WELCOME!

This is to confirm ____'s appointment with
Patient's Name

____
Provider Name

at our MK Plus office on ________________________, __________________________at
Day Date

____________________.
Time

Our office is located at:
31 Cambridge Lane
Suite A
Newtown, PA 18940

Please do not hesitate to call us at **215-968-5151** should you require directions to our office. If you prefer, you can print directions from our website www.mkplusnewtown.com

Prior to your visit, please review and complete the enclosed information and bring it with you to your appointment. Feel free to call our office 215-968-5151 should you have any questions prior to your visit.

If for any reason you need to cancel or reschedule your intake appointment, we ask that you provide our staff with as much notice as possible. **Please call our office 215-9685151** and leave a message in our general mailbox and we will take care of notifying the provider.

We look forward to meeting you!

PAYMENT POLICY

Two copies of this policy are being provided to you. Please review it carefully and sign one copy where indicated. Return the signed copy to our office at the time of your next appointment. The second copy is for you to retain for your reference.

Thank you for your cooperation.

MK Plus Behavioral Health Providers **do not** currently participate with any insurance plans.

MK Plus Behavioral Health services are provided on a payment-for-service basis.

All fees will be discussed and agreed to by you prior to the initiation of treatment.

Full payment is due at each visit and will be collected upon check-in for the appointment. Our office does not *bill* for any services rendered. The fee for these sessions with ____ are ___________________.

For the convenience of our clients, our office accepts the following credit cards: Master Card, Visa, American Express and Discover.

For your convenience, our office may retain your credit card information in a locked and secure file for the duration of the treatment and charge for visits as they occur.

Upon payment, each client will be provided with a receipt. This receipt will be appropriate for submission to your insurance company should you be entitled to any reimbursement for services provided.

Our office requires 24 hours advance notification of any appointment that you wish to cancel and/or reschedule. If for any reason you need to cancel, please call our office at 215-968-5151 and leave us a message in our general mailbox. We will take care of notifying the provider. Out of courtesy to other clients waiting for appointments, please note that you will be charged for any appointment where you do not show up or you cancel the appointment less than 24 hours in advance.

Your signature below acknowledges receipt and understanding of the above payment policies.

____________________________________ ____

Client Name (Please Print) Client Signature

____

Date

(OFFICE COPY)

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___________________________________ ___________________________________

Client Name (Please Print) Client Signature

____

Date

(CLIENT COPY)

Consent for Psychological Testing and Evaluation

I, _______________________________, agree to allow the psychologist named below to perform the following services:

(__) Psychological testing, assessment or evaluation

(__) Report Writing

(__) Consultation with school personnel

(__) Consultation with lawyers

(__) Deposition (written testimony given to a court, but not made in open court)

(__) Testimony in court

(__) Other: ____

This agreement concerns (__) myself or (__)____

I understand that these services may include direct, face-to-face contact, interviewing or testing. They may also include the psychologist's time required for the reading of records, consultations with other psychologists and professional, scoring of test, interpreting the results and any other activities to support these services.

I understand that this evaluation is to be done for the purpose(s) of:

1. ____

2. ____

I also understand the psychologist agrees to the following:

1. The procedures for selecting, giving and scoring the tests, interpreting the results and maintaining my privacy will be carried out in accord with the rules and guidelines of the American Psychological Association and other professional organizations.

2. Tests will be chosen that are suitable for the purposes described above. These tests will be given and scored according to the instructions in the test' manuals, so that valid scores will be obtained. These scores will be will be interpreted according to scientific findings and guidelines from the scientific and professional literature.
3. Tests and test results will be kept in a secure place to maintain their confidentiality.

I agree to help as much as I can, by supplying full answers, making an honest effort and working as best I can to make sure that the findings are accurate.

____ ______________________________
Signature of client (or parent/guardian) Date

(__) Copy accepted by Client (__) Copy kept by Psychologist

This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law.

HIPAA Privacy Practices Acknowledgement Form

I have received the Notice of Privacy Practices for MK Plus and I have been provided an opportunity to review it.

Patient name: ____________________________________

Name of person reviewing the information (if someone other than patient)

________________________________ Relationship to patient: ____________

Patient Date of Birth: _______________

Signature: _______________________________________ ______________ *Patient*

or Patient Representative *Date*

Disclosure of My Personal Health Information

I request the following allowance for the disclosure of my health information:

(In addition to patient/patient representative please list any person(s) with which we may disclose/discuss patient information)

Name of Individual	Relationship to Patient (parent, sibling, relative, friend etc)

Messages on Answering Machine/Cell Phone

Can we leave detailed messages on answering machine? ( ) Yes phone number ( ) ( ) No	On your cell phone? ( ) Yes phone number ( ) ( ) No

Authorization for Consent to Treat a Minor

I, ____, hereby authorize

Name of parent or legal guardian

_______________________________ to bring my child _____________________

Name of person authorized to bring child to appointment *Name of Child*

to his/her appointments at MK Plus. The authorization shall be limited to the following time period: ____. If no time period is designated, this authorization shall terminate one year from today's date. I accept responsibility for all charges related to any medical treatment or hospitalization rendered by reason of this authorization.

Signature ____________________________ Date _____________________