If you are planning on using insurance:

Many people are having unpleasant surprises about the coverage they *thought* they had (large deductibles, higher co-pays than expected, need to pre-authorize visits, etc.) when they try to get reimbursed from their insurance company. Please call your insurance company before our first appointment.

Your insurance policy may have specific coverage rules which you must know in order to get payment.

Please call the number on the back of your insurance card and tell them you want to **"VERIFY OUTPATIENT MENTAL HEALTH BENEFITS."**

Then write down the following information:

1.) Number to call to verify outpatient mental health insurance benefits?_____

2.) Who am I speaking with? _____

3.) Does my policy cover: Individual Psychotherapy? _____
Group Psychotherapy? _____
Psychological Testing? _____
Conjoint Psychotherapy? _____

4.) Do they require pre-certification and if so how do I do it? _____

5.) Do they require authorization and if so how do I do it? _____

6a.) Does my policy have coverage limitations as to number of visits per year? _____
dollar amount per year? _____

6b.) Does my policy cover (check all that apply):
___ 90837 - Psychotherapy - 1 hour
___ 90834 - Psychotherapy - 45 minutes
___ 90832 - Psychotherapy - 30 minutes
___ 90847 - Family Therapy, conjoint therapy with patient present
___ 90846 - Family Therapy, without patient present
___ 90853 - Group Therapy

7.) Is Dr. Litton (Tax ID # 74-2879214) currently a network provider for my plan? _____

8.) What are my in-network benefits? _____ Deductible? _____
Co-payment? _____
Co-insurance_____
% Paid by Policy? _____

9.) What are my out-of-network benefits? _____Deductible? _____
Co-payment? _____
Co-insurance?_____
% Paid by Policy? _____

10.) Does my policy pay for everything but deductibles & co-payments? _____

11.) **What is the Mental Health Insurance Co. Billing Address?**

Insurance Company Name & Address _____

MUST HAVE – Please write it here.

By doing this you will minimize the possibility of incurring unexpected expenses. Should the Insurance Co. refuse to

CLIENT/PATIENT INFORMATION

Client/Patient Name_____ Marital Status_____

Current Address _____ Gender_____ Date of Birth _____/____/_____

City, State, ZIP _____ Soc.Security No._____-_____-_____

Telephone (Home)_____ Telephone(Work) _____

Employer's Name_____ Occupation_____

Employer's Address_____ E-mail address: _____

Spouse's Name_____ Spouse's Date of Birth_____

Family physician _____ Referred by_____*

In case of emergency, notify_____

_____ _____

(Area Code & Telephone) (Relationship)

* If an individual, may I thank them? YES or NO (circle one)

INSURANCE INFORMATION

YES or NO (circle one) I authorize the release of any clinical or other information necessary to process my insurance claim.

Policy Holder's Name_____ Policy Holder's Soc. Sec. # _____-_____-_____

Policy Holder's Date of Birth _____/_____/_____ Group # _____

Policy Holder's address (if different than above): _____

Relationship to client/patient? _____

YES or NO (circle one) I authorize payment of insurance benefits to the provider.

_____ _____

Insured's Signature Date

Mental/Health Insurance Co. Name & Billing Address: _____

MUST HAVE
Who pays the bill? _____

_____

Phone # _____

From time to time I may send out newsletters or informative articles to my clients. If you **do not** want to receive this type of material please initial here:_____

To avoid any confusion about services and fees, please read the following guidelines

Fees

Initial session is $150.00. Subsequent sessions are $125.00 per 45 minutes. Longer sessions are prorated from this basic fee. Fees for other services such as psychological testing, reports, talking with other professionals, extended telephone conversations, etc. will be billed at an hourly rate.

Appointments

I schedule my appointments personally. You may leave a message with the answering system 24 hours a day, seven days a week at 345-6781 ext. 22 to cancel an appointment. **Please remember that without a full 24 hours notice you will be responsible for full payment of your missed session.** A missed session cannot be billed to insurance.

Payment & Billing

If you were referred by an Employee Assistance Program or Preferred Provider List, your portion (co-payment) is expected at each visit. The office accepts MasterCard, Visa, American Express, and Discover as well as cash and checks. Your insurance policy is a contract between the insurance company and you. Dr. Litton will file your insurance claim as a courtesy to you. However, you are responsible for the account balance regardless of what insurance pays. If any amount billed to you remains unpaid for over 30 days (without prior discussion of plan for payment) the account will be turned over to a collection agency and a 42% charge added for collection agency fees (58% if the acccount is over 1 year old) By signing this form you are binding yourself to this contract.

Please be advised that insurance companies are often very slow in resolving accounts and often provide inaccurate coverage information. Because of this and the accounting problems it creates, you may receive a bill from my office months later than expected. This bill is still your responsibility.

Emergencies

In the event of an emergency, please call one of the following emergency numbers first and then call Dr. Litton at 345-6781.

Emergency Services	911	Seton Emergency Room	323-1010
Psychiatric Emergency Services	472-4357	Shoal Creek Hospital	452-0361
St. David's Pavilion	867-5800	CAPE (for teens)	448-0185
Brackenridge Emergency Room	476-6461		

I have read and understand the information on this sheet.

