KELLY COUNSELING & CONSULTING

CLIENT INTAKE FORM

Name: _____ Date: _____

Address: _____

_____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail Address: _____

I give permission for Kelly Counseling & Consulting, LLC to contact me and leave a message

on my Home phone: Yes _____ No_____

Work Phone: Yes _____ No _____

Cell Phone: Yes _____ No_____

Date of Birth: _____ Age: _____ SS#: _____

In case of an emergency, I authorize Kelly Counseling & Consulting, LLC to contact:

_____

Name and relationship

_____

Telephone Number

Financial arrangements for professional services: Self pay Insurance Other

Please give insurance card to Receptionist or Therapist to copy

If other, name of responsible party: _____

Billing address: _____

Payment is due in full at time of service. I Agree to pay for any services that are not covered by insurance, including the deductible and co pay!

Notice: THE FULL FEE WILL APPLY FOR APPOINTMENTS CANCELLED WITHOUT 24 HOURS NOTICE

I have been given the opportunity to review the **Notice of Privacy Practices** and I **do / do not** (circle one) want a copy.

_____ _____ _____ _____

Signature of Patient or Legal Representative Date Signature of Witness Date

_____

Relationship of Legal Representative

38 Regency Plaza , Glen Mills, PA 19342-1000
T: 610-358-2250 - F: 610-358-2251 – Toll Free: 888-571-0464
www.kellycounselingandconsulting.com

INTAKE FORM FOR THERAPY – ADULT

Name: _____ Date: _____

Referred by: _____ DOB: _____

Marital Status: married single separated divorced w/partner religious/celibate

Spouse: _____

Children (ages and names): _____

_____

Occupation: _____

Presenting Problem (include length of time or re-occurrence):

_____

_____

_____

_____

_____

Personal History of Mental Health Treatment:

Condition	Yes/date	No	Previous Treatment	Rate Success high/medium/low
Depression				
Anxiety				
Eating Disorder				
Addiction Alcohol				
Addiction Drugs				
Bereavement				
Suicide				
Other				

Family History of Mental Health Issues:

Condition	Mother	Father	Sibling	Treatment	Rate Success high/medium/low
Depression					
Anxiety					
Eating Disorder					
Addiction Alcohol					
Addiction Drugs					
Bereavement					
Other					

In your lifetime, have you experienced any significant trauma or loss? Yes/No Explain if "yes"

_____

_____

Describe your alcohol use: none once a month once a week several times a week

Do you use recreational drugs? Yes/No Explain if "yes"_____

_____

Describe your gambling pattern: none once a month once a week several times a week

Rate your physical Health: excellent good average fair poor

Are there guns in your home? Yes/No If yes, how many, what type and how are they stored?

_____

Do you suffer from chronic illness? Yes/No Explain if "yes" _____

_____

Do you regularly take medication? Yes/No If yes, please list:_____

_____

Who prescribes your medication (include title, name, and phone number)?

_____

Do you give your permission for your therapist to discuss your treatment with your medical provider? Yes/No (You may change this authorization at any time in the future)

What would you like to get out of this therapy?

_____

_____

_____

_____

Signature

KELLY COUNSELING & CONSULTING, LLC

OUTPATIENT SERVICES CONTRACT

Welcome to Kelly Counseling & Consulting, LLC (KCC). 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 our next meeting. When you sign this document, it will represent an agreement between us.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you bring forward. There are many different methods used to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things talked about both during therapy sessions and at home.

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 also has 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.

Your first few sessions will involve an evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some first impressions of what the therapeutic work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with your therapist. Therapy involves a large commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about procedures, you should raise them whenever they arise. If your doubts persist, your therapist will be happy to help you set up a meeting with another mental health professional for a second opinion.

