Stephen Ross, PsyD, HSPP
Licensed Clinical & Forensic Psychologist
Diplomate in Clinical Psychology
American Board of Professional Psychology

Clinical & Forensic Psychological Services of IN, PC
4630 W. Jefferson Blvd., Suite 5
Fort Wayne, IN 46804
260.436.4100
(Facsimile) 260.432.6282

Dear Patient or Forensic Client:

Welcome to Clinical and Forensic Psychological Services. It's the intent of Dr. Ross to provide you with high quality clinical and forensic psychological services. Choosing to see a psychologist is a very important decision whether it is for individual or family therapy, psychological testing, or a forensic evaluation.

We would like to emphasize several important points:

1] Your records are confidential and cannot be obtained by anyone without your written consent. However, Indiana law requires that we report to the authorities incidents of suspected child physical abuse, neglect, sexual abuse of children, and/or other activities which require reporting by our office. Feel free to discuss these exceptions with Dr. Ross.

2] Our staff has limited office hours. Much of his work is done outside of the office. If it is important that you contact us for **urgent** reasons, call Dr Ross at **436-4100.** You will receive a return call promptly

3] Keeping scheduled appointments with our doctors is very important. If you or your family members are sick, please call and cancel as soon as possible. Likewise, if Dr. Ross is sick or required to go to Court, we will contact you as soon as possible. Late cancellations [less than 24 hours' notice] or no-shows will result in **you** being billed for the time set-aside for the appointment.

4] We expect payment **at the time of service**, including any co-payments required by your insurance. Co-payments cannot be waived. Our Clinic's fees (effective 3-8-2021) are:

Initial evaluation (60 minutes)	$160
Individual therapy (60 minutes)	$150
Family therapy	$150 per hour
Individual or family therapy (75 minutes+)	$220
Psychological testing	$160 per hour
Forensic evaluations	$200 per hour
Late cancellations/no-shows	$95

Please discuss with Drs. Ross any concerns you might have about your charges.

5] Your insurance is an arrangement you have with your insurance company. If they require pre-authorization, it is **your** responsibility to contact them. If necessary, your doctor will discuss your treatment and diagnosis with them to facilitate reimbursement. The least amount of information will be given to your insurance company to insure your privacy. **Please make a copy (front and back) of your insurance card and bring it to your first appointment**

Please complete the accompanying paperwork, sign where indicated, and mail it **prior to** your first appointment, if possible.

Directions have been provided for your convenience.

We look forward to serving your needs.

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Clinical and Forensic Psychological Services
Patient/Consultee Registration and Insurance Verification Form

Please complete the form in its entirety and bring it to your first appointment

Patient Name:_____ DOB:_____

Patient's SS#:_____

Male___ Female___ Marital status:_____

Address:_____ E-Mail_____

_____

_____

Tel. #: (Home):_____ (Work):_____

(Cell):_____

Name of insured/guardian:_____

Guardian address:_____

SS# of insured/guardian:_____

Employer of insured/guardian:_____

DOB of insured/guardian:_____

Relationship of insured to patient:_____

YOU MUST CALL YOUR INSURANCE FOR THIS INFORMATION

Primary insurance:

Insurance Company:_____ Phone:_____

I.D. Policy #:_____ Group#:_____

Effective date:_____

Employer of insured:_____ DOB of insured:_____

Social Security # of Insured:_____

Address where insurance claims are sent:_____

What is your deductible?:_____

Has the deductible been met?_____ If not, how much has been met?_____

Pre-authorization required?:_____ Co-pay required?_____

Insurance year:_____ to_____ Yearly maximum:_____

# of sessions covered:_____

Secondary insurance:

Insurance Company:_____ Phone:_____

I.D. Policy #:_____ Group#:_____

Effective date:_____

Employer of insured:_____ DOB of insured:_____

Social Security # of Insured:_____

Address where insurance claims are sent:_____

What is your deductible?:_____

Has the deductible been met?_____ If not, how much has been met?_____

Pre-authorization required?:_____ Co-pay required?_____

Insurance year:_____ to_____ Yearly maximum:_____

# of sessions covered:_____

It is important that you, the insured, contact your insurance company for benefit information. Insurance companies may require pre-authorization. You must contact them to obtain such information, if so required. Failure to contact them may result in decreased benefits.

