INTEGRATED SLEEP & WELLNESS

Ruth Gentry, Ph.D.

Elizabeth Pritchard Psy.D Lee Purdioux, Ph.D.

GENERAL INFORMATION

NAME OF PATIENT:		M or F	**EMAIL**:
Social Security #: - -	Date of Birth: / /		Referred by:
Mailing Address:			
Street Address:			
Phone: (Home)	(Cell)		(Business)
Employer:	Carrier:		Messages OK? Yes or No

Emergency Contact Name: Relationship: Phone:

Name of Person Responsible for Payment:

Address:	City:	State:	Zip:
Social Security #: - -	Date of Birth: / /	Phone:	
PRIMARY INSURANCE:		Policy:	
Insurance Address:		Phone:	
Insured's Name:		Social Security #:	- -
Insured's Address:		Date of Birth:	/ /

SECONDARY INSURANCE:		Policy:	
Insurance Address:		Phone:	
Insured's Name:		Social Security #:	- -
Insured's Address:		Date of Birth:	/ /

HEALTH INSURANCE PAYMENT AUTHORIZATION

By signing this I authorize Integrated Sleep & Wellness (Ruth Gentry, Ph.D.) and Associates to release any medical information or other information required by my insurance provider or billing service that is needed to process this claim. I understand my medical records may be accessed by an employee of the practice for billing or administration purposes. I understand that I am responsible for the full amount of billed services, including any amount not paid by insurance providers. I will be charged a $50 fee for not cancelling/rescheduling my appointment within 24 hours prior to my appointment time.

Signature Print Name Date

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INFORMATION FOR PATIENTS

You have been referred to Dr. Gentry and Associates for treatment of your sleep, chronic pain, and medical and/or mental health problem. Dr. Gentry is a clinical psychologist that specializes in the practice of health psychology with expertise in treatment of sleep disorders, chronic pain, and other mental health disorders using non-drug treatments. Dr. Gentry and Associates may be focusing on treating your sleep/pain problems and/or medical problems, but your insurance provider will consider treatment to be a mental health service. Information about insurance is outlined below.

INSURANCE

1. Your insurance coverage is a contract between you and the insurance company. Not all services are a covered benefit in all contracts. It is your responsibility to understand the requirements and coverage of your insurance plan as Dr. Gentry may not be a participating provider. It is your responsibility to know if there are referrals or pre-certification requirements along with your copayment or deductible responsibilities. If authorization has not been granted you will be responsible for all charges. If you choose to use your out of network benefits you will be responsible for the full fee. Thus, you may be responsible for FULL payment of your treatment whether your insurance company pays or not.
2. During the process of treatment it may be necessary to release information such as your clinical diagnosis and treatment plan to the insurance company. Please be aware that this information will become part of your insurance company's files.
3. If your account has not been paid for more than 120 days and arrangements have not been agreed upon, a collection agency could be used to secure payment. This will require disclosure of confidential information.

FEES

Dr. Gentry's fees are as follows unless she has a contracted rate with your insurance provider:

Dr. Gentry Initial Evaluation: $250 Individual or Family Therapy 60 minute sessions: $220
Dr. Purdioux or Dr. Pritchard: $150-125

By signing this agreement, you are assuming responsibility of services provided by Dr. Gentry and Associates.

_____ _____
Printed Name Date

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian/Representative Date

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BEHAVIORAL HEALTH SERVICES AGREEMENT

Welcome to Integrated Sleep & Wellness. I thank you for choosing Dr. Gentry and Associates for your behavioral health needs. This agreement contains important information about professional services and business policies. Please read it carefully. If you have any questions, please feel free to ask.

PHILOSOPHY
To identify and treat sleep/pain disorders along with co-existing physical and mental health conditions by providing empirically validated cognitive, behavioral and/or non-pharmacologic interventions.

BEHAVIORAL HEALTH TREATMENT
Behavioral health treatment is not like a medical doctor visit, but instead calls for your active involvement in treatment. Dr. Gentry and Associates will ask you to work on treatment goals during sessions and also on your own in between sessions. Active participation on your part will result in better outcomes, but there are no guarantees made as a result of treatment. If you have questions about procedures please ask Dr. Gentry or your treating clinician. You may stop treatment at any time and will only be responsible for the services you have already received.

CONFIDENTIALITY
The contents of your records in regards to treatment are considered confidential as you have the legal right to have your communication be kept confidential. We cannot share both verbal and/or written information without the consent of the patient or the patient's legal guardian. It is the policy not to release information about a patient's treatment without a signed release of information form.

If you are seeking treatment for a child or adolescent the parent or legal guardian holds legal privilege to the child's healthcare information. Your child may benefit if allowed to have a confidential relationship with Dr. Gentry and Associates and you will be notified if your child is an imminent danger to him/herself or others.

There are limits to confidentiality that you should be aware of. This means Dr. Gentry and Associates will have to break confidentiality. These exceptions are indicated below:

There are certain exceptions to this general rule of confidentiality.
1. *Serious Threat to Your Own Life or Safety of Others:* We may disclose confidential information from your records if we believes such disclosure is necessary to protect you from imminent serious harm to yourself and others. In the case where a patient discloses a plan for suicide it is required to notify legal authorities and make arrangement for the person's safety. If a patient discloses plans to seriously injure others we may disclose confidential information for the safety of the identified person(s).

