# Mark Winborn, Ph.D., NCPsyA
## Psychologist - Psychoanalyst

**Date of Initial Visit _____ Referred By_____**
Client Name_____
Home Address_____
Street City State Zip
Home Telephone _____Work Phone_____Cell Phone _____
Social Security Number_____ Birthdate _____ Age _____
Male _____ Female _____ Marital Status Single____ Married____ Divorced____ Widowed____
Client Status: Employed _____ Full Time Student _____ Part Time Student _____
Email Address_____

Employer_____ Occupation _____
Employment Address_____
Street City State Zip
Person responsible for deductible, coinsurance, and copayments if other than client:_____
Address _____
Street City State Zip
Did you contact your insurance company to verify your benefits and let them know you were coming?
_____
Did you receive an authorization number from your insurance company? Yes_____ No_____
Authorization number _____ Number of visits _____
Did you get a referral from your Primary Care Physician if required by your ins. co.? Yes_____ No_____

| Insurance Information | | For Secondary Insurance Only | |
|---|---|---|---|
| Policy Holder's ID/SS# | _____ | Policy Holder's ID/SS# | _____ |
| Ins Co. Name | _____ | Ins. Co. Name | _____ |
| Policy Holder's Name | _____ | Policy Holder's Name | _____ |
| Relationship to client | _____ | Relationship to client | _____ |
| Policy Holder's Address | _____ | Policy Holder's Address | _____ |
| | _____ | | _____ |
| Policy/Group # | _____ | Policy/Group # | _____ |
| Policy Holder's DOB | _____ | Policy Holder's DOB | _____ |
| Male _____ Female _____ | | Male _____Female _____ | |
| Employer | _____ | Employer | _____ |

Primary Care Physician_____ Phone: _____
Address _____

List current medications prescribed by this doctor:
Medication Daily Dose Condition
_____
_____
_____
_____

Psychiatrist, if applicable _____ Phone: _____
Address _____

List current medications prescribed by this doctor:
Medication Daily Dose Condition

_____
_____
_____
_____

Nearest relative or friend (not spouse) we may contact in case of emergency:

_____
Name Relationship Phone

## Financial Responsibility

I understand that I am financially responsible for all charges incurred with Dr. Winborn whether or not paid by my insurance carrier. This includes fees for late cancellation (less than 24 hours notice) and no show fees (both charged at the full session fee), as well as deductible amounts, co-insurance, copayments, or any other balance not paid by my insurance. I further agree to pay any court costs, collection fees, or attorney's fees in the event my account has to be referred for collection. I hereby assign all health insurance benefits (including Medicare coverage) to which I am entitled to Dr. Winborn. I understand that Dr. Winborn will be required to disclose certain portions of my record (such as diagnosis, dates of service, type of service provided) to my insurance carrier in order to obtain payment from my insurance carrier.

## Limits of Confidentiality

Your participation in psychotherapy, psychological evaluation, and psychological testing is considered confidential. Thus, information about your involvement will not be released to any person or group without written permission from you. However, there are exceptions to this policy. According to Tennessee law, a psychologist may break confidentiality if the psychologist believes disclosure is necessary to protect you or others from harm. Tennessee law also requires that child abuse be reported to the Department of Human Services. Additionally, your individual right to confidentiality is more limited in sessions involving more than one person, such couples therapy. Finally, in some cases, the referring insurance company, referring physician, or preferred provider organization may request confirmation that treatment has been initiated. Dr. Winborn will be happy to respond to any questions or reservations you may have regarding your confidentiality.

My signature below indicates that I have read, understand, and agree to the conditions of financial responsibility and the limits of confidentiality.

Client Signature_____Date_____

Signature of Responsible Party_____Date_____

# HIPAA Consent Form

## Consent to Use and Disclose Health Information

This consent form is required, according to Federal HIPAA regulations, for Dr. Winborn to provide services.

I understand that as part of my healthcare, Dr. Mark Winborn originates and maintains health records describing my health history, symptoms, evaluation, test results, diagnosis and treatment plans. I understand that this information serves as:

1. A basis for planning my care and treatment.
2. A means of communication among the health professionals who contribute to my care.
3. A source of information for applying my diagnosis and the services rendered to my bill.
4. A means by which a third-party payer can verify that services billed were actually provided.
5. A tool for routine healthcare operations such as assessing quality of care and reviewing the competence of healthcare professionals.

I understand and have been provided with, or have been provided access to, a Notice of Information Practices (NIP) that provides a more complete description of information uses and disclosures. I understand that I have the right to review the NIP prior to signing this consent form. I understand that Dr. Winborn reserves the right to change his NIP and prior to implementation will provide access to the new NIP. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Dr. Winborn is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Dr. Winborn has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

Accepted_____ Declined_____

_____ _____

Signature of client or legal representative Date

_____ _____

Printed name of client or personal representative Relationship to client