Kathleen Cramer, Ph.D.
Patient Identification Form and Financial Responsibility Acknowledgment

Patient Name (Last, First, Middle): _____

Date of Birth: _____ (Check One): ☐ Male ☐ Female

Address: _____
Street Address Apt # (if applicable) City State Zip

Phone: _____ Parent/Legal Guardian (if applicable): _____

Address: _____
Street City State/Zip

In case of a medical emergency or any other emergency, please list two emergency contacts below:

Name: _____ Telephone Number: _____

Name: _____ Telephone Number: _____

If patient is under the age of eighteen (18), please list the name(s) of individuals to whom the child may be released:

_____ _____

_____ _____

FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT:

I acknowledge full financial responsibility for services rendered by KATHLEEN CRAMER, PH.D. I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment. I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges. I further authorize and request that insurance payments be made directly to KATHLEEN CRAMER, PH.D. should they elect to receive such payment.

I understand that KATHLEEN CRAMER, PH.D. verifies my mental health benefits through my insurance as a *courtesy* to me. I further understand that it is my responsibility to ensure services are covered and/or what my exact benefits are, not KATHLEEN CRAMER, PH.D. KATHLEEN CRAMER, PH.D. will assist me in this process to the best of its ability. I understand that I am ultimately responsible for payment of all services rendered. I understand that any co-pays, deductibles, or any other payments of outstanding balances are due prior to services being rendered. I understand that it is my responsibility to update KATHLEEN CRAMER, PH.D. of any changes in insurance.

I understand that my health insurance is a contract between me and the insurance company and/or my employer, not KATHLEEN CRAMER, PH.D. If there are any disputes of benefit coverage, I understand that I need to contact my insurance carrier.

I have read and fully understand the above financial responsibility and insurance authorization.

_____ _____
Signature of Patient/Parent/Legal Guardian Date

_____
Printed Name of Patient/Parent/Legal Guardian

Picture Identification Verified _____

This notice describes how health information about you (as a patient of this practice) may be used and disclosed. It also describes how you can gain access to your health information. This is required by the privacy regulations created as a result of the Health Insurance Portability Accountability Act of 1996 (HIPAA).

My commitment to your privacy:
My practice is dedicated to maintaining the privacy of your health information. I am required by law to maintain the confidentiality of your health information. While these laws are complicated, I must provide you with the following important information.

Use and disclosure of your health information in certain special circumstances:
The following circumstances may require me 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 a 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 (I will only make disclosure 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 law enforcement official;
8. For Worker's Compensation and similar programs.

Your rights regarding your health information:

1. Communications: You can request that I communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that I contact you at home, rather than work. I will accommodate reasonable requests.
2. You can request a restriction in my use or disclosure of your health information for treatment, payment, or health care operation. Additionally, you have the right to request that I restrict my disclosure of your health information to only certain individuals involved in your care of the payment for your care, such as family members and friends. I am not required to agree to your request; however, if I agree, then I am 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 review and copy your protected health information;
4. You have the right to have your provider amend your protected health information. In certain cases, I may deny your request for amendment. If that happens, then you have the right to file a statement of disagreement with me; and I may prepare a rebuttal to your statement. A copy of any such rebuttal will be provided to you.
5. You have the right to receive an accounting of certain disclosures I have made, if any, of your protected health information.
6. You have the right to obtain a paper copy of this Notice from my office.

By signing below, I acknowledge that I have read this copy of Dr. Cramer's Privacy Practices.

_____
Print Patient Name

_____ _____
Patient Signature/Acknowledgement Date

Kathleen Cramer, Ph.D.

Consent for Purpose of Treatment, Payment and Healthcare Operations

I consent to the use and disclosure of _____'s Protected Health Information by KATHLEEN CRAMER, PH.D. (hereinafter "Dr. Cramer")

Print Patient Name Here

for the purpose of diagnosing, providing treatment, obtaining payment for health care bills, or conducting health care operations of Dr. Cramer's practice. I understand that the diagnosis or treatment by Dr. Cramer may be conditioned upon this consent as evidenced by the authorizing signature on this document.