Please note that Dr. Ross is a provider for Anthem Blue Cross/Blue Shield.

He is not a provider for Medicaid, Medicare, Lutheran Preferred, Cigna Sagamore, or PHP.

If we are not a provider for your insurance plan, you may be eligible for out-of-network benefits. The appropriate documentation will be provided to you for submission to your insurance company for reimbursement.

Clinical & Forensic Psychological Services of IN, PC

Stephen Ross, PsyD, HSPP, ABPP
Amanda Mayle, PsyD, HSPP
4630 W. Jefferson Blvd., Suite 5
Fort Wayne, Indiana 46804
260.436.4100
260.432.6282 [facsimile]

OUTPATIENT SERVICES CONTRACT

Welcome to Clinical and Forensic Psychological Services. This document contains important information about our professional services and business policies. Please read it carefully and jot down any questions you might have so that we can discuss them at your first meeting. When you sign this document, it will represent an agreement between us for services we provide to you, your child, or to your family [spouse].

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the psychologist and patient and the particular problems you bring forward. Psychotherapy can have 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 has also been shown to have benefits for people who go through it. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience. Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, we will be able to offer some first impressions of what our 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 us. Therapy involves a commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion. We normally conduct an initial evaluation session which lasts 60 minutes. During this time, we can both decide whether our clinic can provide the services you need in order to meet your treatment goals. If psychotherapy is begun, we will usually schedule one 50-minute session (one appointment hour of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more frequent.

The clinic's hourly fee is **$160** for the initial session and **$150** for therapy/consultation sessions thereafter. The charge for psychological testing is **$170** per hour. In the event you fail to keep a scheduled appointment, you may be charged **$95** for either a late cancellation [less than 24 notice] or a forgotten appointment. If you (or your therapist) have a legitimate reason for cancelling, that is understandable. Fees for a review of

any court or legal documents provided for review by our clinicians are billed at a rate of **$200** per hour and are not billable to insurance. The individual responsible for the charges in the case is also responsible for these charges, unless another individual requests that these documents be reviewed.

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 which requires another arrangement. **This clinic accepts cash, check or credit card payment.** 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. If such legal action is necessary, its costs will be included in the claim. 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. There is a $25 charge for returned checks.

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 with whom this clinic has contracted, it will usually provide some coverage for mental health treatment. It is very important that you find out exactly what mental health services your insurance policy covers **and what co-pay**, if any, you must pay at each visit. You should also be aware that insurance companies require you to authorize this clinic to provide them with a clinical diagnosis.

Given the nature of Dr. Ross's practice, which includes forensic psychology, the clinic's premises are under constant video surveillance. The perimeter, foyer, and testing areas will be monitored by video and audio cameras. Only Dr. Ross's office will have the capability of video/audio monitoring. This will only occur in those cases in which Dr. Ross is engaging in forensic evaluations. Psychotherapy sessions will not be video monitored. If I have any questions about this arrangement, I will discuss this with my therapist.

In general, the privacy of all communications between a patient and a psychologist is protected by law, and we can only release information about our work to others with your written permission. But there are a few exceptions. In most legal proceedings, you have the right to prevent us from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order our testimony if he/she determines that the issues demand it. There are some situations in which we are legally obligated to take action to protect others from harm, even if we have to reveal some information about a patient's treatment. For example, if we believe that a child or an elderly/disabled person is being abused, we may be required to file a report with the appropriate

state agency. If we believe a patient is threatening serious bodily harm to another, we may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm himself/herself, we may be obligated to seek hospitalization for them or to contact family members or others who can help provide protection. These situations have rarely occurred in our practice. If a similar situation occurs, we will make every effort to fully discuss it with you before taking any action. At times it is necessary for Dr. Ross to consult with other professionals regarding issues concerning your case. No identifying information will be conveyed to the individual(s) with whom Dr. Ross is consulting. If you do not wish for such professional consultation to take place, please advise Dr. Ross of this; otherwise, we will assume you will consent to such consultation.

