SPRING PSYCHOLOGY

Noah Spring, Psy.D., HSPP, NRHSP
Licensed Clinical Psychologist
450 East 96th Street Suite 500 - #6030
Indianapolis, IN 46240
Tel: (317) 421-9330

Adult Patient Information Form

Today's Date: _____ **Date of Birth:** _____ **Age:** _____

Full Name: _____ **What would you prefer I call you?** _____

Gender: _____ **Sexual Orientation:** _____ **Race/Ethnicity:** _____

Partner/Relationship Status: _____ **Partner Name:** _____

Current Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Preferred Phone Number (home/work/cell): (____)_____

Secondary Phone Number (home/work/cell): (____)_____

Referring Provider or Source:_____

Current Psychiatric Medications: _____

Previous Mental Health Services: _____

Presenting Problems: _____
_____

Emergency Contact Information

Name: _____ **Relationship to Patient:** _____ **Phone:** (____)_____

PRIMARY HEALTH INSURANCE INFORMATION **(If utilizing insurance)**

Insurance Company Name: _____ **Phone:** _____

Insurance Company Address: _____

_____

Policy Holder's Name: _____ **Date of Birth:** _____

Relationship to Patient: _____ **SSN:** _____

ID#: _____ **Group#:** _____

Name of Policy Holder's Employer: _____

SECONDARY INSURANCE INFORMATION

Insurance Company Name: _____ **Phone:** _____

Insurance Company Address: _____

_____

Policy Holder's Name: _____ **Date of Birth:** _____

Relationship to Patient: _____ **SSN:** _____

ID#: _____ **Group#:** _____

Name of Policy Holder's Employer: _____

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CONSENT TO TREATMENT – ADULT INDIVIDUAL TREATMENT

I have fully discussed with Dr. Noah Spring the various aspects of the patient agreement. This has included a discussion of my evaluation/intake as well as the method of treatment. The nature of the treatment has been described, including the extent, its possible side effects, and possible alternative forms of treatment. Dr. Spring has discussed with me scheduling, the nature of the fee and policies regarding missed appointments. Dr. Spring has explained to me the limitations of confidentiality. I understand I may withdraw from treatment at any time, but if I decide to do this, I will discuss my plan with Dr. Spring before acting on it. My only financial obligation, should I decide to stop treatment, is to pay for the services I have already received.

I have read the above and fully understand the diagnosis, the nature of treatment, the alternatives to this treatment, the limits of confidentiality in this relationship, and the circumstances in which confidential communications may need to be breached.

Please initial after the following statements:

I authorize the release of any information acquired in the course of examination or treatment necessary to process an insurance claim. I also assign payment of insurance benefits to the provider for services rendered for in-network benefits.

_____
Initial

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered, regardless of my insurance status. I understand that if collection proceedings are necessary, I will pay all fees associated with collecting this bill.

_____
Initial

(*For out-of-network patients)* I understand that Dr. Spring is not an in-network provider with my insurance company, _____. As a result, I understand that I am responsible for payment at the time of service, and I will obtain the necessary documentation to file a claim with my health insurance company if I choose to do so.

_____
Initial

(*If applicable*) I authorize communication between Dr. Spring and referring physician/clinician _____to inform that I have initiated services (separate release is required for further exchange of information).

_____
Initial

I would like to be contacted for appointment reminders and other correspondence via any of the following ways (check all that apply):

- ☐ Telephone (please provide preferred number): _____
- ☐ Voicemail Message _____
- ☐ Text Message (if different than above):_____
- ☐ Email: _____
- ☐ Postal Mail (include address if other than provided): _____

_____	_____
Patient Signature (may be signed electronically)	Date
_____	_____
Printed Name	Date
_____	_____
Witness Signature	Date
_____	_____
Witness Printed Name	Date

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ACKNOWLEDGMENT: RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I have received a copy of HIPAA Notice of Privacy Practices from Noah Z. Spring, Psy.D., HSPP effective January 1, 2017.

Patient Name (please print): _____

Patient Signature: _____ (may be signed electronically)

Date: _____

(For couples)
Name (please print): _____

Signature: _____ (may be signed electronically)

Date: _____

I am a parent or legal guardian of _____ (patient name). I have received a copy of Notice of Privacy Practices from Noah Z. Spring, Psy.D., HSPP effective January 1, 2017.

Name (please print): _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____ (may be signed electronically)

Date: _____

FOR OFFICE USE ONLY:

Notice of Privacy Practices effective Janury 1, 2017 was given to individual on _____(date)

☐ In Person ☐ Mailing ☐ Email ☐ Other _____

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other _____

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In person conversation_____
☐ Telephone contact_____
☐ Mailing _____
☐ Email _____
☐ Other _____

Staff Name (please print): _____Title: _____

Staff Signature: _____Date: _____