NICOLE RICHMAN, LCSW

88 State Street, Suite 203 Gorham, Maine 04038 Phone: 207-839-3535

Dear ________________________

Please find enclosed the client intake and informational paperwork we discussed on the phone that is used to facilitate reimbursement and assist in providing you with the best quality care.

Please complete the Client Information Sheet for reimbursement purposes (you will need to call your insurance company and get an authorization prior to our first session); as well as read and sign the Clients Rights and Responsibilities, and the Cancellation Policy. In addition, if you are in agreement, please sign the Coverage Disclosure, located on the last page of this packet. Copies of this paperwork will be made available to you are your request.

Please bring all of this paperwork and your insurance ID card with you to your first session on ________________________.

If you have any questions, please feel free to contact me.
I look forward to meeting you and beginning our work together.

Respectfully,

Nicole

* Directions *

We are located at the corner of State Street and Pine Street, in Gorham.

From Rte 114 take Green Street next to the Cemetery. Follow to the end, and take a right onto Pine Street. We are the last driveway on the left, across from Dolby and Dorr Funeral Home. {From State St. you CAN turn onto Pine Street, even though it is marked as a One Way Street}

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Clients Rights and Responsibilities

Client Relations:
This information is utilized to provide all clients entering therapy with me, the information needed to understand their rights and responsibilities. As a Licensed Clinical Social Worker, I provide outpatient clinical assessment, counseling and therapeutic services to children, adolescents, adults and families using strengths based, solution-oriented, and cognitive behavioral therapies. I follow all of the guidelines set up by the National Association of Social Workers. If at any time you have any concerns about our work, please speak to me directly. I am open to questions and any concerns that may arise in our work together. Please be sure to communicate your needs and expectations as clearly as possible to ensure a positive working relationship.

Court Information:
Given the fact that I work with children and families, it is often requested that I be available for expert witness or voluntary court services. Personally, I have found that court proceedings can often compromise the therapeutic relationship already established. Please be aware of this as you enter this relationship and establish your needs. If at any time I am served a subpoena, please be advised that any fees associated with my time (report writing, travel, court appearance) are not reimbursed by insurances, and will be the responsibility of the parent/guardian of the client at the hourly fee of $100/hour. For this reason, these fees may also be requested in the form of a retainer, prior to the court date.

Minor Children:
In addition, any parent who brings in a minor child for services will be held responsible for any part of the balance not paid by insurance. When there is insurance coverage by a non-custodial parent, I must have insurance information and the signature of both parents on or before the first session. If shared custody is an issue, I need permission and signatures from both custodial parents in order to provide therapy.

Fees and Payment Expectation:
I accept most forms of health insurance. All services are billed to the appropriate insurance company at the end of each session. A sliding scale fee is available for folks without insurance benefits. If a co-payment or deductible is required, it is due in full at the beginning of the session; this includes any changes in insurance benefits that incur additional out of pocket expenses during the course of treatment. I accept personal checks or cash at the time of your session, as well as credit/debit cards for a 3% processing fee. I am unable to carry balances from one week to the next; any lapse in payment may cause a lapse in services or cancellation of future appointments until payment arrangements can be made or the balance can be paid in full. Any unpaid balances that are not paid in a timely, agreed upon fashion, may be sent to Collections. If so, at that time, the client/guardian will be responsible for any fees incurred by the Collection Agency.

Appointments:
Every effort is made to schedule an appointment that is convenient for you. Please understand that the time we set up is held for you. If you must cancel a scheduled session, please **do so at least 24 hours** in advance. Since it is not always possible to fill the time that was held for you, I do reserve the right to charge a no show/cancellation fee. This fee is not covered by insurance. Please read, and be mindful of

the attached Office Policy around No shows/Cancellations, and know that you may ask for copies of any of this paperwork at any time. **Effective 2/1/2019 TEXT and EMAIL confirmations will be sent 48 HRS prior to our scheduled appointment. Please utilize this 48 hr. window as the time to contact the office if changes in scheduling are needed. Any cancellations outside the 24 hr. window MAY incur a cancellation fee.**

Availability:
I will always try to make myself available for phone contact at either my office or cell phone during and after business hours. This is a means of maintaining the therapeutic relationship between sessions and in case of emergency. Please be aware, however, that this time is not reimbursable by insurance, and if the calls become lengthy, fees may be associated.