2. *Child Abuse:* If there is reasonable cause to believe that a child has been abused or neglected, she must report this and relevant information within 24 hours to the Nevada Division of Child and Family Services or a law enforcement agency. This also includes prenatal exposure to controlled substances.
3. *Adult Abuse:* If there is reasonable cause to believe that an older adult (over the age of 60) or vulnerable person has been abused, neglected, exploited, or isolated, she must make a report within 24 hours to the local office of the Nevada Department of Human Resources Division of Aging Services or a law enforcement agency.
4. *Professional Misconduct:* If a request from the Nevada Board of Psychological Examiners with respect to an inquiry or complaint about professional misconduct she must make available any relevant records in order to resolve any complaints or concerns.
5. *Judicial/Court Proceedings:* If you are involved in a court proceeding and a request is made for records about the behavioral health services that you have received, which such information is privileged under state law, Dr. Gentry will not release this information without written authorization from you or your legally-appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. Health care professionals are required to release information when a court order is placed.
6. *Minors/Guardians:* Legal parents and/or guardians of nonemancipated minors have the right to access the patient's records.
7. *Worker's Compensation:* If you file a worker's compensation claim, and receive treatment relevant to that claim, then a report on services will be submitted to your employer's insurer or a third party administrator. What this means is the insurance company and the lawyers for the employer can request and obtain a copy of your psychological record and psychotherapy notes. Please keep this in mind when disclosing because there is a specific issue related to your personal history or current functioning that you do not want communicated to your referring physician or the insurance company, please advise Dr. Gentry of this fact.
8. *Other Provisions:* Collection agencies may be used in collecting unpaid fees for services already rendered. Insurance companies may request treatment notes that include diagnosis, dates/times of services, and types of services received.

CONSENT

I understand that Integrated Sleep and Wellness adheres to the regulations mandated by the Health Insurance Portability and Accountability Act (HIPPA, Title II). I understand these policies and have been given a copy. I agree to the fees and services as described and understand confidentiality and limits of confidentiality. I hereby authorize Dr. Gentry and Associates to provide me or my legal dependent with behavioral health services. I also understand that anytime during service, I may withdraw my consent to participate.

_____ _____
Printed Name Date

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian/Representative Date

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

By signing this form I am aware that my records will be kept confidential within Integrated Sleep & Wellness. I also understand that information that is obtained by Dr. Gentry and Associates can be used to assist my referring physician to facilitate my medical treatment. Request for your authorization is needed to provide information regarding your evaluation, and treatment back to your referring provider. This release is voluntary and I understand that refusing to sign this release will not hinder my ability to receive treatment by Dr. Gentry and Associates. If there is specific information you would prefer not to be disclosed (i.e., abuse history) please discuss your concerns with your provider.

By signing this release I agree that I fully understand this authorization to release records to the providers below.

I, _____(Patient/Parents/or Legal Guardian) authorize the release of information including contents of my treatment/psychological records to the following providers:

Circle - Yes or No release records to referring provider.
Name of referring provider: _____

Circle - Yes or No release records to primary care physician.
Name of primary care physician: _____

Please list other providers you would like us to release records on your behalf:
Provider Name:_____
Provider Name:_____
Provider Name:_____
Provider Name:_____

The purpose of this authorization is for diagnostic clarification and treatment planning.
I fully understand that I can revoke this authorization, in writing, at any time during or after my treatment except to the extent that action has already taken place based on this consent.

_____ _____
Signature of Patient Date

_____ _____

Signature of Parent/Guardian/Representative Date

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CONSENT TO TREATMENT

I consent to treatment with Dr. Gentry and Associates at Integrated Sleep and Wellness. I am aware that Dr. Gentry is a clinical psychologist, specializing in the non-drug treatment of behavioral heath and sleep problems. I may stop treatment at any time and am only responsible for payment of services received.

I understand that my insurance provider or third party representative may be given information about the type of treatment including costs and dates of services provided.

Treatment is most successful when both the patient and provider work actively together. I understand that no guarantees have been made as to the results of my treatment.

It is the policy of Dr. Gentry and Associates to avoid being a party to litigation. If you become involved in a legal proceeding that requires Dr. Gentry's participation you will be expected to pay for all of her professional time that includes preparation, transportation costs, and time being involved to testify even if she is called to testify by another party.

You may call your provider at any time, but she may not be immediately available by telephone. She will make every effort to return your call within 24 hours or during the next scheduled day, with the exception of holidays, weekends, and vacation days. In an emergency, call 911 or the Crisis Call Center at 775-784-8090. You may also seek help from the nearest emergency room.

Dr. Gentry and Associates consult with other professionals in order to provide the best possible care. Your treatment may be discussed but no identifying information, including your name, will be disclosed.

By signing this form I understand all the above statements presented to me.

_____ _____
Printed Name Date

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian/Representative Date