Also, it is our practice policy to not regularly use email communications as a means by which to convey confidential information or to communicate with patients. However, if you do communicate with us via email or the internet, we cannot guarantee that others may not access your confidential information by illegal means. Some of our clinicians provide marriage counseling. Unfortunately, however, such counseling may not be successful, resulting in one of the parties filing for divorce. This presents a particularly difficult situation for your therapist should you request that they continue to provide individual therapy to you. It is the practice of this clinic to not continue in individual therapy with one of the couple in the event of the filing of a divorce, unless understood agreements are discussed, warranting a continuation of treatment. We will be happy to discuss your options and transition you to another therapist in the community. Feel free to discuss this with your therapist. Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____	_____
Patient's signature	Stephen Ross, PsyD, ABPP
_____	_____
Patient Signature (for couples)	Patient's name printed

CANCELLATION POLICY

THE CANCELLATION OF AN APPOINTMENT REQUIRES A 24-HOUR NOTICE. IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, PLEASE NOTIFY US 24 HOURS IN ADVANCE, AND YOU WILL NOT BE CHARGED. IF YOU DO NOT APPEAR FOR AN APPOINTMENT YOU MAY BE CHARGED A FEE FOR THAT APPOINTMENT. INSURANCE WILL NOT PAY FOR MISSED APPOINTMENTS. THE CHARGE WILL BE YOUR RESPONSIBILITY.

I HAVE READ THE ABOVE AND UNDERSTAND THE CANCELLATION POLICY

NAME: _____ DATE: _____

FINANCIAL ARRANGEMENTS

I AUTHORIZE DIRECT PAYMENT OF MENTAL HEALTH BENEFITS TO CLINICAL AND FORENSIC PSYCHOLOGICAL SERVICES FOR SERVICES PROVIDED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES FOR ALL SERVICES RENDERED. I FURTHER AUTHORIZE THE ABOVE TO DISCLOSE INFORMATION NECESSARY TO PROCESS MY INSURANCE CLAIMS. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS TO CLINICAL AND FORENSIC PSYCHOLOGICAL SERVICES.

IF YOU HAVE INSURANCE: We will file the claim for you if at the time of service our clinic is in your insurance network. We will accept as your payment the portion that insurance does not cover. If for any reason your insurance does not pay within sixty (60) days or if you have not met your deductible you will be responsible for the total payment.

PLEASE NOTE THAT PROOF OF INSURANCE DOES NOT ALWAYS QUALIFY FOR COVERAGE. ALTHOUGH THIS OFFICE WILL BILL THE INSURANCE COMPANY, IT IS ULTIMATELY THE PATIENT/RESPONSIBLE PARTY'S RESPONSIBILITY TO CHECK COVERAGE PRIOR TO SERVICE. I WILL BE RESPONSIBLE FOR ATTORNEYS FEES IF THE ACCOUNT GOES TO COLLECTIONS, INCLUDING 18% PER ANNUM INTEREST CHARGE. RECORDS WILL NOT BE RELEASED TO THIRD PARTIES UNTIL YOUR BILL IS PAID IN FULL.

I HAVE READ THE ABOVE AND UNDERSTAND MY OBLIGATION FOR PAYMENT. I UNDERSTAND THAT I MAY BE REPORTED TO A COLLECTION AGENCY AND/OR CREDIT BUREAU FOR NON-PAYMENT.

NAME: _____ DATE: _____

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Directions to Clinical & Forensic Psychological Services
Drs. Ross

If coming from I-69 at the US 24 exit:

- Take the exit for Lutheran Hospital [you will be on Highway 24/Jefferson Boulevard]; the office is approximately 9 stoplights east of I-69.
- Go through the light at Highway 24/Jefferson Boulevard and Engle Rd.
- Continue heading eastbound past Times Corners towards Jefferson Pointe.
- On your left hand side **before Jefferson Pointe** you will see Professional Park West.
- Make a **left** into the complex and follow the drive back to 4630, Unit 5.