I understand I have the right to request a restriction as to how protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of Dr. Cramer's practice. Dr. Cramer is not required to agree to the restrictions that I request. If she agrees to a restriction, then such restriction is binding on her. I have the right to revoke this consent at any time, in writing, except to the extent that Dr. Cramer has taken action in reliance on this consent.

My "Protected Health Information" means health information (including demographic information) that is collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to past, present, or future physical or mental health conditions and identifying information.

I understand that I have the right to review Dr. Cramer's HIPAA Notice of Privacy Practices (a copy of which has been provided to me) prior to signing this Consent. The HIPAA Notice of Privacy Practices describes various uses and disclosures of protected health information that may occur in (1) the course of my treatment/bill payment or (2) the performance of healthcare operations by Dr. Cramer's office. The HIPAA Notice of Privacy Practices also describes patient's rights and Dr. Cramer's duties with respect to protected health information.

Dr. Cramer reserves the right to change the privacy practices that are described in the HIPAA Notice of Privacy Practices. I may obtain a revised HIPAA Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for same at the time of my next appointment.

_____
Signature of Patient/Parent/Legal Guardian

_____
Printed Name of Patient/Parent/Legal Guardian

_____
Date

Kathleen Cramer, Ph.D.

Office Policies and Procedures

Date: Updated 09/14/2022

Purpose: To inform all clients about the following office policies: registration, no-show/late cancellation fees, billing procedures, and termination of treatment. This information is provided in order to establish consistent guidelines in receiving and refunding any fees.

Registration Policy and Procedure:

1. All patients (or the patient's legal guardian) will be provided with a copy of this written policy regarding registration procedures, no show/cancellation policy and procedures, billing policies, and termination policy. This copy will be offered when patients arrive at the office for their first appointment. It is the patient's responsibility to read the policies and to acknowledge agreement with same by signing below. Patients may receive a copy of Dr. Cramer's office policies by requesting same.
2. Insurance coverage will be verified as a courtesy for patients who have insurance coverage, prior to the first appointment. If any coverage issues are found during insurance verification, we will communicate the information to the patient prior to their visit. However, the ultimate responsibility for verifying insurance coverage rests with the patient. Benefit information obtained from the insurance company and/or authorization(s) are not a guarantee of payment. Any charges not paid by the insurance company will be the financial responsibility of the patient. Any changes in insurance, deductibles, and/or co-pays are the responsibility of the patient. It is not our responsibility to review the balance of any deductibles, changes in insurance or insurance information, or coordination of benefits. Any charges incurred due (but not limited) to deductibles, loss or change of insurance, or failure to coordinate benefits will be the patient's financial responsibility. If authorization for services is required with the patient's insurance, we will obtain authorization for the initial services (first visit). It is the responsibility of the patient to obtain additional authorizations after the initial authorization has lapsed and/or all authorized visits have been used. If the patient fails to obtain authorization for services – and the insurance company subsequently refuses to pay for such services – then any charges incurred will be the financial responsibility of the patient.
3. Co-pays, deductibles, co-insurance, and/or any outstanding amounts on the patient's account are due and payable prior to the patient's appointment and will be collected prior to services being rendered; a follow-up appointment will not be scheduled if there is a balance due UNLESS we determine that the patient is in an emergency situation. In that case, a follow-up appointment will be offered; and the patient will be given a 30-day written termination notice with referral sources. Outstanding balances on the patient's account include no-show and/or late cancellation fees that have not been collected.

New patients will be provided a written statement regarding the billing policies, termination policy and no-show/cancellation policy;

No-Show/Cancellation Policy and Procedure:

1. Patients who fail to show for an appointment ("no show") or who fail to provide 24-hour notice of cancellation will be assessed a no-show/late cancellation fee of $125.00 *per hour*. The office can be reached at all times for cancelling/rescheduling appointments at 480.355.4261, and a message may be left after hours. It is the patient's responsibility to ensure they are present for their scheduled appointment(s) or to provide notice of their cancellation. No-show/late cancellation fees are not negotiable, except in extenuating circumstances that would have to be approved by Dr. Cramer. If an appointment is late cancelled (without 24-hour notice) but rescheduled for the same day, then no late cancellation will be assessed.
2. If patients have a second no-show/late cancellation, then they may be sent a letter terminating care with 30 days notice. This issue will be addressed on a case-by-case basis, but final decisionmaking will be at the discretion of Dr. Cramer.