_____ _____

Signature Date

Credit Card Information

Please provide the required information about the credit card you will use to pay any fees for missed appointments or to make payments on your account.

Type of Credit Card: ❑ Visa ❑ Master Card ❑ American Express ❑ Discover

Credit Card Number: _____

3 Digit Security Code on Back of Card: _____ Expiration Date: _____

Name as printed on card: _____

Billing address for credit card: _____

_____

_____

By my signature below, I grant David Litton, Ph.D my permission to charge the account described above for missed session fees.

_____ _____
Signature Date

_____
Printed Name

(Optional – Line through if you do not wish to grant this permission)

By my signature below, I grant David Litton, Ph.D. my permission to charge the account described above for any outstanding balance on a monthly basis.

_____ _____
Signature Date

_____
Printed Name

PAYMENTS DUE: Your payment or co-payment is expected at the beginning of each session. Also, please realize that any amounts left unpaid by your insurance (such as annual deductibles) will be your responsibility to pay.

CANCELED APPOINTMENTS: Please remember that without a full 24-hours notice, your credit card will be billed for full payment of your missed session. A missed session cannot be billed to insurance. If you do have to cancel an appointment, you may leave a message 24 hours a day, seven days a week at 512-345-6781 x22.

Summary Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

My commitment to your privacy

My practice is dedicated to maintaining the privacy of your personal health information. I am required also by law to do this. These laws are complicated, but we must provide you with important information. This is a shorter version of the full, legally required NPP that you will receive at my office so refer to it for more information. However, I can't cover all possible situations so please talk to me about any questions or problems.

I will use the information about your health that I get from you or from others mainly to provide you with treatment, to arrange payment for my services or for some other business activities that are called, in the law, health care operations. After you have read this NPP I will ask you to sign a Consent Form to let me and share your information. If you do not consent and sign this form, I cannot treat you.

If I or you want to use or disclose (send, share, release) your information for any other purposes I will discuss this with you and ask you to sign an Authorization to allow this.

Of course I will keep your health information private but there are some times when the laws require me to use or share it such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. I will only share information with a person or organization who is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If a law enforcement official requires me to do so.

4. For Workers Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP.

Your rights regarding your health information

1. You can ask me to communicate with you about your health and related issues in a particular way or at a certain place. For example, you can ask me to call you at home, and not at work to schedule or cancel an appointment. I will try my best to do as you ask.

2. You have the right to ask me to limit what we tell certain individuals involved in your care or the payment for your care, such as family members and friends. While I don't have to agree to your request, if I do agree, I will keep our agreement except if is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you such as your medical and billing records. You can even get a copy of these records but I may charge you. Contact me to arrange how to see your records.

4. If you believe the information in your records is incorrect or incomplete, you can ask me to make some kinds of changes (called amending) to your health information. You have to make this request in writing and send it to me. You must tell me the reasons you want to make the changes.

5. You have the right to a copy of this notice. If I change this NPP I will post it in the office and you can always get a copy of the NPP from me.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with me and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or my health information privacy policies, please contact me, my practice's Privacy Officer by phone or email information supplied on my card

The effective date of this notice is April 14, 2003 Signature_____

Consent to use and disclose your health information

This form is an agreement between you, _____ and me, David S. Litton, Ph.D.

(When I use the word "you" below, it will mean your child, relative, or other person if you have written his or her name here) _____.)

When I examine, diagnose, treat, or refer you I will be collecting what the law calls Protected Health Information (PHI) about you. I need to use this information to decide on what treatment is best for you and to provide treatment to you. I may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form you are agreeing to let me and my staff use your information and send it to others. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information. Please read this before you sign this Consent form. Your signature also indicates that you are aware of the availability of the full version of the Privacy Protection Notice on my web site or at my office.

If you do not sign this consent form agreeing to what is in my Notice of Privacy Practices I cannot treat you.

In the future I may change how we use and share your information and so may change my Notice of Privacy Practices. If I do change it, you can get a copy by calling me (Privacy Officer) at 345-6781.

If you are concerned about some of your information, you have the right to ask me to not use or share some of your information for treatment, payment or administrative purposes. You will have to tell me what you want in writing. Although I will try to respect your wishes, I am not required to agree to these limitations. However, if we do agree, I promise to comply with your wish.

After you have signed this consent, you have the right to revoke it (by writing a letter telling me you no longer consent) and I will comply with your wishes about using or sharing your information from that time on but I may already have used or shared some of your information and cannot change that.

Your signature also implies that you agree to utilize my professional services.

_____ _____

Signature of client or his or her personal representative Date

_____

Printed name of client or personal representative

_____

Relationship to the client

_____ _____

Description of personal representative's authority Date

The federal Health Insurance Privacy and Portability Act requires that certain forms be made available to you. Those that were not included in your new client/patient paperwork are available to you at my office. They include:

• The standard authorization form (to use and disclose protected health information).

• Form to revoke an authorization (given prior).

• Form to request limitations on disclosure of private health information.

• Request for alternative communication channels (limits call back numbers, etc.).

• Form to request access to one's health information.

• Form to request an accounting of disclosures.

• Complaint form

Should you have need for any of these, I will be happy to provide them for you.

Keep this for your records