If you are an EAP patient, and you miss an appointment without 24-hour notice one EAP session may be forfeited. If you are a patient whose services are being covered by a health plan, and you miss an appointment without 24-hours' notice, you may be expected to pay a \$35 fee. It is important to note that insurance companies do not provide reimbursement for cancelled sessions

PROFESSIONAL FEES

For patients who are not covered by either an EAP or a health plan, our hourly self-pay fee is \$175, after an initial assessment visit which is charged at \$200. In addition to weekly appointments, we charge this amount for other professional services you may need, though we will break down the hourly cost if we work for periods of less than one hour. Other services include report writing, telephone conversations lasting longer than 30 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of us. If you become involved in legal proceedings that require your clinician's participation, you will be expected to pay for all professional time, including preparation and transportation costs, even if your therapist is called to

testify by another party. Because of the difficulty of legal involvement, we charge \$325 per hour for preparation and attendance at any legal proceeding.

CONTACTING MATRIX

Your doctor often is not immediately available by telephone, especially when s/he is with another patient. Matrix telephones are answered by our office staff daily from 9 am to 6 pm for routine calls and by trained crisis counselors after office hours for emergencies. We will make every effort to return your call on the same day you make it. In the event of an emergency, either the staff or the crisis service will page your doctor. If s/he is not available, you may ask them to leave a message for the doctor to return your call, or you may speak directly to the crisis counselor, who will then provide a report to your doctor. If you feel you are in serious crisis, and these options are not enough, you should immediately contact your family physician or the nearest emergency room and ask for the psychologist [psychiatrist] on call.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of our patients. The other professionals are also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together. We will note all consultations in your Clinical Record (which is called "PHI" in the Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Health Information).
- You should be aware that we practice with other mental health professionals and that we employ administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- We also have contracts with an answering service, computer programmer, accountant, and a collection agency. As required by HIPAA, we have formal business associate contracts with these businesses in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where we are permitted or required to disclose information without either your consent or Authorization:

- 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 the psychologist-patient privilege law. We cannot provide any information without your (or your personal or legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.

- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.
- If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.
- If a patient files a worker's compensation claim, the patient must execute a release so that we may release the information, records, or reports relevant to the claim.

There are some situations in which your therapist is legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and s/he may have to reveal some information about a patient's treatment. These situations are unusual in this practice, but they include:

- In the event of known or suspected child abuse or neglect, the law requires that your therapist file a report with the appropriate government agency. Once such a report is filed, we may be required to provide additional information.
- If your therapist has reasonable cause to believe that an "adult" (as defined below) is being abused, neglected, or exploited, or is in a condition which is the result of such, the law requires that s/he report such belief to the county Department of Job and Family Services. Once such a report is filed, we may be required to provide additional information. "Adult" is defined as any person sixty years of age or older within this state who is handicapped by the infirmities of aging or who has a physical or mental impairment which prevents the person from providing for the person's own care or protection, and who resides in an independent living arrangement
- If your therapist knows or has reasonable cause to believe that a patient or client has been the victim of domestic violence other than child or "adult" abuse or neglect, s/he must note that knowledge or belief and the basis for it in the patient's or client records.
- If your therapist believes that a patient presents a clear and substantial risk of imminent serious harm to him/herself or someone else and believes that disclosure of certain information may serve to protect that individual, then s/he must disclose that information to appropriate public authorities, and/or the potential victim, and/or professional workers, and/or the family of the client.

If such a situation arises, the therapist will make every effort to fully discuss it with you before taking any action and we will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, Matrix keeps Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others, you may examine and/or receive a copy of your Clinical Record if you request it in writing and the

request is signed by you and dated not more than 60 days from the date it is submitted. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in my presence, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, we are allowed to charge a copying fee of \$1 per page for the first ten pages, 50 cents per page for pages 11 through 50, and 20 cents per page for pages in excess of fifty, plus \$15 fee for records search, plus postage. The exceptions to this policy are contained in the attached Notice Form. If we refuse your request for access to your Clinical Record, you have a right of review, which we will discuss with you upon request.

In addition, your file will also contain a set of Psychotherapy Notes. These Notes are for the therapist's own use and are designed to assist in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of your conversations, his/her analysis of those conversations, and how they impact on your therapy. They also contain particularly sensitive information that you may reveal to him/her that is not required to be included in your Clinical Record. These Psychotherapy Notes are kept separate from your Clinical Record. While insurance companies can request and receive a copy of your Clinical Record, they cannot receive a copy of your Psychotherapy Notes without your signed, written Authorization. Insurance companies cannot require your Authorization as a condition of coverage nor penalize you in any way for your refusal. You may examine and/or receive a copy of your Psychotherapy Notes unless we determine that such disclosure would have an adverse effect on you.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. Your therapist will be happy to discuss any of these rights with you.

MINORS & PARENTS

Patients under 14 years of age who are not emancipated and their parents should be aware that the law allows parents to examine their child's treatment records unless the therapist decides that such access would injure the child or the therapist and the parents agree otherwise. Children between 14 and 18 may independently consent to and receive up to 6 sessions of psychotherapy (provided within a 30-day period) and no information about those sessions can be disclosed to anyone without the child's agreement. While privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, parental involvement is also essential to successful treatment.

LEGAL ISSUES

It is Matrix policy not to accept clients who indicate that legal matters are either expected or in process regarding their case. These issues include but are not limited to court ordered treatment, custody matters, visitation, divorce issues, etc. A psychologist cannot ethically function as both therapist and evaluator and these roles must be determined during the first contact. Deception regarding this will result in immediate termination of the therapeutic relationship. Since your clinician will not have performed a detailed legal evaluation, s/he will not be able to provide assistance/testimony in any court cases that might ensue.

BILLING AND PAYMENTS (for non-EAP patients)

You will be expected to pay for each session at the time it is held, unless we agree otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested.

If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require us to disclose otherwise confidential information. In most collection situations, the only information we release regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT (for non-EAP patients)

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of my fees. It is very important that you find out exactly what mental health services your insurance policy covers. We will contact them for you to help you understand your specific coverage.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis. Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above.

NOTE TO EAP CLIENTS:

If you are seeing a Matrix therapist as part of your company's Employee Assistance Program, there will be no insurance billing, and thus no notification to any third parties without your written consent unless you require more than the allotted number of sessions.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THE OHIO PSYCHOTHERAPIST PATIENT AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE READ THE HIPAA NOTICE FORM DESCRIBED WITHIN. COPIES OF BOTH ARE AVAILABLE UPON REQUEST.

Signature

Date _____

Print Name