MEETINGS

The therapist normally conducts an evaluation that will last from 2 to 4 sessions. During this time, you can both decide if your therapist is the best person to provide the services you need in order to meet your treatment goals. If psychotherapy is begun, the therapist will usually schedule one 50-minute session (one appointment of 50 minutes duration) per week at a time we agree on, although some sessions may be longer or more or less frequent. Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation, unless your therapist determines that you were unable to attend due to circumstances beyond your control. **For appointments cancelled without 24 hours notice, you will be billed for that session.**

PROFESSIONAL FEES

The charge for the first session is $170.00, as it is necessary for the therapist to complete extensive paperwork following the first session. Subsequent sessions are $140.00 per session. In addition to weekly appointments, $150.00 per hour is charged for other professional services you may need, though the hourly cost will be broken down for periods of work of less than one hour. Other services include report writing, telephone conversations lasting longer than 5 minutes, consultation (via phone, webcam, e-mail, or face-to-face) with other professionals you have authorized, preparation of records or treatment summaries, and the time spent performing any other service you may request of your therapist. If you become involved in legal proceedings that require your therapist's involvement, you will be expected to pay for your therapist's professional time even if your therapist is called to testify by another party.

BILLING AND PAYMENTS

You will be expected to pay for all services at the time they are provided, unless agreed otherwise or unless you have insurance coverage, which requires another arrangement (see **INSURANCE REIMBURSEMENT**, below). In circumstances of unusual financial hardship, KCC may be willing to negotiate a fee adjustment or payment installment plan upon demonstrated need.

Any outstanding balances, copayments and deductibles are due at the time you check in for your appointment. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, KCC has 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 KCC releases regarding a patient's treatment is his/her name, the nature of services provided, and the amount due.

KCC accepts cash, credit cards, and personal checks (made out to Kelly Counseling & Consulting, LLC). For returned checks, a $25.00 charge and related bank fees will be assessed.

INSURANCE REIMBURSEMENT

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, it will usually provide some coverage for mental health treatment. KCC staff will fill out forms and provide you with whatever assistance they can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of fees incurred. You also are responsible for updating KCC of any insurance changes that occur.

KCC will bill your insurance carrier for covered benefits, and non-covered services will be provided at our regular rate of $150.00 per hour. Since your agreement with your insurance carrier is a private one, KCC does not routinely investigate why an insurance carrier has not paid for covered services. If any insurance carrier has not paid within 60 days of billing, you are responsible for full payment of fees incurred.

KCC is a Medicare participating provider and will bill Medicare for covered benefits. KCC will bill secondary insurances that automatically crossover through the Medicare System (CSM). If your secondary insurance does not crossover, it is your responsibility for filing these claims. We will provide you with a claim form that you can send to your secondary insurance carrier.

It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course KCC will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, KCC staff will be willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy after a certain number of sessions. While a lot can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end.

You also should be aware that most insurance companies require you to authorize KCC to provide them with a clinical diagnosis. Sometimes your therapist may have to provide additional clinical information such as treatment plans or summaries, or copies of the entire record (in rare cases). This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, KCC has no control over what they do with it once it is in their possession. In some cases, they may share the information with a national medical information databank. KCC will provide you with a copy of any report submitted, if you request it.

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your treatment. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above.

CONTACTING YOUR THERAPIST

Your therapist often will not be immediately available by telephone. While he or she is usually in the office during regular business hours, your therapist probably will not answer the phone when he or she is with another client. You may, however, leave a private voicemail for your therapist, or leave a message with a receptionist. Your therapist will make every effort to return your call within 24 hours, with the exception of weekends and holidays. If you are difficult to reach, please inform your therapist of some times when you will be available. If you are unable to reach your therapist and feel that you can't wait for your call to be returned, contact your family physician or the nearest emergency room and ask for the psychologist [or psychiatrist] on call. If your therapist will be unavailable for an extended time, you will be provided with the name of a colleague to contact, if necessary.