Email/Cell Phone use and Privacy concerns:

With your permission, I will utilize email or TEXT to confirm appointments, or communicate business issues that may arise. It is very important to be aware that computers, e-mail and fax and cell phone communication can be relatively easy to access by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Additionally, e-mails are not encrypted, and faxes can be sent erroneously to the wrong address. My computer is equipped with a firewall, a virus protection and a password, and I also back up all confidential information from my computers on a regular basis. Please notify me if you decide to avoid or limit, in any way, the use of any or all communication devices, such as e-mail, cell-phone or faxes. If you communicate confidential or highly private information via e-mail, I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and I will honor your desire to communicate on such matters via e-mail. Please, be aware that e-mails are part of the medical records, and do not use e-mail for emergencies. Due to computer or network problems e-mails may not be deliverable, and I may not check my e-mail daily.

Confidentiality:
Confidentiality is of the utmost importance. All information in your file, including the information shared in the therapy session is strictly confidential. No information can be disclosed without your written consent at any time. There are rare exceptions to this rule of confidentiality, in which certain information may need to be shared without your written permission. In such instances, I would make every attempt to discuss this with you beforehand, and only disclose the necessary information. The exceptions to confidentiality include the following:

* if there is reason to believe that you might be in danger of hurting yourself or someone else
* if there is reason to believe that a child or vulnerable adult is being harmed or about to be harmed

* if there is a valid court order that requires disclosure of information

HIPAA Compliance and use of Protected Health Information (PHI):
Your health record contains personal information about you and your health. This is information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of my legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of the Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on my website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

Emergencies:
During business hours, I can be reached at either 839-3535 or my cell phone 468-8108. In an emergency after business hours, you can leave a message at the above numbers, and I will return you call as soon as I am able to. If I am not available, and you need immediate assistance, please contact Crisis Response at 774-HELP, 1-888-568-1112 or utilize your local emergency room.

I, ___________________________have read the above agreement and agree to the terms. I also authorize Nicole Richman, LCSW to release any information necessary for third party claim submission and/or payment of services. Third party Payments are authorized to be made directly to Nicole Richman, LCSW, for services rendered.

_______________________________________ Date: ___________________

(guardian/parent signature)

____ Date: ____________________

(client/2nd parent signature)

CANCELLATION POLICY AND PROCEDURES

The time we set up, is set aside and held especially for you. As always, I will try to be as flexible and understanding as possible, but please remember that if you are not meeting with me, and I am not able to fill your session time, that I do not get paid/reimbursed by your insurance company.
In addition, I have an active waiting list of potential clients who are patiently waiting to be seen. Your mindfulness and understanding of these details is greatly appreciated!

PRIVATE INSURANCE CLIENTELE

Snow Cancellations:

* If you call and cancel your scheduled session time, at least 24 hours prior to your appointment, no fee will be applied
* If School is cancelled, either in your home town, or in Gorham, and you call to cancel the day of your no fee will be applied
* If neither of the above apply, there will be a $50 cancellation fee

General Cancellations:
* If you call and cancel your scheduled session time, within 24 hours of your appointment, no fee will be applied
* If you cancel your session the same day of your appointment, and you are either willing and able to make up that session within the same week, or you are willing to have 2 sessions the following week, no fee will be applied
* If neither of the above apply, there will be a $50 cancellation fee.

No Shows:
* If at any time, you do not show up for your session, and do not call ahead, you will be charged the full session fee appropriated by your insurance carrier.

Account Fees/Balances:
* Any no show/cancellation fees applied to your account must be paid in full prior to your next session, or therapy may be suspended until the balance can be paid
* Balances will not be carried over from one week to the next unless specific arrangements have been made
* Any balances more than 30 days overdue, will be handled legally. Any outstanding balances may be sent to Collections, for which the Client/Guardian will then incur any fees associated with the Collections process.