If coming from downtown Ft. Wayne:

- Get onto Washington Boulevard [Washington Boulevard will turn into Jefferson Boulevard] going west toward Jefferson Pointe.
- You'll go through the stop light at Jefferson Boulevard and Apple Glen. Best Buy will be directly off to your right and prominently displayed.
- Drive one-half block down to Professional Park West which will be directly to your right.
- Make a **right** into the complex and follow the drive back to 4630, Unit 5

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

The clinic may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. In those instances when the clinic is asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "*Psychotherapy Notes*" are notes we have made about our conversation during a private, group, joint, or family counseling session, which the clinic has kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy. **In addition, should your records be sent to another party upon your request or upon the order of a court, this clinic cannot be held liable for re-disclosure by the party receiving your PHI. They are responsible for maintaining the integrity and security of your records.**

The clinic may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* - If we believe that a child is a victim of child abuse or neglect, we must report this belief to the appropriate authorities.

- *Adult and Domestic Abuse* - If we believe or have reason to believe that an individual is an endangered adult, we must report this belief to the appropriate authorities.

- *Health Oversight Activities* - If the Indiana Attorney General's Office (who oversees complaints brought against psychologists instead of the Indiana Sate Psychology Board) is conducting an investigation into the clinic's practice, then we am required to disclose PHI upon their request.

- *Judicial and Administrative Proceedings* - If the patient is involved in a court proceeding and a request is made for information about the professional services we provided you and/or the records thereof, such information is privileged under state law, and we will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case. Should you initiate civil proceedings against the clinic or its clinicians, it may need to release your records to legal representatives for the purposes of defense.

- *Serious Threat to Health or Safety* - If you communicate to us an actual threat of violence to cause serious injury or death against a reasonably identifiable victim or victims or if you evidence conduct or make statements indicating an imminent danger that you will use physical violence or use other means to cause serious personal injury or death to others, we may take the appropriate steps to prevent that harm from occurring. If we have reason to believe that you present an imminent, serious risk of physical harm or death to yourself, we may need to disclose information in order to protect you. In both cases, we will only disclose what we feel is the minimum amount of information necessary.

- *Worker's Compensation* – we may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

In the event we must utilize the services of a collection agency for the purposes of procuring payment of your bill, limited information can be divulged to the extent that payment of your bill can be obtained.

Patient's Rights:

- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing a clinician at the clinic. On your request, we will send your bills to another address.)

- *Right to Inspect and Copy* - You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, your clinician will discuss with you the details of the request and denial process.

- *Right to Amend* - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. The clinic may deny your request. On your request, we will discuss with you the details of the amendment process.

- *Right to an Accounting* - You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.

- *Right to a Paper Copy* - You have the right to obtain a paper copy of the notice from the clinic upon request, even if you have agreed to receive the notice electronically.

You have specific rights under the Privacy Rule. WE will not retaliate against you for exercising your right to file a complaint.

Acknowledgment of Receipt of HIPAA Notice

By signing below, I am acknowledging that I have received a copy of this notice. I understand that I have the right to review this notice prior to services being provided to me or I can review this notice at a later date. I am free to ask Drs. Ross any questions related to what is written in the HIPAA notice.

_____ _____

Patient's name printed **Patient's (or Guardian's) signature**

_____ **Date Signed**_____

Stephen Ross, PsyD, ABPP, HSPP

I permit the following individuals access to my Protected Health Information (PHI)

1._____

2._____

Credit/Debit Card Payment Consent Form

Patient Name _____
Print Last *First* *Middle Initial*

Name on Card if different _____

I authorize Clinical & Forensic Services and ProfessionalCharges.com to charge my card for professional services as follows:

_____ **to charge my card for the balance of fees not paid by my insurance company for each visit.**

Type of Card: ☐ VISA ☐ MasterCard ☐ Discover Exp. Date _____

Card Number _____ - _____ - _____ - _____ CVV Number _____

Card Holder's Billing Address for Monthly Card Statements

_____
Street *City* *State* *Zip*

If I have questions about these charges, I agree to contact **Clinical & Forensic Services** and if necessary ProfessionalCharges.com via email (info@professionalcharges.com). I agree that I will not pursue a refund directly through my credit/debit card company, bank, or financial institution. If any of my actions yield a chargeback for any reason, I agree to pay any and all penalty fee(s) incurred by **Clinical & Forensic Services.**

Card Holder Signature _____ Date:_____

Email Address_____

Charges may appear on your card statement as an abbreviation of **ProfessionalCharges.com** *usually* **ProfCharges.com**