PROFESSIONAL RECORDS

The laws and standards of the profession require that your therapist keep treatment records. Under Pennsylvania law, KCC owns the records and a client age 14 years or older is entitled to examine (not to possess or to copy) his or her records unless your therapist determines that seeing them will constitute a substantial detriment to treatment, or when that disclosure will reveal the identity or breach the trust or confidentiality of people who have provided information upon an agreement to maintain their confidentiality. These limitations also are applicable to parents, guardians, and others who may control access over records, except that the possibility of substantial detriment to the parent, guardian, or other person may also be considered.

Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. It is recommended that they be reviewed with your therapist so that you can discuss the contents. You will be charged at our hourly rate for any time spent in preparing information requests.

CONFIDENTIALITY

In general, the law protects the privacy of all communications between a patient and a psychologist, and information about your treatment can only be released to others with your written permission. But there are a few exceptions. These situations rarely occur. If a similar

situation occurs, your therapist will make every effort to fully discuss it with you before taking any action.

EXCEPTIONS TO CONFIDENTIALITY:

In most legal proceedings, you have the right to prevent your therapist 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 your therapist to testify if he/she determines that the issues demand it.

There are some situations in which your therapist is legally obligated to take action to protect others from harm, even if some information about your treatment is revealed. For example, if your therapist believes that a child is being abused, he or she may be required to file a report with the appropriate state agency.

If your therapist believes that you are threatening serious bodily harm to another, your therapist is required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for you. If you threaten to harm yourself, your therapist may be obligated to seek hospitalization for you or to contact family members or others who can help provide safety.

Your therapist may occasionally find it helpful to consult other professionals about your case. The consultant also is legally bound to keep the information confidential. If you don't object, your therapist will not tell you about these consultations unless it is important to the treatment.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have at your next meeting. Your therapist will be happy to discuss these issues with you if you need specific advice, but formal legal advice may be needed because the laws governing confidentiality are quite complex. If you request, you will be provided with relevant portions or summaries of the state laws regarding these issues.

SIGNATURE PAGE

I have reviewed the Outpatient Services Contract and have been provided with a copy for my records. My signature below indicates that I have been provided the opportunity to ask questions and raise concerns about its provisions, and I understand that I may ask questions as they arise in the future. My signature below indicates that I understand the information in this document and agree to abide by its terms during my professional relationship with KCC.

Signature of Client (14 years or older) or Legal Representative	Date
Print Name of Client (14 years or older) or Legal Representative	(Client's Name or n/a)

OFFICE USE ONLY
Please detach this signature page and make a photocopy. The original should be placed in the client's chart, and the photocopy should be returned to the client along with the contract in its entirety.

KELLY
COUNSELING &
CONSULTING LLC

Notice of Privacy Practices (NPP) – Short Version

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 CAREFULLY.

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your personal health information. We are required also by law to do this. These laws are complicated, but we must provide you with important information. This pamphlet is a shorter version of the full, legally required NPP which will be made available at your request. However, we can not cover all possible situations, so please talk to our Privacy Officer, Patricia Kelly, Ph.D., about any questions or problems.

We will use the information about your health, which we get from you or from others, mainly to provide you with **treatment**, to arrange **payment** for our services or for some other business activities, which are called, in the law, health care **operations**. After you have read this NPP we will ask you to sign a **Consent Form** to let us use and share your information. If you do not consent and sign this form, we cannot treat you.

If we or you want to use or disclose (send, share, release) your information for any other purposes, we will discuss this with you and ask you to sign an Authorization to allow this.

Of course we will keep your health information private, but there are some times when the laws require us to use or share it, such as:

1. When there is a serious threat to your health and safety or the health and safety of another individual or the public. We will only share information with a person or organization that is able to help prevent or reduce the threat.

2. Some lawsuits and legal or court proceedings.

3. If a law enforcement official requires us to do so.

4. For Workers Compensation and similar benefit programs.

There are some other situations like these but which don't happen very often. They are described in the longer version of the NPP.