MAINE CARE CLIENTELE

All of the above details apply; however, please be reminded and aware I am not permitted to charge you or Maine Care in the event that you do not show/cancel your scheduled session time.
Therefore, after 2 No Shows services will be terminated.

I have read and understand the terms of this policy. I agree to pay all fees as described in the agreement outlined above.

____ _______________ (signature of client/guardian, date)

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CLIENT INFORMATION

Please complete all information in entirety prior to your first session

Last Name_____________________________ First Name__________________ M.I.
_____________ Date of Birth: __________________ Social Security # _______________
Address: ____
Phone: Home - __________________________ Work/Cell -___________________________

Email Address: ____
School Attending: ____
Parent/Guardian Name: ____
Secondary Parent/Guardian Name and Address: (If Joint custody, please provide current information) Name: _______________________Address: ________________________

Phone: ______________ *Primary Insurance Carrier: _______________________________

Policy Holder's Name _______________________Place of employment: __________________

Relationship to Client ___________________Social Security # ___________DOB:_________

Insurance ID #: ________________________________ Group # ______________

* Prior to Initial Session, please contact your insurance company for Outpatient Mental Health approval. Ask for an authorization number, if you have a deductible, the amount due and what your co-pay/visit is:

Authorization #: _______________________# of sessions approved: _________Co-pay______

*Secondary Insurance Company (If applicable): ______________________________________
Insured Name: ___________________________ Relationship to client _____________________
Policy # __________________________ Group # _________________________ Copay ____
Primary Care Physician Name ____
Address: ____Phone: __________________
Names/ages of others in home ____
Presenting concerns: ____
Previously in counseling: YES/NO Current medications: ______________________Diagnosis: YES/NO

COVERAGE DISCLOSURE

Nicole Richman, LCSW **Karen Verdelli, LCSW**

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To 198 Main Clientele,

In an effort to provide you with the most comprehensive therapeutic care, Karen Verdelli and Nicole Richman would like to designate each other for emergency coverage in the event of vacation, sickness, unforeseen absence from work, or family emergency preventing us from seeing our clients as scheduled.

In so doing, we would like your permission to allow your Therapist to have available your contact information for the covering Therapist, should an event present itself that makes in impossible for your Therapist to contact you directly.

This release would allow the covering Therapist to contact you, the client or the client's guardian, to make you aware of any changes in scheduling.

In addition, if your Therapist is on vacation, the covering Therapist will be available for coverage in the event of a crisis that can not wait until the return of your Therapist.

Please know that only the least amount of information will be shared and any information shared will only be used to provide what is therapeutically necessary at that time. This information will in no way be shared with anyone else, for any reason, without your prior permission. In addition, this release will be valid for as long as you are an active client, and may be ended at any time if so chosen and put in writing.

Please initial:
_____ I give permission for my name and phone number to be shared in case of emergency only.

_____ Additionally, I give permission for my therapist to share only necessary information to provide treatment in case of emergency or in the absence of my therapist of record.

I give permission for my Therapist, Nicole Richman, LCSW to share my contact information with the covering clinician Karen Verdelli, LCSW in the event of an emergency that prevents Nicole Richman, LCSW from contacting me directly.

___________________________________ __________ (Client/Guardian Signature) (Date)

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The following is a summary of your rights as a recipient of outpatient (nonresidential) services under the Rights of Recipients of Mental Health Services. You have received a copy of the Rights of Recipients of Mental Health Services booklet from the DHHS, 11 State House Station, Augusta, ME 04333 (For Adults 287-4243, For Children 624-7900, or TTY 287-2000). If you are deaf or do not understand English, an interpreter will be made available to assist you understanding your rights.

1. **Basic Rights.** You have the same civil, human and legal rights, which all citizens are entitled. You have the right to be treated with courtesy, respect and dignity.

2. **Right to Confidentiality and Access to Records.** You have the right to have your records kept confidential; to be released only with your informed and signed consent. (Specific circumstances where the agency can release or share information as described in the Rights book.) You have the right to review your record at any reasonable time and to add written comments to clarify information you believe is inaccurate or incomplete.