Billing Policy and Procedure:

1. Residual amounts due after insurance adjudication will be billed directly to the patient and are the patient's financial responsibility. Payment is due prior to additional services being rendered.
2. If a refund is owed to the patient, the refund will be paid within approximately 6-8 weeks of adjudication.
3. We bill the patient's insurance company as a courtesy to the patient. The patient's insurance benefits are a contract between the patient and the patient's insurance company. *It is the patient's responsibility to verify his/her mental health benefits.* If benefits are exhausted, the patient is liable for all charges incurred. Whatever disagreements the patient has with his/her insurance company including benefit information, it is the patient's responsibility to contact their insurance company to resolve. It is our policy to collect any amounts as verified through the patient's insurance company, such as co-pays or deductibles. We will not make multiple verifications if the patient disagrees with the information obtained from the insurance company. It is the patient's responsibility to contact their insurance company if there are any discrepancies.
4. If there are billing issues, the patient is to contact their insurance company.

5. For self-paying patients who are filing their own claims with insurance companies with which we are not affiliated, the patient will be issued a receipt of payment.
6. All payments for self-pay patients for services are due and payable prior to the visit, prior to services being rendered.

Termination Policy and Procedure:

1. Patients may terminate treatment at any time.
2. Dr. Cramer may terminate treatment for the following reasons:
    a. She determines that she does not have appropriate expertise to treat the patient's problems.
    b. She determines that the patient needs a higher level of care that is outside the scope of her practice.
    c. The patient fails to comply with his/her treatment plan, including missed appointments that result in significant periods of time without treatment.
    d. The patient fails to comply with policies and procedures set forth in this memo.
    e. The patient fails to pay outstanding charges on his/her account.
    f. The patient exhibits inappropriate behavior (e.g., threats, derogatory language, or any other disruptions to the practice).
3. If Dr. Cramer terminates care, the patient will be provided written notice including the reasons for the termination and referrals for alternative sources of treatment. Notice period will be 30 days UNLESS termination is due to non-adherence with the treatment plan or inappropriate behavior, in which case the patient will be considered to have violated the treatment contract and waived the notice period.
4. If a patient's treatment has been terminated for any of the reasons listed above, the patient's record will not be re-opened in the future for any reason.

Kathleen Cramer, Ph.D.

Kathleen Cramer, Ph.D.
Psychologist

By signing below, I acknowledge that I have read and agree with this copy of Dr. Cramer's Office Policies and Procedures.

_____ _____

Signature of Patient Date

_____

Printed Name of Patient

NON-SECURE ELECTRONIC COMMUNICATIONS

(EMAIL, TEXT MESSAGE, AND OTHER NON-SECURE MEANS)

It may become useful during the course of treatment to communicate by email, text message, or other non-secure methods. Please be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with Dr. Cramer, there is a chance that third parties may be able to intercept them. Parties that may intercept non-secure messages include, but are not limited to, the following:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages;
- Your employer, if you use your work email or phone to communicate with Dr. Cramer;
- Third parties on the Internet such as server administrators and/or others who monitor Internet traffic in your environment;
- Etc.

If there are people in your life that you don't want accessing these communications, then please talk with Dr. Cramer about ways to keep your communications safe and confidential.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH

INFORMATION BY NON-SECURE MEANS

I consent to allow Dr. Cramer to use unsecured email, telephone, and/or text messaging to transmit the following protected health information:

- Information related to the scheduling of appointments;
- Information related to billing and/or payment issues;
- Information related to coordination of care with other treatment providers;
- Information related to therapeutic homework assignments;
- Etc.

I have been informed of the risks of transmitting my protected health information by non-secure means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time and that such termination must be in written/typed form.

_____ _____

Signature of Patient Date

_____

Printed Name of Patient