Kelly Counseling & Consulting
38 Regency Plaza | Glen Mills | PA | 19342
Phone (610) 358-2250 | Fax (610) 358-2251

Your rights regarding your health information

1. You can ask us to communicate with you about your treatment and health related issues in a particular way or at a certain place. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to do as asked.

2. You have the right to ask us to limit what we tell certain individuals involved in your care or the payment for your care, such as family members and friends. While we don't have to agree to your request, if we do agree, we will keep our agreement except if it is against the law, or in an emergency, or when the information is necessary to treat you.

3. You have the right to look at the health information we have about you such as your medical and billing records. You might even get a copy of these records, but we may charge you. Contact our Privacy Officer, Patricia Kelly, Ph.D., to arrange how to see your records.

4. If you believe the information in your records is incorrect or incomplete, you can ask us to make some kinds of changes (called "amending") to your health information. You have to make this request in writing and send it to our Privacy Officer, Patricia Kelly, Ph.D. You must tell us the reasons you want to make the changes and we must advise you that access to your record is not automatic but must be reviewed.

5. You have the right to a copy of this notice. If we change this NPP we will post it in our waiting room and you can always get a copy of the NPP from the Privacy Officer.

6. You have the right to file a complaint if you believe your privacy rights have been violated. You can file a complaint with our Privacy Officer and with the Secretary of the Department of Health and Human Services. All complaints must be writing. Filing a complaint will not change the health care we provide to you in any way.

If you have any questions regarding this notice or our health information privacy policies, please contact our Privacy Officer, Patricia Kelly, Ph.D., and can be reached by telephone at (610) 358-2250 or by e-mail at pmkelly@kellycounseling.com.

The effective date of this notice is June 1, 2016.

My signature, or the signature of my designated representative, acknowledges receipt of this notice. I DO / DO NOT (circle one) **want a copy of this form.**

_____
Signature of Patient & Date

_____
Signature of Designated Representative & Date

_____
Print Name

_____
Print Name

_____
Authority of Personal Representative

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KELLY COUNSELING & CONSULTING

Client Intake
Symptom Screener

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
8. Little interest or pleasure in doing things	0	1	2	3
9. Feeling down, depressed, or hopeless	0	1	2	3
10. Trouble falling/staying asleep, sleeping too much	0	1	2	3
11. Feeling tired or having little energy	0	1	2	3
12. Poor appetite or overeating	0	1	2	3
13. Feeling bad about yourself- or that you are a failure or have let yourself or your family down	0	1	2	3
14. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
15. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
16. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Circle one	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult

Clinicians: Sum 1-7: _____ and see GAD-7 Notes:

Sum 8-16: _____ and see PHQ-9 Notes:

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T: 610-358-2250 - F: 610-358-2251 – Toll Free: 888-571-0464
www.kellycounselingandconsulting.com

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

COMPLETE STARRED PORTIONS ONLY

PICA ☐☐☐ — PICA ☐☐☐

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) ★	3. PATIENT'S BIRTH DATE MM DD YY ★ SEX M ☐ F ☐
4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐
7. INSURED'S ADDRESS (No., Street)	
CITY / STATE	8. RESERVED FOR NUCC USE
CITY / STATE	
ZIP CODE / TELEPHONE (Include Area Code) ( )	
ZIP CODE / TELEPHONE (Include Area Code) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐	
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)
b. OTHER CLAIM ID (Designated by NUCC)	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? ☐ YES ☐ NO
c. INSURANCE PLAN NAME OR PROGRAM NAME	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

★ SIGNED _____ ★ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

★ SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.		22. RESUBMISSION CODE / ORIGINAL REF. NO.
A. B. C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1								NPI	
2								NPI	
3								NPI	
4								NPI	
5								NPI	
6								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. b.		33. BILLING PROVIDER INFO & PH # ( ) a. b.		

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature also authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law); 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI, license #, or SSN) of the primary individual rendering each service is reported in the designated section. For services to be considered "incident to" a physician's professional services, 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate routine uses for information contained in systems of records. Information may be disclosed to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0999. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.