3. **Right to an Individualized Treatment Service Plan.** You have the right to a written service plan, developed by you and your worker, based on your needs and goals. The plan must: be based on your actual needs, identify how a need will be met if the service is not available; include tasks to be completed and by whom; time frames for accomplishment of tasks and goals; and criteria to determine success. If you do not agree with the plan, you have the right to request and receive a second opinion. You have a right to a copy of the plan.

4. **Right to Informed Consent**. No service or treatment can be provided to you against your will. You have the right to be informed of possible risks and anticipated benefits of all services and treatment. You may designate a representative who is authorized to help you understand and exercise your rights, help you make decisions, or to make decisions for you. The guardian also has the right to be fully informed.

5. **Right to File a Grievance and Appeal.** You have the right, without retribution, to grieve any violation of your rights or a questionable practice. You have the right to a written response, including reasons for the decision. You may appeal any decision to the Department of Behavioral & Developmental Services. For assistance contact: Office of Advocacy, 60 State House Station, Augusta, Maine 04333 (287-2205) or Disability Rights Center, P.O. Box 2007, Augusta, Maine 04330 (1-800-452-1948).

My signature acknowledges that I have been offered a copy of the Rights of Recipients booklet and that I understand my Rights.

Client/Guardian: ______________________________ Date: ______________

Clinician: ______________________________ Date: ______________

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Consent to Use Health Care Information

Client Name: ____

Client #: _______

Clinician Name: ____

I understand that Nicole Richman, LCSW will make use of my health care information for purposes of treatment and other lawful functions of Nicole Richman LCSW's practice, including securing payment and other usual health care operations. I understand that this information may be available to person working on Nicole Richman LCSW's behalf, who will be subject to the same duty of confidentiality as Nicole Richman, LCSW with respect to any of my information.

I understand that if Nicole Richman, LCSW holds certain sensitive information related to my health care, such as:

Records covered by Federal rules governing confidentiality of alcohol and drug abuse treatment programs

Records covered by State rules governing mental health services
Records concerning my, or my child's diagnosis or treatment for HIV or AIDS

then my specific authorization will be required to disclose such information to others. However, I consent to use of such information by Nicole Richman, LCSW for purposes of my evaluation and treatment, and other lawful functions of Nicole Richman, LCSW's practice, including securing payment and other usual health care operations. I understand that such information may be made available to persons working on Nicole Richman LCSW's behalf, who will be subject to the same duty of confidentiality as Nicole Richman, LCSW with respect to such information. I understand that I may refuse to allow the sharing of some or all such information, but that refusal may result in improper diagnosis or treatment or other adverse consequences.

Signatures

Client (14 years and older): __________________________________Date: ___/___/___
Parent/Guardian: ____Date: ___/___/___
Witness: ____Date: ___/___/___

Notice of Privacy Practices Receipt and Acknowledgment of Notice

Patient/Client Name: ____

DOB: __________________________ SSN: ____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Nicole Richman, LCSW's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Nicole Richman, LCSW, 198 Main Street, Suite One, Gorham, Maine 04038.

· If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc).

Signature of Patient/Client Date

Signature of Parent/Guardian/Personal Representative Date

Patient/Client Refuses to Acknowledge Receipt: Signature of Staff Member

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Authorization
Contact by Telephone/Verbally in Event of Breach of PHI

I, ________________________________ [Insert Name of Patient/Client], authorize Nicole Richman, LCSW to provide notice to me by telephone or verbally in the event of a breach of my protected health information (PHI) by Karen Verdelli LCSW. Such conversation shall be documented by Karen Verdelli LCSW.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Final Rule modifying the HIPAA Privacy, Security, Enforcement and Breach Notification Rules, the verbal or telephonic notice provided to me pursuant to this authorization shall not be simply for the administrative convenience of Nicole Richman, LCSW.

Signature of Parent, Guardian or Personal Representative Date

____

Signature of Patient/Client Date

____

Signature of Parent, Guardian or Personal Representative Date