CLIENT INFORMATION

Client Name:_____D.O.B._____

Address:_____City_____Zip Code_____

Sex: M F (please circle) Marital Status: S M W D (please circle)

If under 18, Parent/Guardian name:_____

Home Phone:_____Office Phone:_____

Cell Phone:_____E Mail_____

Occupation:_____Employer:_____

Family members:	**Name**	**Relationship**	**D.O.B.**
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Emergency Contact:_____Relationship:_____

Telephone:_____

Primary Care Physician:_____Telephone:_____

Referred by:_____Relationship:_____

Insurance Carrier (Primary):_____

Subscriber:_____Employer:_____

Group#:_____Policy#_____

Subscriber's SS#:_____

Insurance Carrier (Secondary):_____

Subscriber:_____Employer:_____

Group#_____Policy#_____

Subscriber's SS#:_____

CONFIDENTIALTY POLICY
Client/Clinician

Confidence in client/clinician confidentiality is one of the major factors of successful psychotherapy. Both verbal communication and written records are confidential and are protected by law. Written client release for information is usually required for the transfer of records. However, there are some exceptions where information may be shared without a patient release. We feel that it is important that you are informed of these exceptions:

1. **ABUSE:** Abusive treatment and/or neglect to a child, elderly, or disabled person is reported to the proper agency.
2. **HARM:** Threat of serious bodily harm to oneself or others is reported. Provider may seek the client's hospitalization, and notification to any or all of the following may be warranted:
    - The potential victim
    - Family members
    - Police
3. **LEGAL/COURTS:** In some legal proceedings, upon a court order, testimony and/or records may be rendered.
4. **SELF DEFENSE:** If legal actions are brought against clinician by the patient and/or family, information may be disclosed if necessary and relevant to the case.
5. **CHILDREN:** General feedback on the treatment progress is reported to the parents/guardians of children under 18.
6. **PEER CONSULTATION:** Occasionally, peer consultation is needed for the success of treatment. In these cases, no names will be disclosed in order to protect confidentiality.
7. **INSURANCE:** Disclosing information to a third-party payer and/or MCO for the purposes of administering benefits and managing care.
8. **PAYMENTS:** Information (name/address/dx/$) may be disclosed to a billing or collection service for the purpose of collecting the payments owed for services rendered.

CLIENT/GUARDIAN SIGNATURE:_____

Client NAME:_____**DATE**:_____

FEES NOT COVERED BY INSURANCE

The following services are not covered by insurance:

1. Appointments canceled with less than 24 hours notice and missed appointments.
2. Visits to other agencies, e.g. school visits, conferences at hospital, court appearances.
3. Telephone consultations, crisis calls, and telephone calls other than those requested by the individual's therapist.
4. Letters and reports, e.g. to hospitals, workman's compensation, agencies, disability forms, information to lawyers requested by you.

I AGREE TO BE RESPONSIBLE FOR FEES NOT COVERED BY INSURANCE, WHICH INCLUDES A $35.00 FEE FOR FREQUENTLY MISSED AND/OR CANCELLED APPOINTMENTS WITH LESS THAN 24 HOURS NOTICE

_____

Signature of responsible party Date

FINANCIAL AGREEMENT

Insurance payments are accepted per contracted fee schedule.

I will be responsible for co-payments and deductibles established by the insurer.

I agree to have this office submit my claims either electronically or on paper.

I assign payments to this office from my insurer for services rendered to me, or my dependents by Jon E.Perlman,Ed.D.

I agree to pay any co-payments, deductibles as established by my insurer.

It is my (client/parent or guardian) responsibility to know my insurance benefits. Therefore, I am responsible for any non-covered services rendered to me or my dependent.

Signature_____Date_____

PERMISSION TO DISCUSS YOUR TREATMENT WITH YOUR PRIMARY CARE DOCTOR

I give permission to Jon E. Perlman, Ed.D. permission to discuss my therapy with my primary care physician:

This permission can be withdrawn by me at any time

CLIENT/GUARDIAN SIGNATURE:_____

CLIENT NAME:_____**DATE**:_____

Consent to Use E-Mail:

I, _____, hereby authorize Jon E. Perlman, Ed.D. to send electronic mail

to me at the following E-mail address:_____

The purpose of this E-mail communication is limited to scheduling and confirmation of appointments. There will be no use of E-mail for discussion of clinical issues or emergencies. I understand that Dr. Perlman cannot assure the protection or confidentiality of E-mail communications with me.

I understand that I may revoke this consent at any time.

Signature: _____Date of Consent: _____

Acknowledgement of Receipt of
Notice of Policies and Practices to Protect the Privacy of
Your Health Information

The federal government mandated that as of April I4, 2003, all health care patients are to receive from their clinicians a notice (hereafter referred to as ‘‘notice’’) regarding the protection of their private health care information in compliance with the Health Care Portability Act (“HIPAA”) Privacy Rule (45 C.F.R. parts 160 and 164).

HIPAA covers what is called ‘‘protected health information’ (PHI) that is used for treatment, payment, and health care operations. PHI is information in your health record that could identify you.

The Notice contains basic information about:

1. How your PHI may be used and disclosed for treatment, payment and health operations (those terms are defined in the Notice).
2.. Which uses and disclosures require authorization from you and which do not.
3 How you may revoke authorization you have made.
4. Certain rights you have to restrict use and disclosure of PHI, to receive confidential communication by alternative, means and at alternative locations, to inspect and copy your records, to amend your records, to have an accounting of disclosures.
5. Duties of the clinician to protect
the privacy of your PHI, the clinician’s right to change the privacy policies and practices described in the Notice, and how the clinician will inform you of changes.
6. What you can do it you have any complaints about violations of your privacy rights, and about decisions regarding access to your records the clinician may make.
7. Any allowed restrictions and limitations you or your clinician wish to put on the use and disclosure ot your PHI.

The Privacy Notice. is a few pages in length. Generally, this Notice is given on a patient’s first visit unless there is a good reason to delay.

This page with your signature documents that I have given you a copy of the Notice.

I acknowledge that Jon E.Perlman, Ed.D. has given me a copy of the Privacy Notice, (version dated_____.) as required by the federal government HIPAA legislation.

Date_____

Print Patient’s Name	Patient’s Signature (or parent. legal guardian, or personal representative if applies)
role/authority of person signing	Printed Name of person (if other than patient) signing