DR. CHRIS ILER, Psy.D. P.A.

PATIENT INFORMATION

NAME_____ DATE:_____
last first m.i.

Address:_____
street

_____
city state zip code

Phone: _____ Gender:_____
home work male/female

Date of Birth: _____ SS#: _____

Marital Status: _____ Spouse's name_____

Health Insurance: yes or no Workman's Comp: yes or no

Occupation: _____ Employer: _____

Emergency #: _____ Person to contact:_____

Insurance Co.: _____

Address: _____

Insured's Name:_____ Insured's SS#_____

Insured's DOB:_____ Employer_____

Policy#:_____ Group#:_____

Secondary Insurance Co.:_____

I authorize the release of any medical information to process this claim and request payment of benefits to either myself or to the party who accepts assignment below.

Signature:_____ Date:_____

I authorize payment of medical benefits to the undersigned physician or supplier for the services described below.

Signature:_____ Date:_____

I hereby accept financial responsibility for professional services rendered by Dr. Chris A. Iler.

Signature:_____ Date:_____

I authorize Dr. Chris A. Iler to release information to:_____

_____

# HIPAA Notice of Privacy Practices


## Christopher A. Iler, Psy.D.,P.A

**Licensed Psychologist**


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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

- Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected Health Information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

- **Other Permitted and Required Uses and Disclosures** Will be made only with your consent, Authorization or opportunity to object unless required by law.

- **You may revoke this authorization** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action on the use or disclosure indicated in the authorization.

**Your Rights:**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information,** under federal law, however, you may not inspect or copy any of the following records: Psychotherapy notes; information compiled in reasonable anticipation of or use in civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information,** this means you may ask us not to use or disclose any part of your protected health information for the purposes of treatments, payments or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members of friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us** by alternative means or at an alternative location, you have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e.; electronically.

**You may have the right to have your physicians amend your protected health information**, if we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made,** if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints:**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

**This notice was published and becomes effective on/or before April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with your therapist in person or by phone at our main phone number: (813)-876-9401

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____

**Christopher A. Iler, Psy.D.,P.A.**
Licensed Psychologist

Child, Adolescent and Adult
Psychologist
Assessment and Therapy

201 N. MacDill Avenue
Tampa, FL 33609

Phone (813) 876-9401
Fax (813) 876-0133
Chrisiler@verizon.net

# Duty To Warn

Although confidentiality and privileged communication remain the rights of all patients of psychotherapists according to state law, some courts have held that if an individual intends to take harmful or dangerous action against another human being, or against themselves, it is the psychotherapists duty to warn the person who is likely to suffer the results of the harmful behavior, or the family of the patient who intends to harm himself of such an intention.

State law requires that all mental health professionals report incidents of any type if child abuse to appropriate agencies.

The psychotherapist will under no circumstances inform such individuals without first sharing that intention with the patient. Every effort will be made to resolve the issue before such a breach of confidentiality takes place.

I have read the above and understand the psychotherapists' social responsibility to make such decisions where necessary.

Date: _____ Signature: _____

## Christopher A. Iler, Psy.D.,P.A

# Consent for Treatment

I, the undersigned_____
(Please print your full name)

Or

I, the undersigned, a (parent of a minor), (guardian of), (guardian advocate of)

_____
(Please print your full name)

Do hereby give consent to Dr. Christopher A. Iler, Psy.D.,P.A located at:
201 N. MacDill Avenue Tampa, FL 33609, and/or his associated staff to provide the necessary diagnosis and treatment of the personal or interpersonal situation for which I am seeking help.

Dated this_____ day of_____ 20_____

Signature: _____

## CANCELLATION OF APPOINTMENTS

**ALL CANCELLATIONS MUST BE MADE 24 HOURS IN ADVANCE. IF YOU DO NOT SHOW OR DO NOT CANCEL WITHIN 24 HOURS IN ADVANCE, YOU WILL BE CHARGED $50.00 PER SESSION. INSURANCE COMPANIES DO NOT REIMBURSE FOR MISSED APPOINTMENTS. YOU WILL NOT BE BILLED FOR APPOINTMENTS THAT ARE CANCELLED WITHIN 24 HOURS.**

**THANK YOU.**

_____ _____

Signature of Parent/Guardian Date

# HISTORY AND PERSONAL DATA QUESTIONNAIRE

NAME:_____ DOB:_____ AGE:_____

MAIN REASON FOR SEEKING HELP AT THIS TIME?_____

_____

## CURRENT PROBLEMS OR SYMPTOMS

Please read each item below and determine which statement is true for you. Then place an "X" in the appropriate box to indicate how often you feel the statement applies to you during the past month. Be sure to rate every item.

EXAMPLE:

| DURING THE PAST MONTH | NONE OR ALITTLE OF THE TIME | SOME OF THE TIME | MOST OR ALL OF THE TIME |
|---|---|---|---|
| I FEEL SAD | | | |

QUESTIONNAIRE:

| DURING THE PAST MONTH | NONE OR ALITTLE OF THE TIME | SOME OF THE TIME | MOST OR ALL OF THE TIME |
|---|---|---|---|
| A: | | | |
| 1. Wake up at night or in the early morning and unable to return to sleep. | | | |
| 2. Very restless sleep. | | | |
| 3. Sleeps excessively | | | |
| 4. Disturbing dreams. | | | |
| 5. Loss of energy or fatigue | | | |
| 6. Decreased sex drive. | | | |
| 7. Less able to enjoy things you used to enjoy. | | | |
| 8. Have withdrawn from others. | | | |
| 9. Think you would be better of dead. | | | |
| 10. Strong thoughts about suicide. | | | |
| 11. Loss of appetite | | | |
| 12. Do you move more slowly than normal? | | | |
| 13. Do you have memory problems? | | | |
| 14. Are you forgetful? | | | |
| 15. Do you have difficulty concentrating? | | | |
| 16. Do you have difficulty making decisions? | | | |
| 17. Weight loss: How much in the past month? _____<br>Weight gain: How much in the past month? _____<br>Have you been dieting? YES_____<br>NO_____ | | | |

| | | | |
|---|---|---|---|
| 18.Can't get to sleep. | | | |
| 19. Sudden episodes of nervousness or panic. | | | |
| 20. Fear of loosing self-control. | | | |
| 21. Palpitations or rapid heart beat. | | | |
| 22. Shortness of breath. | | | |
| 23. Strange or unusual thoughts | | | |
| 24. Hallucinations, hear voices, or see things that aren't there. | | | |
| 25. Very peculiar experiences. | | | |
| 26. Ready to explode. | | | |
| 27. Thoughts about harming someone. | | | |
| 28. Excessive use of alcohol/drugs. | | | |
| 29. Low self-esteem. | | | |
| 30. Feeling worthless. | | | |
| 31. Crying. | | | |
| 32. Feeling sad. | | | |
| 33. Feeling worried. | | | |
| 34. Feeling guilty. | | | |
| 35. Feeling frightened. | | | |
| 36. Anticipating problems. | | | |

| | YES | NO |
|---|---|---|
| Have you had a period of time when you were feeling "up" or "high" or so full of energy that you got into trouble? | _____ | _____ |
| Have you ever been persistently irritable, so that you had arguments or fights with people outside your family? | _____ | _____ |
| Do you feel you could do things other's couldn't do? | _____ | _____ |
| Do your thoughts race faster than you can speak them? | _____ | _____ |
| Do you talk too much without stopping? | _____ | _____ |
| Do you become so active or physically restless that others are worried about you? | _____ | _____ |
| Do you engage in pleasurable activities that you ignore the risk of the consequences? | _____ | _____ |
| Have you drank alcohol more than once when you had other responsibilities at school, at work, or at home? | _____ | _____ |
| Have you had any legal problems because you were drinking? | _____ | _____ |
| Do you continue drinking even if your drinking caused problems with family? | _____ | _____ |

When you drink alcohol, do you end up drinking more often than you planned _____ _____

| | YES | NO |
|---|---|---|
| Have you tried to reduce drinking alcohol but failed? | _____ | _____ |
| Have you continued to drink even though you knew that the drinking caused you Health, mental or legal problems? | _____ | _____ |
| Have you had spells or attacks when you felt anxious and frightened? Did the spells peak within 10 minutes? | _____ | _____ |
| Do you feel anxious in places or situations where escape might be difficult: like being in a crowd, standing in a line, when crossing a bridge or traveling in a bus, train, or car? | _____ | _____ |
| Are you fearful or embarrassed being the focus of attention, or fearful of being judged or humiliated by people? | _____ | _____ |
| Are you uncomfortable in being in social situations? | _____ | _____ |
| Are you bothered by recurrent thoughts, impulses, or images that are unwanted and distressing? E.g. fear of contamination, fear of harming others? | _____ | _____ |
| Do you do something repeatedly without being able to resist doing it, like washing, counting or checking things over and over? | _____ | _____ |
| Have you experienced or witnessed an extremely traumatic event? E.g. serious accident, sexual or physical assault, being held hostage, or being involved in a fire. | _____ | _____ |
| Have you re-experienced the event in a distressing way? (Have you had disturbing dreams, flashbacks or memories of the traumatic event that interfere with daily activities)? | _____ | _____ |
| Do you go out of your way to avoid objects, situations, places, people or thoughts that reminds you of the event? | _____ | _____ |

How tall are you? _____ Your weight? _____

| | | |
|---|---|---|
| Are you afraid to gain weight or becoming fat, even though you were underweight? | _____ | _____ |

·Does your body weight or shape greatly influence how you feel about yourself? _____ _____

·How much do you exercise per week? _____ _____

| | YES | NO |
|---|---|---|
| ·In the past three months, did you have eating binges (you ate a very large amount of food within a 2-hour period)? | _____ | _____ |
| ·Do these eating binges happen as often as twice a week? | _____ | _____ |
| ·Do you feel that your eating is out of control? | _____ | _____ |
| To prevent weight gain from these binges, do you vomit, take laxative, enemas, diuretics, or other medications? | _____ | _____ |

**PREVIOUS TREATMENT FOR EMOTIONAL PROBLEMS.**

| YEAR | PROBLEM | THERAPIST/ LOCATION | HOSPITALIZATION OR MEDICAL TREATMENT |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**MEDICATION HISTORY**

| ALL CURRENT MEDICATIONS | DOSAGE | SCHEDULE (# OF PILLS AND WHEN TAKEN)? | PRESCRIBING DOCTOR |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |